2023-2024 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.

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

  - 3 Newly Retired Capabilities (4.28, 8.7, 8.8)

  - 20 Total Retired Capabilities (1.9, 2.5, 4.6, 4.7,4.28, 4.29, 6.3, 8.7, 8.8, 8.9, 8.11, 12.1, 12.2, 12.8, 13.8, 13.9, 14.2, 14.3, 14.5, 14.10)

- 6 New capabilities

  - 2.30, 3.24, 5.17, 5.18, 9.16, 9.17

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

New Capabilities

2.30

Registry is being used to manage all patients with: Chronic Obstructive Pulmonary Disease (COPD)

<u>PCP and Specialist Guidelines :</u>

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 information. - How is the information entered in the registry? - How is the registry list used to address gaps in care for patients with COPD?	

3.24

Performance reports are generated for the population of patients with: Chronic Obstructive Pulmonary Disease (COPD)

PCP and Specialist Guidelines :
a. Reference 3.1(a)-(g).

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. • Are the relevant measures included in the performance reports? • What sort of review is being done with these reports? • What actions are taken?	

5.17

Practice unit has inclusive policies and procedures that ensure LGBTQ+ patients have access to affirming care

PCP and Specialist Guidelines :

a. To support an inclusive and affirming environment for LGBTQ+ patients, practice unit has inclusive policies, processes, and procedures to support their LGBTQ+ patients.
b. Practice has protections for patients from discrimination based on sexual orientation, gender identity, and gender expression.
   i.   The non-discrimination policy should use inclusive terms (e.g., sexual orientation, gender identity or expression).
c. Practice unit's policies, processes, and procedures are inclusive for LGBTQ+ patients.
   i.   Examples of inclusive processes and procedures include, but are not limited to:
      - Collecting sexual orientation and gender identity (SOGI) information, including how to answer patient questions
      - Avoiding procedures that might assume gender identity (e.g., calling patients from a waiting room using Mr./Mrs.)
      - Using preferred name instead of legal name, if different.
      - Documenting SOGI, pronouns, preferred name in patient chart or EHR
      - Data privacy – sharing SOGI information, confidentiality for minors (per state laws)
      - Regular review and updating of forms, policies, and procedures to ensure continued inclusivity and appropriateness.
      - Inclusive outreach scripting on sex-specific gaps in care (e.g., breast cancer, cervical cancer, or prostate cancer screenings)
      - Connecting patients to LGBTQ+ community resources
      - Collecting, monitoring, and responding to patient feedback regarding inclusivity
   ii.   Practice conducts regular assessment of all policies and procedures to ensure inclusivity.

5.17 *(continued)*
Practice unit has inclusive policies and procedures that ensure LGBTQ+ patients have access to affirming care

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
- Provide documentation of written non-discrimination policy - Provide documentation of written procedures that support an inclusive environment for patients - Discuss the regular review process of assessing written procedures. How often is review done? How does the practice ensure the procedures are up to date and appropriate? - How is staff trained on changes?	

5.18
Practice unit has forms that use inclusive language to ensure LGBTQ+ patients have access to affirming care

PCP and Specialist Guidelines :

a. To support an inclusive and affirming environment for LGBTQ+ patients, practice unit has forms and documents that use inclusive language.

b. Paper and electronic forms use inclusive language and include components such as:
   i. Where appropriate, forms include specific fields for patients to indicate:
      - Gender identity
      - Sexual orientation
      - Sex assigned at birth
      - Pronouns
      - Chosen name (if different than legal name)
   ii. Forms 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. Inclusive language is used where applicable.
      - References to parents, caregivers and family should be general.
      - Remove assumptions of marital status or sexual activity (e.g., assuming female patients have a male partner)

Consider replacing...	With inclusive language, such as...
He/she	They, the patient, the provider, etc.
Mother/Father	Parent(s)/Guardian(s), Blood Relative (when taking family history)
Husband/Wife	Spouse/Partner(s)
Biologically Male/Female	Assigned male/female at birth

c. Practice conducts regular assessment of all forms to ensure inclusivity.

5.18 *(continued)*
Practice unit has forms that use inclusive language to ensure LGBTQ+ patients have access to affirming care

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
- Provide examples of forms that use inclusive language and have fields for patients to indicate preferred name and pronouns - Discuss the regular review process of assessing forms. - How often is review done? - How does the practice ensure the forms are up to date and appropriate?	

9.16

Secondary prevention program is in place to identify and screen symptomatic adult patients who are at risk for developing Chronic Obstructive Pulmonary Disease (COPD) [Applicable to Family Medicine and Internal Medicine practices only]

PCP Guidelines :

a. Practice has a written process for identifying and screening patients who are at risk for developing COPD using an evidence-based tool. Resource used by INHALE CQI: 2023 GOLD Report - Global Initiative for Chronic Obstructive Lung Disease - GOLD (goldcopd.org).

b. Screening should be performed on patients with clinical indicators, i.e.: dyspnea, chronic cough, recurrent wheezing, recurrent lower respiratory infections, etc.

c. Screening should be performed on patients with a history of tobacco smoke exposure and/or work and environmental exposure history.

d. Systematic process is in place for conducting follow-up on positive screening for COPD.

e. Practice establishes point of care alerts to provide additional screenings for ongoing assessments.

f. Practice has a written procedure for administering spirometry tests or referral to have tests completed.

   i. If spirometry is performed in the practice, practice clinical staff has completed training on administering spirometry tests upon hire, and training is repeated annually.

   ii. Training resource example - **https://www.lung.org/professional-education/training-certification/spirometry-training**

9.16 *(continued)*
Secondary prevention program is in place to identify and screen symptomatic adult patients who are at risk for developing Chronic Obstructive Pulmonary Disease (COPD) [Applicable to Family Medicine and Internal Medicine practices only]

Required for PCMH Designation: NO	Predicate Logic: 9.5
PCMH Validation Notes for Site Visits	
- Provide written process and procedures - Provide spirometry training resources used for staff and training log with dates, if spirometry is performed in the practice - Demonstrate evidence-based screening tool - Provide patient example from documentation in EHR - Demonstrate follow-up for positive screening results	

9.17

Systematic approach is in place to screen patient's caregivers for post-partum depression at well child visits in the first month of life and at the 2-month, 4 month and 6-month visits [Applicable to family and pediatric practices only]

<u>PCP Guidelines :</u>

a. Systematic process is in place to screen caregivers of infants utilizing established behavioral health screening tools (e.g., PHQ-9 or Edinburgh Postpartum Depression Score (EPDS))
    i. Systematic process is in place for following up on any positive screening results including referral to OBGYN provider, PCP, behavioral health provider or community resources.
        ▪ Recommended site for more information: Postpartum Support International - PSI
    ii. Systematic process is in place to ensure caregiver completed the referral process.

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 • Demo workflow • Provide examples of community resources	

Capability Updates

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

<u>PCP and **Specialist Guidelines**</u>:

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

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

5.16

All practice unit staff is trained on providing inclusive and affirming care to LGBTQ+ patients

<u>PCP and Specialist Guidelines:</u>

a. To support an inclusive and affirming environment for LGBTQ+ patients, all practice unit team members are educated and trained on the specific healthcare needs of LGBTQ+ patients and unconscious bias concepts.
    i.   Potential training topics include but are not limited to:
        - LGBTQ+ health disparities
        - Implicit bias and how it affects care for LGBTQ+ people
        - Effective and affirming communication
        - Creating a welcoming environment
        - Sexual orientation and gender identity (SOGI) data collection, confidentiality and privacy
        - Unique health needs/considerations of LGBTQ+ people (including differences in sub-populations)
        - LGBTQ+ mental health
        - Social determinants of health and community resources for LGBTQ+ people
        - Caring for transgender patients
    ii. All staff employed by the practice unit must complete training. Third-party contracted team members who interact with patients (e.g., billing company) represent the practice and are encouraged but not required to complete training.
    iii. Clinical and non-clinical staff may need to complete different trainings to ensure it pertains to their specific job duties.
    iv. Examples of training websites include, but are not limited to:
        - National LGBTQIA+ Health Education Center, Fenway Institute - https://www.lgbtqiahealtheducation.org/
        - OutCare Health - https://www.outcarehealth.org/training/
        - GLMA Health Professionals Advancing LGBTQ+ Equality - https://www.glma.org/education.php
        - https://mydiversepatients.com/le/lgbt/home.html
b. Training/educational activity is documented in personnel or training records, and content material used for training is available for review.
    i.   Process is in place to ensure new staff receive training.
    ii. Process is in place to ensure all staff receive training updates on LGBTQ+ health and affirming care topics every 1-2 years.

5.16 *(continued)*
All practice unit staff is trained on providing inclusive and affirming care to LGBTQ+ patients

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Provide documentation of staff training completion within the past 2 years. What training sources were used? • Discuss process of training, review educational materials used, and documentation of training.	

Other Reminders
and Announcements

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

- Practice screening for community resource needs- during site visits we often hear our population has no real needs, they are affluent, and we have a connected community. The expectation is the practice is using tools and resources to screen their patient populations for needs other than clinical needs that will impact success with the plan of care. Social needs cross all communities.

- For domain 10 capabilities to be fully in place, the practice should have a culture of supporting patient social needs and all practice staff are educated on resources and referral options for patients in need.

- Consider Social Prescribing referrals for patients in need (see next slide)

10.4 *(continued)*

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

Social prescribing emphasizes co-creating solutions with clients, staff and community providers. Health care professionals work together with individuals to connect them to services based on identified social needs which are typically provided by volunteers and the community sector. For example, social prescriptions could include art and dance classes, supportive peer networks, cooking classes, caregiver supports, volunteering roles, gardening, communal dining programs, bereavement support groups, etc.

- Suggested resource: https://www.oha.com/Bulletins/Social%20Prescribing.pdf

Domain 5 for Specialists

- **5.3** - As applies to SCP-*Applicable ONLY to those specialists who refer their patients to urgent cares after hours.*

- **5.4** - As applies to SCP-*Applicable ONLY to those specialists who refer their patients to urgent cares after hours.*

- **5.5** - As applies to SCP-*Applicable ONLY to those specialists who refer their patients to urgent cares after hours.*

- **5.11 and 5.12** - *Applicable ONLY to those practices who provide after hours URGENT CARE services WITHIN the practice*

Reminders

- Please remember to revert any capabilities in the SAD tool that were reverted at 2023 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.**
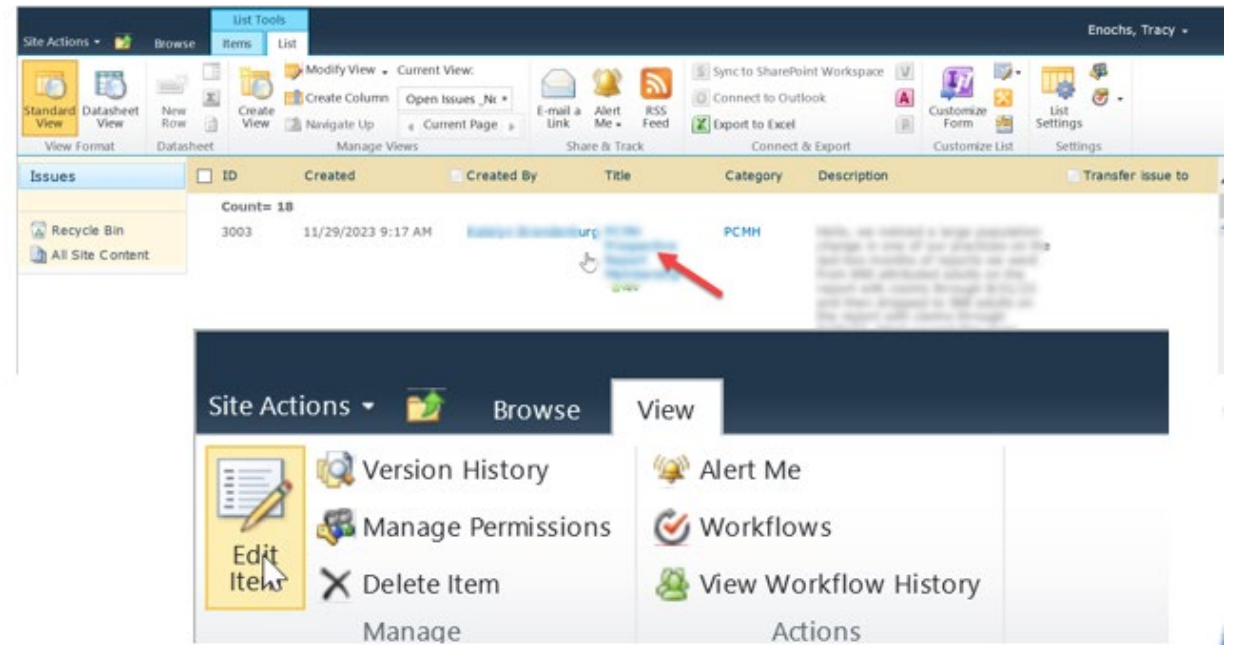
Issue Log Submission Reminders

- Do <u>not</u> store, share, or post any personally-identifiable information ("PII") or protected health information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") or other applicable state or federal law, on the PGIP issue log.

- Please select a category for your issue (Examples: PCMH, PDCM, CQI) instead of OTHER (default). Subject matter experts are copied on all issue log tickets based on the category selected.

- POs Field Representative receive notification of all issue log submissions for their assigned POs.

Issue log submissions can be modified by:
- Open the PO collaboration site and find your issue
- Click on the Title to open the issue
- Click Edit
- Update the comments and attach any additional documentation
- Click the Save button at the bottom of the page.
- Both the initiator and the designated owner will receive an email

2024 PCMH Site Visits

- **Time frame:** April – September

- **Format:** In-person site visits at the practice unit location

- **Documentation:**

  - Selected documents for REQUIRED capabilities will be collected one week prior to visit. More information on next slide.

  - POs will <u>not</u> 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 2023 snapshot.

- **Notification:** POs will receive notification of selected practices in March.

- **Volume:** Each PO will receive a minimum of 3 site visits.

2024 PCMH Site Visits

Capability	Requested Documentation
1.1	Patient Provider Partnership tool provided to patients (e.g., flyer, brochure, etc.)
4.1	Staff Education (staff sign-off <u>not</u> required)
6.2, 6.5, 6.6	Complete Test Tracking Policy

Documentation Update for 2024 Site Visits: BCBSM is implementing a process to obtain certain documentation for required capabilities prior to site visit.

- **Documentation will <u>not</u> be used to validate the capability before the site visit.**
- Only the documents listed above are requested. Please no patient examples.
- Documents may be sent via email.
- Information can be sent anytime between notification of scheduled site visit and 1 week prior to site visit.

Reviewing requested documentation prior to visit will eliminate some down time during visit and enable more time allotted to reviewing barriers, opportunities, and best practices within PGIP practices.

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	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

Register now for the virtual workshop: Inclusive care for LGBTQ+ older adults

Blue Cross Blue Shield of Michigan is partnering with **Michigan LGBTQ+ Elders Network (MiGEN)**
- MiGEN is an organization that provides services, advocacy, and connection to LGBTQ+ people ages 45 and older in Michigan along with training and resources.
- There are more than 68,000 LGBTQ+ people aged 65 and up living in Michigan, many who often feel unsafe or unwelcome when accessing care.

Register by visiting the [Upcoming Webinars](#) page of the [Patient Experience Site](#)
- **Part 1 on January 31, 2024 from 12:00 pm – 12:45 pm**
  - Focuses on foundational concepts regarding the LGBTQ+ older adult population by introducing terminology, creating awareness of historical context of key communities within the LGBTQ+ population, and exploring challenges such as discrimination, health, and services among varying communities.
- **Part 2 on February 6, 2024 from 12:00 pm-12:45 pm**
  - Focuses on practical ways to make your medical practice feel like a more safe space for the LGBTQ+ population by discussing use of inclusive language in intake forms, confidentiality in the intake process, and engagement strategies for both in-person and phone interactions.

This workshop is 90 minutes total and meets the following training requirements:
- Education requirements for **Patient-Centered Medical Home capability 5.16**.
- Michigan Public Health Code / LARA requirements for Implicit Bias professional development for medical professionals seeking license renewal.
- CME credits are available for physicians.
- CEUs are available for medical assistants and social workers, and contact hours for nurses.
- A general certificate of completion and implicit bias credit will also be available to participants.

For more information, please email PatientExperience@bcbsm.com

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