VALUEPartnerships
Better Care. Better Outcomes. Better Value.

Blue Cross Blue Shield of Michigan

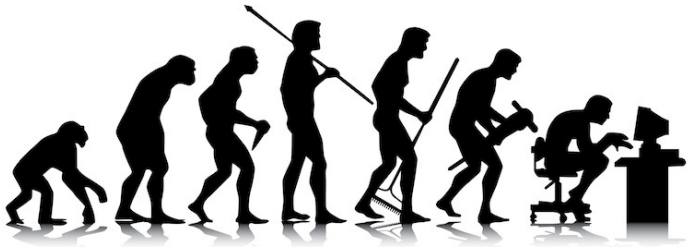
2017-18 PCMH IG Updates

10/30/17

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

Program Evolution

- The PCMH program must evolve to meet the needs of BCBSM, our customers and their members.
- This will require substantive changes to the program over time.
- Existing capabilities will change, substantially in some instances.
- We recognize that the modification of existing capabilities may be frustrating. Nonetheless, these changes are necessary to ensure that the program remains relevant.



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".

Capability Demonstration

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

NO DOCUMENTATION EXAMPLES CAN BE PROVIDED AFTER THE SITE VISIT

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Summary of Changes

- IG Layout Changes
- Required Capabilities (6)
- Retired Capabilities (6)
- New capability (1)

Changes to the IG Layout

- The Interpretive Guidelines continue to evolve, and in this version we are including "PCMH Validation Notes," which are examples of the ways in which a practice may be asked to demonstrate that capabilities are in place during the site visit validation process. Please note that these are just illustrative examples; during the actual site visit a practice may be asked different or additional questions.
- Example: 4.2

Required for PCMH Designation: NO	**Predicate Logic: n/a**
PCMH Validation Notes for Site Visits	
• Multidisciplinary team (include RN, DM educators, etc.), regular team meetings, travel teams, ongoing communication w/ PU • Have office describe team and condition addressed • Must be a multi-disciplinary team (min of 3 with RN). Examples of structured communication between team-members on planned intervals.	

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Required Capabilities

- In 2018 we plan to begin requiring that practices have six core capabilities implemented in order to qualify for PCMH designation.
- These six core capabilities are relevant to all PCP practices and are central to a patient's PCMH experience. Requiring them for designation will enable us to assure customers that every BCBSM PCMH-designated practice in Michigan has the foundational care processes that they and their employees expect from a high-value primary care practice.

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

Retired Capabilities

- Starting in 2018, capabilities are retired when they no longer require substantive time and or resources to implement, due to the evolution of practice transformation.

PCMH Domain	PCMH Capability #	Description
Patient-Provider Partnership	1.9	Health care information is shared among care partners as necessary.
Registry	2.5	Registry identifies individual practitioners
Test Tracking	6.3	Process is in place for ensuring patient contact details are kept up to date
Patient Portal	12.1	Available vendor options for purchasing and implementing a patient web portal system have been evaluated
Patient Portal	12.2	PO or Practice Unit has assessed liability and safety issues with portal
Specialist Referral	14.5	Practice Unit or designee ensures patients are scheduled for specialist appointments in timely manner

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New Capability

- 12.14 - Practice routinely uses patient portal to prepare patient for planned visits, alerting patients to needed tests that can be done in advance, gathering information about questions and issues patients would like to discuss

Required for PCMH Designation: NO	Predicate Logic: n/a
PCMH Validation Notes for Site Visits	
• Provide examples of alerts or questionnaire	

Capability Clarifications

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2.20

- *2.20 - Registry contains advanced patient information that will allow the practice to identify and address disparities in care*

- Registry contains relevant advanced patient demographics, as listed in the guidelines (a minimum of four out of seven).
  - primary/preferred language
  - measures of social support (e.g., caretaker for disability, family network)
  - disability status
  - health literacy limitations
  - type of payer (e.g., uninsured, Medicaid)
  - relevant behavioral health information (e.g., date of depression screening and result)
  - social determinants of health such as housing instability, transportation limitations, food insufficiency, risk of exposure to violence

4.10

Medication review and management is provided at every visit for all patients with conditions requiring management

- *PCP Guidelines:*
- At a minimum, medication review and management is provided by clinical decision-maker at every visit for all patients with chronic conditions.
  - Chronic conditions under 4.10 are defined as any condition requiring maintenance drug therapy.
  - During every patient encounter, a list of all medications currently taken by the patient is reviewed and updated, and any concerns regarding medication interactions or side effects are addressed.
    - **Adjustments are made during every encounter to ensure list is current and matches current clinical needs, and any medication discrepancies or contraindications are resolved by a clinician**

4.14

- ***Planned visits are offered to all patients with chronic conditions (or, for some specialists, all sub-acute conditions) prevalent in practice population***

  – Added language from 4.8 clarifying expectations of planned visits (see guidelines)

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***

Interpretation clarification

- Advance Care Planning; conversation with patients, documentation, and demonstration of follow-up to patients who have been given advance care planning but have not returned paperwork.

4.22

Provider initiating advance care plan in 4.16 ensures that all care partners are aware of and have copies of advance care plan

PCP and Specialist Guidelines:

- Provider with lead responsibility must ensure that all care partners are aware of and have copies of advance care plan
- When all practitioners are on a common EHR platform, there must be a systematic approach such as a flag or other notification mechanism to ensure all providers are aware that an advance care plan is in place

Domain 5 – Extended Access

- Goal: All patients have timely access to health services that are patient-centered and culturally sensitive and are delivered in the most appropriate and least intensive setting based on the patient's needs. Practice must be routinely referring non-emergent patients to after-hours care, whether located at the practice site or another urgent care center (i.e., specialist practices that always send patients to ED do not meet the criteria for having after-hours care capabilities in place).

5.1

Patients have 24-hour access to a clinical decision-maker by phone, and clinical decision-maker has a feedback loop within 24 hours or next business day to the patient's PCMH

- *PCP and Specialist Guidelines:*
- Clinical decision-maker must be an M.D., D.O., D.C., licensed psychologist, P.A., or N.P. If not M.D. or D.O., clinical-decision maker must have ability to contact supervising

5.3

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

- For urgent care centers, after-hours care is defined as additional evening (or early morning) and weekend availability (not 9 am- 5 pm) beyond the standard BCBSM urgent care participation agreement, which requires urgent care centers to be open at minimum 5-8 pm weekdays and 6 hours per day on Saturday and Sunday

8.8

Electronic prescribing system is routinely used to prescribe controlled substances

- *PCP and Specialist Guidelines:*
- All practitioners routinely use an e-prescribing system to prescribe controlled substances
  - When possible, EHR or other automated system should be set to default to e-prescribing
  - At least 75% of controlled substance prescriptions should be electronic

- The field team may choose to review the rates prior to the site visit and evaluate the capability accordingly

9.4

- ***Practice has process in place to inquire about a patient's outside health encounters and incorporates information obtained from those sources about relevant preventive services in patient tracking system or medical record***

- ****This is a change – this is not appropriate for most specialist offices, especially those that do not co-manage key chronic conditions****

10.3

PO in conjunction with Practice Units has established collaborative relationships with appropriate community-based agencies and organizations

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- *PCP and Specialist Guidelines:*
- **Practice** or PO in collaboration with practice is able to provide a list of organizations providing services relevant to their patient population in which collaborative, ongoing relationships are directly established

****Practice MUST have active role****

Capabilities frequently reverted in 2017

Cap	% REV
4.2	62%
12.6	60%
12.11	60%
11.4	57%
5.8	56%
4.18	44%
10.5	41%
3.6	40%
12.4	36%
2.17	33%
12.7	33%
4.16	31%
14.9	30%

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