VALUEPartnerships
Better Care. Better Outcomes. Better Value.

Blue Cross Blue Shield of Michigan

2019-20 PCMH IG Updates

12/04/19

With NPO Comments 1/23/2020

PGIP Field Team, Value Partnerships
Blue Cross Blue Shield of Michigan

Applicable to All Capabilities

Any capability reported to BCBSM as "in place" must be in place and *in use by all appropriate members of the practice unit team on a routine and systematic basis, and, where applicable, patients must be able to use the capability.*

Must be able to demonstrate the capability is currently in use versus "can do" at the time of the reporting and site visit

Annually is defined as within the last 12 months.

Capability Demonstration

- All capabilities must be proven
- POs should inform practices that demonstration will be required for certain capabilities. Examples:
  - If the practice is asked to show the field team how patient contacts were tracked in the practice system for abnormal test results, the practice should have patient examples identified ahead of time and be prepared to discuss them with the field team during the site visit.
  - 5.2 – After hours – must have example in EHR or chart
  - Registries – must demonstrate active outreach via worksheets, medical record notes, contact log, tickler file, etc.

NO DOCUMENTATION EXAMPLES CAN BE PROVIDED AFTER THE SITE VISIT

NPO: Capabilities requiring training: Must document training (staff meetings, read & sign etc.) at least once/yr. New staff training must also be documented. Do not want to see training signed one week/month before site visit.

Summary of Changes

- Required Capabilities for PCMH Designation (15)
  - 10 New Required Capabilities (4.1, 4.3, 4.10, 4.12, 4.13, 6.6, 9.1, 9.2, 10.4, 13.1)
- Retired Capabilities
  - 16 Total Retired Capabilities
  - 7 Retired Capabilities in 2020 (*4.6*, 4.7, 8.9, 8.11, 13.8, 13.9, 14.2)
- New capabilities (12)
  - 2.24, 2.25, 2.26, 2.27, 3.19, 3.20, 3.21, 4.29, 5.11, 5.12, 9.10, 9.11

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SAD Tool Reporting Timeline

- For nominated PCPs to be considered for 2020 - 2022 designation (VBR that begins 9/1/2020)
  - 6 required capabilities must be in place at the January 2020 snapshot
  - 1.1, 4.6, 5.1, 6.2, 6.5, and 10.2.

- For nominated PCPs to be considered for 2022-2024 designation (VBR that begins 9/1/2022)
- All 15 required capabilities must be in place at the Spring 2021 snapshot
  - 1.1, 4.1, 4.3, 4.10, 4.12, 4.13, 5.1, 6.2, 6.5, 6.6, 9.1, 9.2, 10.2, 10.4, and 13.1

NPO: BCBSM changing timing on capability reporting. Rather than end of year, will be moving to Spring.

- ***If a practice does not have a required capability in place by the Spring 2021 snapshot, the practice will lose its designation at the time of the snapshot***

NPO: BCBSM is moving to a 2-year designation cycle, starting with this nomination that just occurred. BCBSM will be sharing details w/POs in February, but has verbally stated that annual site visits will continue.

Required Capabilities

- In 2018 we began requiring that practices have six core capabilities implemented in order to qualify for PCMH designation. In 2019 we have added 10 capabilities.
- Requiring them for designation will enable us to assure customers that every BCBSM PCMH-designated practice in Michigan has the foundational care processes that they and their employees expect from a high-value primary care practice.
- **Required capabilities are for PCMH designation and therefore applicable only to PCPs.**

PCMH Domain	PCMH Capability #	Description
Patient-Provider Partnership	1.1	Prepared to implement patient-provider partnership with each current patient
Individual Care Management	4.6	Systematic approach in place for appointment tracking and reminders
Extended Access	5.1	24-hour phone access to clinical decision-maker
Test Tracking	6.2	Process in place to ensure patients receive needed tests and practice receives results
Test Tracking	6.5	Systematic approach to ensure patients receive abnormal test results
Linkage to Community Services	10.2	PO maintains community resource database/central repository of community resources

NPO: If selected for site visit, expect to be asked about these.

Newly Required Capabilities

NPO: Must be in place by Spring 2021

PCMH Domain	PCMH Capability	Description
Individual Care Management	4.1	Practice and staff have been trained in PCMH and PCMH-N Models, Chronic Care models and practice transformation concepts
Individual Care Management	4.3	Evidence-based care guidelines are in use at the point of care by all team members of the practice unit
Individual Care Management	4.10	Medication review and management is provided at every visit
Individual Care Management	4.12	Appointment tracking and generation of reminders for all patients
Individual Care Management	4.13	Systematic approach to ensure follow-up for needed services
Test Tracking	6.6	Systematic approach for communicating abnormal results and receiving follow up care within defined timeframes
Preventive Services	9.1	Primary prevention program in place to identify and educate patients about personal health behaviors
Preventive Services	9.2	Systematic approach is in place to provide primary preventive services
Linkage to Community Services	10.4	Practice and staff have been trained on how to identify and refer patients to community resources appropriately
Coordination of Care	13.1	Notification of admit and discharge or other type of encounter, at facilities with which the physician has an ongoing relationship

Retired Capabilities

- In 2019, an additional 7 capabilities were retired.

PCMH Domain	PCMH Capability	Description
Individual Care Management	4.6	Systematic approach is in place for appointment tracking and generation of reminders for the patient population selected for initial focus
Individual Care Management	4.7	Systematic approach to ensure follow-up for needed services for patient population selected for initial focus
Electronic Prescribing	8.9	MAPS (renamed "PMP AWARxE") reports run prior to prescribing controlled substances
Electronic Prescribing	8.11	Controlled substance agreements are shared with all patient's care providers
Coordination of Care	13.8	Care coordination capabilities as defined in 13.1-13.7 are in place and extended to multiple populations
Coordination of Care	13.9	Coordination capabilities as defined in 13.1-13.7 are in place for all patients that need care coordination
Specialist Referral Process	14.2	Documented procedures in place to guide the specialist referral process

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New Capabilities

2.24

Registry is being used to manage patients identified as at-risk for future chronic conditions (e.g., pre-diabetes as evidenced by rising BMIs or, rising hemoglobin A1C, and assessment of relevant patient history, including medical, social, and hereditary factors) etc.) ***[Applicable to PCPs only]***

PCP Guidelines:

a. *Registry may be paper or electronic*
b. *Reference 2.1(a)-(g)*
c. *An example of a diabetes prevention program is available here from the CDC*

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info such as which screening tool was used to identify condition and related results from screening, along with next steps/treatment plan • How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care?	

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2.25

Registry is being used to identify patients with concerns related to social determinants of health, such as transportation limitations, housing instability, interpersonal violence, or food insecurity

PCP and Specialist Guidelines:

a. Registry may be paper or electronic
b. Reference 2.1(a)-(g)

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population • Registry should contain relevant clinical info such as which screening tool was used to identify condition and related results from screening, along with next steps/treatment plan	
• How is the info entered in the registry? • What do you do with it when you receive it, how do you address gaps in care?	

2.26

Social determinants of health data collected as part of 2.25 is shared routinely and electronically with the Michigan Institute for Care Management and Transformation

PCP and Specialist Guidelines:

a. Data sharing must be consistent with the guidelines set forth by the Michigan Institute for Care Management and Transformation (MICMT)
b. Visit the MICMT website for more information about data sharing guidelines

*MICMT is developing the ability to accept data by mid-year 2020

Required for PCMH Designation: NO	Predicate Logic: 2.25
PCMH Validation Notes for Site Visits	
• MICMT is able to verify that they receive actionable, properly formatted data from the practice; practice demonstrates the can send data to MICMT.	

2.27

Registry is being used to identify patients in need of advance care planning, to ensure conversations are tracked appropriately

PCP and Specialist Guidelines:

a. Registry may be paper or electronic
b. Reference 2.1(a)-(g)

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo the process of using the registry tool to identify the patient population. How do you define population that needs advance care planning? What are parameters (e.g., what is your target population for discussion about ACP? Why is that meaningful to your patient population?) • Registry should contain relevant clinical info such as which screening tool was used to identify condition and related results from screening, along with next steps • How is the info entered in the registry? • What do you do with it when you receive it, how do you address patients that have no completed advance care planning documentation?	

3.19

Performance reports are generated for the population of patients with: advance care planning needs

PCP and Specialist Guidelines:

- Reference 3.1
- Reference 2.27

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• The practice must demo how they are using these performance reports to improve population management. • Steps: 1) Are the relevant measures included in the performance reports? What is the patient population? 2) What sort of review is being done with these reports? o Percent of ACP completed and documented in HER o Percent of ACP not completed 3) What actions are taken?	

3.20

Performance reports are generated for the population of patients who are: at-risk for future chronic conditions (e.g., pre-diabetes as evidenced by rising BMIs, rising hemoglobin A1c, etc.)

PCP Guidelines:

- Reference 3.1
- Reference 2.24

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• The practice must demo how they are using these performance reports to improve population management. o What condition has been chosen? • Steps: 1) Are the relevant measures included in the performance reports? What is the patient population? 2) What sort of review is being done with these reports? 3) What actions are taken?	

3.21

Performance reports are generated for the population of patients with: concerns related to social determinants of health, such as transportation limitations, housing instability, interpersonal violence, or food insecurity.

PCP and Specialist Guidelines:

- Reference 3.1
- Reference 2.25

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• The practice must demo how they are using these performance reports to improve population management. • Steps: 1) Are the relevant measures included in the performance reports? What is the patient population? 2) What sort of review is being done with these reports? 3) What actions are taken?	

4.29

Physician organizations work with practices that employ Advanced Practice Providers, as outlined in the PGIP APP Acceleration Policy, and ensure consistency with attestation process and oversight responsibilities as described in section (g) in that document.

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Show team-based conference agendas including dates, patient lists, and EMR chart/note review • PO or PU provides dates of visits within the past year for purpose of verifying capabilities	

5.11

Provider has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs during at least 8 after-hours per week, located <u>within the provider's office</u>

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• 8 after-hours available (non-ED Urgent Care in the provider's office)	

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5.12

Provider has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs during at least 12 after-hours per week, located <u>within the provider's office</u>

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• 12 after-hours available (non-ED Urgent Care in the provider's office)	

9.10

Systematic approach is in place to screen for adult behavioral health disorders (e.g., substance abuse, depression, anxiety) for all patients

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo which evidence-based screening tools are routinely utilized, and how they are utilized • Provide examples in EHR of both positive and negative results. If positive, what does follow-up look like? Who on the care team is responsible for follow-up care, and how is that tracked?	

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9.11

Systematic approach is in place to screen for pediatric behavioral health disorders (e.g., autism, eating disorders) for all patients

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Demo which evidence-based screening tools are routinely utilized, and how they are utilized • Provide examples in EHR of both positive and negative results. If positive, what does follow-up look like? Who on the care team is responsible for follow-up care, and how is that tracked?	

Capability Clarifications

1.1

Practice unit has developed PCMH-related patient communication tools, has trained staff, and is prepared to implement patient-provider partnership with each current patient, which may consist of a signed agreement or other documented patient communication process to establish patient-provider partnership

**Intent is to define the partnership between the practice and the patient

Discussion should include:

- Must be a discussion – just handing out a flyer does not meet the intent of the capability
- Discussion should include, but are not limited to:
  - What it means to the patient being part of a PCMH PU
  - After hour access to the provider
  - Same day or tiered access appointments (if applicable)
  - Patient may receive outgoing phone calls, texts or emails regarding significant health needs that need to be addressed (TOC, UC/ED visits, gaps in care etc.)
  - The PU care team are partnering with the patient to improve the health outcomes

1.11

Practice has a regularly scheduled in-person new patient orientation that is distinct from a regularly scheduled visit, to set expectations about being a patient within that practice, and provide education about the value of a patient-centered medical home model

PCP and Specialist Guidelines:

- Orientation can be in a group setting and led by a mid-level provider, care team member (such as MSW, NP, PA, pharmacist, etc.), or nurse
- This should ideally be presented as a group "interview" between the practice and prospective new patients, to ensure a good fit
- Intended to be scheduled in advance as a group visit

**MAs cannot lead the group visit*

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Show agendas, patient handouts, meeting schedules for new patient orientation	

5.3 and 5.5

5.3

Provider has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs during at least 8 after-hours per week in a location different from the PCMH office, and after-hours provider has a feedback loop within 24 hours or next business day to the patient's PCMH

5.5

Practice Unit has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs in a location different from the PCMH office (as defined under 5.3), during at least 12 after-hours per week

- *Location must be different from the PCMH Office, but does not need to be an Urgent Care*

9.1

Primary prevention program is in place that focuses on identifying and educating patients about personal health behaviors to reduce their risk of disease and injury

- Counseling on isolated elements of prevention, such as tobacco cessation, does not meet the intent of this capability; only comprehensive primary prevention meets the intent.
- If this capability is being reported as in place for a specialist practice, the specialist must be addressing **all** primary prevention measures including colorectal screenings, mammograms, immunizations, etc.
- Update to PCMH Validation Notes for Site Visits

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9.7

Secondary prevention program is in place to identify and treat asymptomatic persons who have already developed risk factors or pre-clinical disease, but in whom the disease itself has not become clinically apparent; or tertiary prevention to prevent worsening of clinically established condition

- *Removed predicate logic for 9.1*
- *Updated Specialist Guidelines: only secondary preventive guidelines and testing recommendations that are applicable to the specialty type need to be addressed*
  - *May not be applicable to some specialty types*

10.5

Systematic team approach is in place for assessing and educating all patients about availability of community resources and assessing and discussing the need for referral

PCP and Specialist Guidelines:

a. Systematic process is in place for the practice unit team to educate new patients and all patients during annual exam (or other visits, as appropriate) about availability of community resources, and assessing and discussing the need for referral

**If this capability is reported as in place, there needs to be a proactive process for screening patients using a screening tool for social determinants of health

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Capabilities frequently reverted in 2019

NPO: If your practice has any of these in place, please be prepared that they will likely be selected for review during site visit.

Capability	FIP	NIP	# Reviewed	% Reverted	Description
10.5	33	14	47	30%	Assessing and educating all patients about availability of community resources
14.9	20	8	28	29%	PU regularly evaluates patient satisfaction with most commonly used specialists
4.18	8	3	11	27%	Assessing palliative care needs and ensuring patients receive needed palliative care services
2.2	14	5	19	26%	Registry incorporates substantial majority of health care services received at other sites for all established patients
2.9	10	3	13	23%	Registry is fully electronic, integrated with analytic capabilities
11.8	19	5	24	21%	Staff is trained in self-management support concepts, and regularly works with appropriate staff to actively use self-management support concepts
11.1	23	5	28	18%	Clinician is educated and familiar with self-management to ensure active use of self-management support concepts
4.2	16	3	19	16%	Integrated team of multi-disciplinary provideres to deliver coordinated care management services
8.8	35	6	41	15%	eRx for controlled substances
13.11	12	2	14	14%	Actively participating in Michigan ADT Initiative
9.6	26	4	30	13%	Written standing order protocols in place
3.4	20	3	23	13%	Data in performance reports has been fully validated
5.10	14	2	16	13%	Patient Education materials available in languages common to established patients

BCBSM Focus 2020

BCBSM continues to focus on processes that support the reduction of UC, ED and IP rates. **NPO:** These have been an NPO focus for many years.

- PDCM: Domain 4
  - Best practice: Team huddles every morning & select just one patient to focus on that needs more help or assistance
  - More opportunity for VBR
    - Simplified billing process & relaxation of PDCM codes
    - Making the CM process more sustainable
    - New capabilities added to improve opportunity for the PO and improve outcomes for the members

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BCBSM Focus 2020

- Access to Care: Capabilities 5.11 & 5.12
  - Education and re-education of patients on provider availability
    - Simple reminders such as the provider reminding the patient at the end of the visit to please call them instead of going to an UC or ED.
      - We have seen 3 different PUs that reduced their UC & ED numbers significantly because the provider & the check-out person, the last thing they said to the patient was “please call us anytime if you need something rather than going to the ED.” This is a no-cost fix to a big problem and it is giving the patient permission to “bother the doctor”.

- Coordination of Care
  - Ensuring that ADT information has a strong process & is being completed on a daily basis
  - Ensuring that a proactive reach out is occurring for TOC appointments
  - Working with CMs to focus on mid-high acuity Patients
  - Again, new VBR opportunities now available