2022-2023 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

Payment for each capability that is implemented in the payment time-frame will be made for practices that are already existing practices. Payment will not be made for new practices or existing practices that are reporting capabilities for the first time.

Annually is defined as within the last 12 months.

Capability Demonstration

- Capabilities for site visits are randomly selected from the Fall (October) Snapshot
- All capabilities must be verified by either demonstration or documentation
- 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**
- Required documentation must be from the site visit practice and completed. Templates, tip sheets and training documents will not be accepted for validation

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
  - 17 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)
- 1 New capability
  - 9.15

New Capability

9.15

A systematic process is in place to screen adult patients for cardiovascular disease (CVD) risk using evidence-based guidelines.

*PCP Guidelines (**applicable to PCPs only**):*

a. Practice has a written process for **screening adult patients** for CVD risk using evidence-based guidelines and an evidence-based tool
   i. Resource: Integrating cardiovascular disease risk calculators into primary care (ahrq.gov) (https://www.ahrq.gov/sites/default/files/wysiwyg/evidencenow/heart-health/cvd-risk-calculator.pdf)
b. Practice has a systematic process used at point of care
c. Systematic process is in place for conducting follow up on high-risk screening results
d. Process is in place for conducting future screenings

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Which evidence-based guidelines were used, i.e.: USPSTF, ACC, AHA? • Describe the population based on the guidelines used (I.e.: age range) • Demo the point of care process using an evidence-based screening tool • Provide examples from the patient record of both negative and positive results • Provide examples from the patient record of the follow-up process for positive results • Provide timeframe for future screenings	

Capability Clarifications

1.10

Providers have an established process for repeating Patient-Provider Partnership discussion.

PCP and Specialist Guidelines:

a. Providers have an established process for repeating Patient-Provider Partnership discussion, particularly with non-adherent patients and patients with significant change in health status.
b. Providers track date of Patient-Provider Partnership discussion and repeat discussion at least every 2-3 years.

Clarification:
Practice should provide examples of patient repeat PPP discussion

1.12

Practice establishes a Patient and Family Advisory Council to better understand patient and caregiver perspectives, and how those perspectives can be used to optimize patient care

PCP and Specialist Guidelines:

a. For more information on creating a Patient and Family Advisory Council, review this module from
b. the American Medical Association: https://www.stepsforward.org/modules/pfac.
c. Cannot be solely hospital-based.
d. Patients on committee must be current patients of the practice or their family members.

Clarification: The PFAC may be part of a health system's council, but it is critical that there is sufficient patient/family representation from each practice, and discussion should be practice-specific.

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

Clarification:

Removed requirement for sharing among all care partners from 4.16 because it is present in 4.22

9.13

Systematic approach in place to screen adult patients 65 and over or when clinically appropriate for reducing the risk of falling and for monitoring physical activity

PCP and Specialist Guidelines:

a. Screening tool should include yearly assessment sheet regarding fall risk.
   i. Examples of acceptable tools may include https://www.cdc.gov/steadi/pdf/STEADIBrochure-StayIndependent-508.pdf.
   ii. Practice must have a scripted discussion with the patient about fall risk.
b. Approach for fall risk should include education related to fall prevention or treating problems with balance and walking.
   i. Discuss balance problems, falls, difficulty walking and other fall risks.
   ii. Suggest cane or walker use.
   iii. Check blood pressure with patient standing, sitting, and reclining.
   iv. Suggest exercise, physical or occupational therapy.
   v. Suggest vision/hearing test.
   vi. Perform bone density screening, especially for high-risk members.
   vii. Discuss home safety
      - *https://www.cdc.gov/steadi/pdf/STEADI-Brochure-CheckForSafety-508.pdf*

Clarification:
Added home safety to guideline, updated screening tool reference to Stay Independent (cdc.gov). Specified the age range for screening (65+).

9.14

Systematic approach in place to screen adult patients 30 and over or when clinically appropriate to identify those with bladder control issues

PCP and Specialist Guidelines:

a. Practice must have a scripted discussion yearly regarding bladder control and if bladder control is a problem. Also, discuss when it has been a problem and other symptoms that may be accompanying this problem (for adult patients only).
    i. Discuss treatments for bladder control issues that may arise as patient ages, such as behavioral therapy, exercises, medications, medical devices, or surgery.
    ii. Provide educational brochures and materials such as conversation starters.
b. Approach for improving bladder control should include education related to bladder incontinence.
    i. Discuss how leaking of urine impact daily activities or interferes with sleep.
    ii. Discuss urgency and frequency of elimination.

Clarification:

Clarified ***adult patients 30 and over or when clinically appropriate***

10.4

All members of practice unit care team involved in establishing care treatment plans have received training on community resources and on how to identify and refer patients appropriately

PCP and Specialist Guidelines:

a. Training may occur in collaboration with community agencies that serve as subject-matter experts on local resources.
b. Training occurs at time of hire for new staff and is repeated at least annually for all staff.
c. Practice unit care team is trained to empower and encourage support staff to alert them to patient's possible psychosocial or other needs.
d. PO or Practice Unit administrator assesses the competency of Practice Unit staff involved in the resource referral process at least annually. This may occur in conjunction with community agencies.
    i. For example, practice unit staff are able to explain process for identifying and referring (or flagging for the clinical decision-maker) patients to relevant community resources.
    ii. Practice Unit is able to demonstrate that training occurs as part of new staff orientation

Reminder:

Practice should provide staff training sign in sheets for validation

12.7

Providers are routinely using patient portal to electronically send automated care reminders and health education materials

PCP and Specialist Guidelines:

a. Both types of communications must be occurring.
b. An automated care reminder is a patient-specific communication, such as a reminder about gaps in care.
c. Information must be actively transmitted to patients (not merely available on website).

Clarification:

- Health education materials must accompany the care reminder about gaps in care.
- Reminder and education materials must be specific to the patient.

Other Reminders and Announcements

Reminders

- Please remember to revert any capabilities in the SAD tool that were reverted at site visits
- Practices that have a required capability reverted or go below the required minimum of 50 capabilities will be at-risk to lose PCMH Designation if the required capabilities and the minimum of 50 capabilities are not put back in place **by the Fall cycle (nomination cycle) prior to the PCMH Designation process**
- Capabilities 8.7 and 8.8 are not paid capabilities, however they do count toward the 50 total capabilities that are needed for designation
- Domain 9
  - 9.1 PCP and SCP-*Applicable ONLY TO co-managing specialty providers (Cardiology, Pulmonology, Endocrinology, Nephrology, Oncology and OB/Gyn)*
  - 9.2 SCP- Applies to full range of primary preventive services (for example, an ob-gyn ensuring patients receive mammograms and pap tests, but not flu shots, would not meet the intent of this capability).
    - Must be **actively assessing gaps in care and be an active participant in closing gaps**, i.e., referring for preventive care directly or referral to PCP to address and actively participate in follow up.

2023 PCMH Site Visits

- ***Time frame:*** April – September
- ***Format:*** Returning to in-person site visits at the practice unit location
- ***Documentation:***
  - Documentation will not be required prior to the visit.
  - POs will not receive the list of capabilities ahead of the visit. Practices should be prepared during the site visit to demonstrate and provide patient examples for any of the capabilities that are reported as in place as of the Fall 2022 snapshot.
- ***Notification:*** POs will receive notification of selected practices in March
- ***Volume:*** Each PO will receive a minimum of 3 PUs

At-Risk Populations VBR Opportunity

Capability	Key Requirements	Adult & Family	Pediatrics
5.13	• Unconscious bias training for clinical staff • Process for new hires and training every 2 years • Documentation of completed training	Required	2 of 3 fully in place
5.14	• Unconscious bias training for non-clinical staff • Process for new hires and training every 2 years • Documentation of completed training	Required	
5.16	• Training on specific healthcare needs of LGBTQ+ patients and unconscious bias concepts • Non-discrimination policy inclusive of sexual orientation and gender identity • Inclusive procedures and language on forms – assessed annually	Required	
9.10	• Systematic approach to screen for ***adult*** behavioral health disorders annually • Comprehensive screening includes all conditions deemed relevant to practice's patient population • Screening tools are evidence-based • Process to follow up on positive results • Process to educate patients on BH resources	1 of 2 fully in place	N/A
9.11	• Systematic approach to screen for ***pediatric*** behavioral health disorders annually • Comprehensive screening includes all conditions deemed relevant to practice's patient population • Screening tools are evidence-based • Process to follow up on positive results • Process to educate patients on BH resources		Required
9.12	• Systematic approach to screen high risk patients aged 50-77 for lung cancer • Assessment tool includes number of packs per day and number of years the patient has smoked • Process in place to complete low-dose CT screen for patients identified as high risk	Required	N/A
9.13	• Systematic approach to screen adult patients 65+ for fall risk and monitoring physical activity at least annually • Evidence-based screening tool and scripted discussion regarding fall risk and monitoring physical activity • Process in place to follow up with high-risk patients	Required	N/A
9.14	• Systematic approach to screen adult patients 30+ and when clinically appropriate for bladder control issues • Scripted discussion regarding bladder control issues, including patient education.	Required	N/A

QUESTIONS?

Appendix

Required Capabilities

As of April 2021, practices must have fifteen core capabilities implemented to qualify for PCMH designation.

Requiring them enables 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 PCP practice.

PCMH Domain	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	4.10	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