2020-2021
Patient-Centered Medical Home (PCMH) Interpretive Guidelines Updates

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., **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

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)

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 <u>PCPs, and must be Fully in Place as of the Spring 2021 Snapshot</u>**

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	4.29	Physician Organizations work with practices that employ Advance Practice Providers in the PGIP APP Acceleration Policy

- Total retired capabilities: 17

New Capabilities

2.28

Registry is being used to manage all patients with: Adult Obesity

PCP and Specialist Guidelines:

a. 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 • 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	

3.22

Performance Reports are generated for the population of patients with: Adult Obesity

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 in the performance report? 2) What sort of review is being done with these reports? 3) What actions are taken?	

5.13

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.

a. Licensed clinical staff will include but is not limited to:
   i. Advanced Practice Practitioners
   ii. Care Managers
   iii. Medical Assistants
   iv. Nurses
   v. Pharmacists
   vi. Physician Assistants
   vii. Social Workers

b. Training/educational activity is documented in personnel or training records, and content material used for training is available for review
   i. A process is in place to train all current staff initially
   ii. Training occurs at time of hire for new staff
   iii. 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:
   i. Includes scientific basis for the existence and cause of unconscious bias
   ii. Addresses how unconscious bias can affect healthcare and influence treatment
   iii. 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-cme.com/default.aspx
   Course name: Unconscious Bias in Medicine

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
   i. Billing Specialists
   ii. Call center personnel
   iii. Office Manager
   iv. Receptionists
   v. Scheduling personnel

b. Training/educational activity is documented in personnel or training records, and content material used for training is available for review
   i. A process is in place to train all current staff initially
   ii. Training occurs at time of hire for new staff
   iii. 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:
   i. Includes scientific basis for the existence and cause of unconscious bias
   ii. Addresses how unconscious bias can affect healthcare and influence treatment
   iii. 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-cme.com/default.aspx
   Course name: Unconscious Bias in Medicine

5.15

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:
    i. 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

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:

a. 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/or gender 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:
   i. 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 a gender-nonspecific way that provides safety for patients.
   ii. Forms and procedures should be developed to ensure that a patient's gender, marital/partner status, and/or sexual activity is not assumed by forms or staff members.
   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:
      - https://www.lgbtqiahealtheducation.org/wp-content/uploads/Improving-the-Health-of-LGBT-People.pdf
      - https://www.lgbtqiahealtheducation.org/wp-content/uploads/Building-PCMH-for-LGBT-Patients-and-Families.pdf

Capability Clarifications

2.26

Social determinants of health data collected as part of 2.25 is shared routinely and electronically with the Michigan Health Information Network

PCP and Specialist Guidelines:

a. Data sharing must be consistent with the guidelines set forth by Michigan Health Information Network (MiHIN)
b. Visit the MiHIN website (https://mihin.org/wp-content/uploads/2020/01/MiHIN-Exchange-SDOH-Implementation-Guide-v11-010820.pdf) for more information about data sharing guidelines

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: 4.16
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?)	

4.16

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 in the 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, basic care
   ii. Training and information about advance care planning is available from the Centers for Disease Control and through a number of healthcare organizations
b. 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 plan**

11.8

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. Training for self-management techniques should include:
   i. Motivational interviewing
   ii. 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 as completing the formal self-management training
   i. 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.
   ii. 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

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 tools.
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 patient's medical record.
d. Please refer to the AAFP guidelines for e-visits for more information. The guidelines are available here: https://www.aafp.org/about/policies/all/virtual-visits.html

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.
b. Facilities must include hospitals, and may include long-term care facilities, home health care, and other ancillary providers.

Required for PCMH Designation: YES	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• With which hospitals and other facilities do the providers have admitting privileges or other ongoing relationships and how are notifications received from each of these for one chronic condition? • How is information requested and received by the practice? • If hospitalists follow hospital inpatients, how does the PCP receive and exchange information with the hospitalists? • If electronic, demo notification of need for info and how the info is sent	

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 with other health care facilities and providers (for example, SNFs, rehab facilities, non-primary hospitals)
c. 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?	

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 Notes for Site Visits	
• Process for case management coordination: BCBSM and BCN members is 1-800-845-5982, Blue Cross Complete is-888-288-1722 • Discuss process for referrals to case managers	

13.7

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

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Provide written procedure or guidelines for care coordination process with clearly defined roles of care team members (i.e. providers, home care, rehab, acute hospital, SNF). • Provide staff training log which shows training has been completed within 12 months	

13.11

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

PCP and Specialist Guidelines:

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
b. The practice has a process for managing protected health information in compliance with applicable standards for privacy and security.
c. 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 how often? • 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 visit or 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.	

13.12

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.	

Reminders

Domain/Capability	Clarification
8.7; 8.8	Validated from 3Q2020 Opportunity Reports sent from BCBSM to POs. If practices are not at or above 75%, please provide a report from the practices EHR to demonstrate the 75% practice average for the same time period.
9.6	Refers to **preventive services.** As described in the introduction, Domain 9 capabilities are applicable to PCPs and select specialists managing the **full scope of preventive services.**
10.5	There must be a proactive process for educating **all** patients about availability of community resources and assessing and discussing the need for referral. Staff observations or assuming the patient will vocalize a need do not alone meet the intent.
Domain 11.0	Action plans are one component of self-management, and on its own does not meet the intent of self-management support capabilities.
12.7	Sending **health education materials** that are patient-specific through the portal is a requirement of the capability along with patient-specific care reminders.

Frequently Reverted Capabilities 2020

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 did not 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	

**This year the Field Team reverted 1% of capabilities reviewed