

# 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.

NPO: Each year, BCBSM clarifies capability language as needed. Please review the 2020-2021 PCMH Guidelines for the capabilities the practice has in place and in use. Redline version easiest to see changes.





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# **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., conditions must be relevant to and managed by the practice reported as having fully in place.
  - Patient examples should be recent (within 12 months).

#### NO DOCUMENTATION EXAMPLES CAN BE PROVIDED AFTER THE SITE VISIT

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



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# **Summary of Changes**

# **Required Capabilities for PCMH Designation** (15)

Required Capabilities (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, 13.1)

NPO: BCBSM capability reporting now due Spring (first week of April) instead of the end of year, so NPO will be reaching out to you <u>very</u> soon.

#### **Retired Capabilities**

- Newly Retired Capabilities 2020 (4.29)
- 16 Total Retired Capabilities (1.9, 2.5, 4.6, 4.7, 4.29, 6.3, 8.9, 8.11, 12.1, 12.2, 12.8, 13.8, 13.9, 14.2, 14.3, 14.5, 14.10)

#### **New Capabilities** (6)

-2.28, 3.22, 5.13, 5.14, 5.15, 5.16





# **Required Capabilities**

- In 2021, practices are required to have fifteen (15) core capabilities implemented to qualify for PCMH designation.
- Requiring them for designation enables us to assure our 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, and must be Fully in Place as of the Spring 2021 Snapshot





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# **Required Capabilities**

PCMH Domain	PCMH Capability	Description
Patient-Provider Partnership	1.1	Prepared to implement patient-provider partnership with each current patient
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	4.6	Systematic approach in place for appointment tracking and reminders
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
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
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	10.2	PO maintains community resource database/central repository of community resources
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 2020, one (1) additional capability was retired – 4.29.

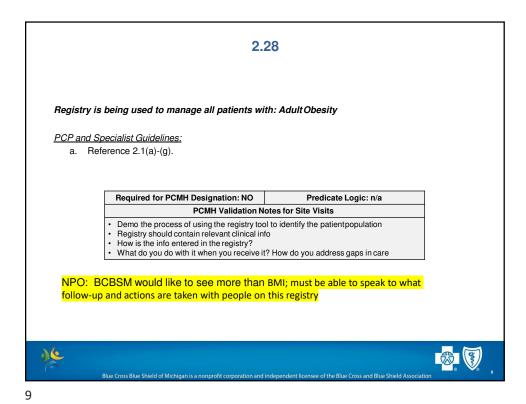
PCMH Domain	PCMH Capability	Description
Individual Care Management		Physician Organizations work with practices that employ Advance Practice Providers in the PGIP APP Acceleration Policy

• Total retired capabilities: 17



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Performance Reports are generated for the population of patients with: AdultObesity

PCP and Specialist Guidelines:

a. Reference 3.1

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

1) For each chronic condition are the relevant measures included inthe performance report?

2) What sort of review is being done with these reports?

3) What actions are taken?

Clinical Staff has been trained/educated about Unconscious Bias and a systematic approach is in place to train new hires and conduct additional training periodically [Applicable to PCPs only]

#### PCP Guidelines:

All clinical staff, excluding physicians, will complete training about unconscious bias. Content should include key concepts to understand and overcome unconscious bias.

- Licensed clinical staff will include but is not limited to:
   Advanced Practice Practitioners

  - Care Managers Medical Assistants iii.

  - Nurses
  - Pharmacists
  - Physician Assistants
  - vii. Social Workers
- Training/educational activity is documented in personnel or training records, and content material used for training is available for review
  - A process is in place to train all current staffinitially Training occurs at time of hire for newstaff

  - Additional training is required every 2 years
     Maintain completion certificate document (if available) in personnel record
- c. Training module must meet the following criteria:
  - Includes scientific basis for the existence and cause of unconscious bias
  - Addresses how unconscious bias can affect healthcare and influence treatment Provides resources to identify an individual's own bias and tools to overcome these biases
  - One example of a training module is provided by Stanford University and can be accessed at: https://stanford.cloudcme.com/default.aspx

Course name: Unconscious Bias in Medicine



NPO: BCBSM requirement that PCPs must take training by June 2021 to continue to receive VBR - ask Kris at NPO if questions



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# 5.14

Non-Clinical Staff has been trained/educated about Unconscious Bias and a systematic approach is in place to train new hires and conduct additional training periodically [Applicable to PCPs only]

#### PCP Guidelines:

All non-clinical staff will complete training about unconscious bias. Content should include key concepts to understand and overcome unconscious bias

- a. Non-clinical staff will include but is not limited to
  - Billing Specialists
    Call center personnel

  - Office Manager Receptionists
  - Scheduling personnel
- b. Training/educational activity is documented in personnel or training records, and content material used for training is available for review
  - A process is in place to train all current staffinitially Training occurs at time of hire for newstaff Additional training is required every 2 years

  - iv. Maintain completion certificate document (if available) in personnel record
- c. Training module must meet the following criteria:
  - Includes scientific basis for the existence and cause of unconscious bias
  - Addresses how unconscious bias can affect healthcare and influence treatment Provides resources to identify an individual's own bias and tools to overcome these biases
- d. One example of a training module is provided by Stanford University and can be accessed at: https://stanford.cloud-

Course name: Unconscious Bias in Medicine





Practice unit has a written Disaster Preparedness Plan and a Disaster Response Team. Practice staff are trained and educated on the Disaster Preparedness Plan and have defined roles and responsibilities within the Disaster Response Team. A competency assessment is completed and tracked. Practice unit has written operational guidelines for conducting business remotely in the event that the practice should remain closed due to unforeseen circumstances (e.g. COVID-19 pandemic)

#### PCP and Specialist Guidelines:

- a. Practice unit has a written Disaster Preparedness Plan. Topics include:
  - Communicating with patients; patient flow and triage; patient, practice, and staff safety and security; infection control
    including disinfection and sanitization protocols; inventory and resupply of PPE.
  - ii. Communicating with employees; stepwise approach to maintaining or re-opening the practice; employee pre-work self-screening; and patient pre-visit screening.
- b. Practice unit has identified their Disaster Response Team and has outlined roles and responsibilities for all members of the team, including the physician and APP.
  - i. Disaster Response Team includes: Disaster Coordinator and Planning Team (one member from each area)
- c. All practice team members, including the physician and APP have been trained and educated on the Disaster Preparedness Plan
- d. Practice unit has written operational guidelines for conducting business remotely during a disaster
  - i. Practice unit has written guidelines in place to run the practice remotely
  - ii. Practice unit has written telehealth policy
  - iii. Practice unit has defined staff roles and responsibilities while conducting patient visits remotely
  - iv. Practice has created a "return to work" checklist in the event that the practice has been closed for any amount of time





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# 5.16

# Practice Unit is inclusive and trained on specific needs of LGBTQ+patients

Practice unit is LGBTQ+ inclusive. Practice staff receives training on specific needs of LGBTQ+ patients and uses inclusive language on their forms and procedures.

# PCP and Specialist Guidelines:

- All practice unit team members are educated and trained on the specific healthcare needs of LGBTQ+ patients and unconscious bias concepts.
  - i. Examples of trainings include, but are not limited to: https://www22.anthem.com/lgbt/
  - http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=1025&grandparentID=534&parentID=940
- b. Practice has protections for patients and staff from discrimination based on sexual orientation and/orgender identity/expression.
- i. The non-discrimination policy should use inclusive terms (e.g. sexual orientation; " and "gender identity or expression)."
- c. All forms and procedures use inclusive language and include components such as:
  - Specific fields on all forms for patients to inform practice that they use a name and/or pronouns that are different from their legal name and sex.
    - Practice has specific procedures for handling these forms and for calling patients from the waiting room in agendernonspecific way that provides safety for patients.
  - Forms and procedures should be developed to ensure that a patient's gender, marital/partner status, and/orsexual
    activity is not assumed by forms or staffmembers.
  - iii. Practice conducts an annual assessment of all forms and procedures to ensure inclusivity.
  - iv. Examples of inclusive questions to use on forms, and additional information on incorporating LGBTQ+ inclusive care into your PCMH can be accessed at:
    - <a href="https://www.lgbtqiahealtheducation.org/wp-content/uploads/lmproving-the-Health-of-LGBT-People.pdf">https://www.lgbtqiahealtheducation.org/wp-content/uploads/lmproving-the-Health-of-LGBT-People.pdf</a>
  - <a href="https://www.lgbtqiahealtheducation.org/wp-content/uploads/Building-PCMH-for-LGBT-Patients-and-Families.pdf">https://www.lgbtqiahealtheducation.org/wp-content/uploads/Building-PCMH-for-LGBT-Patients-and-Families.pdf</a>

NPO: BCBSM still working on details – if your practice is interested in this capability, please let NPO know ASAP so we can consult BCBSM as needed



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# 2.13 - NPO Note

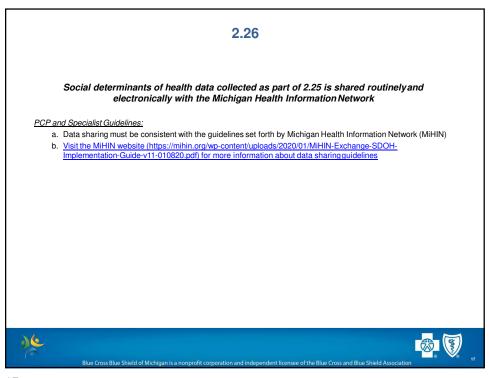
Registry includes at least 2 other conditions

#### **PCP Guidelines:**

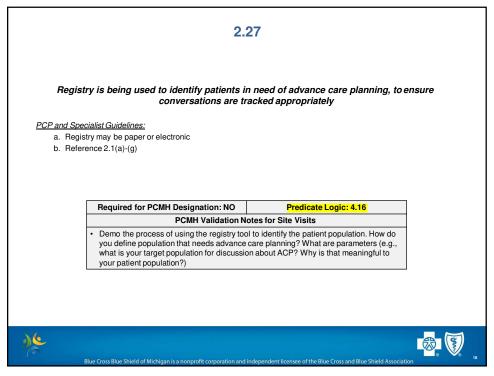
- a. Reference 2.1(a)-(g).
- b. Registry includes at least 2 other chronic conditions not addressed in other 2.0 capabilities for which there are evidence-based guidelines and the need for ongoing population and patient management, and which are sufficiently prevalent in the practice to warrant inclusion in the registry based on the judgment of the practice leaders
- i Examples of other chronic conditions include (but are not limited to) depression in adults, sickle cell anemia, hypertension, hyperlipidemia, anxiety
- c. Managing patient adherence to a medication is not considered a condition and does not meet the intent of this capability

NPO: Tracking and or monitoring patient PT INR levels for Coumadin use, for example, is not considered a condition and does not meet the intent of the capability





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A systematic approach is in place for tracking patients' use of advance care plans, including engaging patients in conversation about advance care planning, executing an advance care plan with each patient who wishes to do so and including a copy of a signed advance care plan inthe patient's medical record, and where appropriate conducting periodic follow-up conversations with patients who have not yet executed an advance care plan

#### Specialist Guidelines:

- a. Specialist(s) must have systematic process in place to communicate with PCP and identify who has lead responsibility for discussing and assisting each patient with advance care planning
  - i. Advance care planning may not be appropriate for with patients visiting for routine, basiccare
  - ii. Training and information about advance care planning is available from the Centers for Disease Control and through a number of healthcare organizations
- Specialist must have systematic process in place to track care plans distributed to patients and returned to specialist, and where appropriate, to conduct periodic follow-up conversations with patients who have not yet executed an advance care plan
- c. Practice unit must be actively engaged in the education, development, and support of the advance care blan





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# 6. 4 NPO Note

Mechanism is in place for patients to obtain information about normal tests

PCP and Specialist Guidelines:

a. Patients are informed about how to access normal test results

b. Process may use any of the following mechanisms:

i. Phone call, text, or other secured messaging from practice to patient

ii. Mail from practice

iii. Direct conversation with patient

iv. Patient access via secure web portal (in conjunction with one of the above options for patients without internet access)

v. Telling patients that "no news is good news" does not meet the intent of this capability; verbally telling patients to call a number without providing written instructions does not meet the intent of this capability. Patients must have clear understanding of how to obtain information about normal test results.

Required for PCMH Designation: NO Predicate Logic: n/a PCMH Validation Notes for Site Visits

- Discussion of how patients are notified (phone, mail, email, portal).
- Demo with an example letter sent to patient and documentation in Patient Chart/Registry/EHR. If done through patient portal, practice will walk through the process of how info is transmitted from paper to portal.

NPO: Reminder card or business card was removed from the guideline definition - If the reminder or business card gives the patient a direct timeframe within which to call (within a week etc.) can be used with clear instructions

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At least one member of PO or practice unit is formally trained through completion of a nationally or internationally-accredited program in self-management support concepts and techniques, and regularly works with appropriate staff members at the practice unit to educate them so they are able to actively use self-management support concepts and techniques.

#### PCP and Specialist Guidelines:

- $a. \quad \text{Training for self-management techniques should include:} \\$ 
  - i. Motivational interviewing
  - Health literacy/identification of health literacy barriers
  - iii. Use of teach-back techniques
  - iv. Identification of medical obstacles to self-management
  - v. Establishment of problem-solving strategies to overcome barriers of immediate concern to patients
  - vi. Systematic follow-up with patients
- b. Practices should seek structured information/approaches/processes, which can be from any legitimate source
- c. Self-management training of the practice unit staff must be provided directly by the individual(s) certified ascompleting the formal self-managementtraining
  - Note: Not meeting this requirement is a "train the trainer" model, where, for example, a PO staff person who has completed a formal self-management training program subsequently trains practice consultants, who in turn train practice unit staff., does not meet the requirements for this capability.
  - Examples of training programs include that meet the criteria are available from the PGIP Care Management Resource Center at:

    https://micmt-cares.org/training/patient-engagement

    - https://www.miccsi.org/training/
    - https://www.selfmanagementresource.com/programs/online.programs/chronic-disease/
    - https://www.ncoa.org/healthy-aging/chronic-disease/chronic-disease-self-management-programs/
    - https://www.cdc.gov/arthritis/interventions/self\_manage.htm



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# 12.6

#### Patients actively participate in Telehealth and Virtual E-visits

### PCP and Specialist Guidelines:

- a. POs and/or Practice Units have developed and implemented protocol for responding to patient messages/requests for e-visits in a consistent and timely manner (e.g., a triage system), using structured online
- b. POs and/or Practice Units have developed and implemented HIPAA-compliant tools and processes for providing telehealth services
- c. Practice appropriately documents the date of the telehealth encounter and the details of the encounter in the
- d. Please refer to the AAFP guidelines for e-visits for more information. The guidelines are available here:



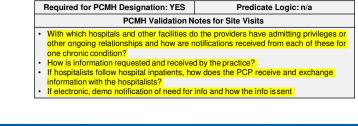


#### 13.1- REQUIRED

For patient population selected for initial focus, mechanism is established for being notified of each patient admit and discharge or other type of encounter, at facilities with which the physician has admitting privileges or other ongoing relationships

#### PCP and Specialist Guidelines:

- a. Standards for information exchange have been established among participating organizations to enable timely follow-up with patients.
- Facilities must include hospitals, and may include long-term care facilities, home health care, and other ancillary providers.



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# 13.2

Process is in place for exchanging necessary medical records and discussing continued care arrangements with other providers, including facilities, for patient population selected for initial focus

# PCP Guidelines:

- a. Patients are encouraged to request that their practice unit be notified of any encounter they may have with other health care facilities and providers (for example, SNFs, rehab facilities, non-primary hospitals)
- b. Practice units are responsible for ensuring that other providers have relevant medical information in a timely manner necessary to make care decisions

#### Specialist Guidelines:

- a. Specialists systematically request that patients provide name of PCP
- b. Patients are encouraged to request that their PCP be notified of any encounter they may have withother health care facilities and providers (for example, SNFs, rehab facilities, non-primary hospitals)
- Practice units are responsible for ensuring that other providers have relevant medical information in a timely manner necessary to make care decisions

Required for PCMH Designation: NO Predicate Logic: n/a
 PCMH Validation Notes for Site Visits
 For other providers/facilities with whom the PCP does not have admitting privileges or other ongoing relationships, how is information exchanged between the provider/facility and the PCP?





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# 13.4 - NPO Note

Process is in place to systematically flag for immediate attention any patient issue that indicates a potentially time-sensitive health issue for patient population selected for initial focus

#### PCP and Specialist Guidelines:

a. For example, home monitoring of CHF patient indicates weight gain, or diabetes patient is treated for cellulitis in ER, or a CHF patient has a change in mental health status

Required for PCMH Designation: NO Predicate Logic: n/a

**PCMH Validation Notes for Site Visits** 

- •Provide examples of high-risk triage patient situations (i.e. patient calls w/high glucose, weight gain).
- •What is the process during and after office hours?

NPO: Note the addition of "after office hours". Show how these patients are flagged to make sure someone follow up the next day if applicable. An example is if provider tells patient someone from Home Health Care will be contacting patient tomorrow, what is follow-up to ensure this happens?





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# 13.6

Process is in place to coordinate care with payer case manager for patients with complex or catastrophic conditions

# PCP and Specialist Guidelines:

- a. Process may be directed by PO or practice unit
- b. Process should include ability to respond to and coordinate with payor case managers when the patient is enrolled in formal case management program
- c. Process should include ability to contact health plan case managers when, in the clinician's judgment, unusual circumstances may warrant the coverage of non-covered services, particularly to avoid inpatient admissions or use of other higher-cost services

Required for PCMH Designation: NO		Predicate Logic: n/a
	PCMH Validation N	Notes for Site Visits
•	Process for case management coordination	tion: BCBSM and BCN members is 1-800-
	845-5982, Blue Cross Complete is-888-28	288-1722
•	Discuss process for referrals to case mana	nagers





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Practice has written procedures and/or guidelines on care coordination processes, and appropriate members of care team are trained on care coordination processes and have clearly defined roles within that process

#### PCP and Specialist Guidelines:

- a. Written procedures and/or guidelines are developed for each phase of the care coordination process
- b. The procedures or guidelines are developed by either the PO or practice unit
- c. Training/education of members of care team are conducted by either the PO or practice
- d. Training occurs at time of hire for new staff, and is repeated at least annually for all staff

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	Required for PCMH Designation: NO	Predicate Logic: n/a
	PCMH Validation N	otes for Site Visits
•	SNF).	providers, home care, rehab, acute hospital,
•	Provide staff training log which shows train	ning has been completed within 12 months



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# 13.11

#### Practice is actively participating in the Michigan statewide Admission, Discharge, Transfer (ADT) **Notification Use Case**

- a. POs and/or practice unit maintains and submits a monthly all-patient list to MiHIN's Active Care Relationship Service
- (ACRS) in accordance with MiHIN's use case specifications
  The practice has a process for managing protected health information in compliance with applicable standards for privacy and security.
- The practice connects information received through the statewide HIE process with clinical processes, such as
- transition of care management following hospitalization.

  d. The practice appropriately documents receipt of notification of ED and inpatient admission on the day of admission or within the following 2 calendar days. Documentation must include the date the notification was received.

#### Required for PCMH Designation: NO Predicate Logic: n/a **PCMH Validation Notes for Site Visits** What is the process for managing protected health information in compliance with applicable standards for privacy and security?. Who accesses the ADT information and howoften?

- How does the practice connect information received through the HIE process with clinical processes, such as transition of care management following hospitalization?. What is the practice's patient outreach process after an ED visitor
- IP visit (include timeframe)? Provide example: The practice appropriately documents receipt of notification of ED and inpatient admission on the day of admission or within the following 2 calendar days. Documentation must include the date the notification was received.



NPO: "2 calendar days" - weekends are exception so if practice receives ADT Friday evenings, the practice expected to respond next business day

#### Practice is actively participating in the Michigan statewide Exchange CCDA Use Case

#### PCP and Specialist Guidelines:

- a. The practice connects discharge information received through the statewide HIE process with clinical processes, such as transition of care management following hospitalization.
- b. The practice has a process for managing protected health information in compliance with applicable standards for privacy and security.
- c. The practice appropriately documents receipt of discharge information in the patient medical record on the day of discharge or within the following 2 calendar days. Documentation must include the date the notification was received.
- d. MiHIN Use case was previously referred to as the "Medication Reconciliation" use case.

Required for PCMH Designation: NO Predicate Logic: 13.11

 PCMH Validation Notes for Site Visits

 Provide an example of documentation of receipt of discharge information in the patient medical record on the day of discharge or within 2 calendar days.

Documentation must include the date the notification was received.

 Discuss the process: who accesses the discharge information, how often, and how the information is used.





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# **14.11 NPO Note**

When patient has self-referred to specialist, specialist obtains information from patient about PCP and informs PCP of patient's visit, so PCP follow-up can be conducted

#### PCP Guidelines:

a. PCP conducts follow-up with patients who have self-referred to specialist

#### Specialist Guidelines:

a. Specialist routinely notifies PCP of visits when patients have self-referred

Required for PCMH Designation: NO Predicate Logic: n/a PCMH Validation Notes for Site Visits

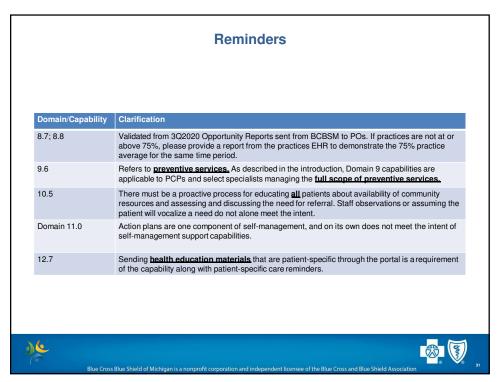
- PCP demonstrates examples of patient follow-up.
- Discuss how the PU would follow up with the patient and SCP or PCP when this situation occurs.

NPO: Would expect that PCP would follow up with patient as needed





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Capability	Times Reviewed	Times Reverted	Reason
8.8	20	5	PU was not at 75% or greater on the 3Q2019 Opportunity Report or did not have a PU report from EHR
9.6	35	3	
8.7	59	3	PU was not at 75% or greater on the 3Q2019 Opportunity Report or didnot have a PU report from EHR
4.9	2	2	
13.12	3	2	
10.3	52	2	PU did not demonstrate collaborative two-way relationship with community resource
11.4	2	1	
12.4	2	1	
2.20	3	1	
11.5	6	1	
4.21	7	1	
**T	his year the	Field Team	reverted 1% of capabilities reviewed