BCBSM
Physician Group Incentive Program

Patient-Centered Medical Home and Patient-Centered Medical Home-Neighbor Domains of Function

Interpretive Guidelines

2015-2016
V1.0

4.0 Individual Care Management

Goal: Patients receive organized, planned care that also empowers them to take greater responsibility for their health

Applicable to PCPs and specialists (specialist practice must have lead responsibility for care management for at least a subset of patients for a period of time; e.g., oncology care manager has lead responsibility for patients when they are in active chemotherapy). For patients with an ongoing care relationship with a specialist, PCP and specialist must establish agreement regarding who will have lead responsibility for care management.

To receive credit for an individual care management capability, basic care management delivered in the context of office visits must be available to all patients. Advanced care management, delivered by trained care managers in the context of provider-delivered care management services, is expected to be available only to those members who have the provider-delivered care management benefit.

To facilitate phased implementation of capabilities, providers may select a subset of their patient population for initial focus for capabilities 4.2, 4.5, 4.6, 4.7, 4.8, and 4.9

4.1
Practice Unit leaders and staff have been trained/educated and have comprehensive knowledge of the Patient-Centered Medical Home and Patient Centered Medical Home-Neighbor models, the Chronic Care model, and practice transformation concepts

PCP Guidelines:

a. Training content should include comprehensive information about the Chronic Care Model
    i. Reference information provided at the Improving Chronic Illness Care website: http://www.improvingchroniccare.org
b. Training/educational activity is documented in personnel or training records, and content material used for training is available for review.
c. Process is in place to ensure new staff receive training
d. Process is in place to ensure all staff are apprised of changes in the PCMH and PCMH-N Interpretive Guidelines, and of the capabilities that have been implemented by the practice

Specialist Guidelines:

a. Training content should include comprehensive information about the Chronic Care Model and population management, and its relevance to specialists
    i. Reference information provided at the Improving Chronic Illness Care website: http://www.improvingchroniccare.org
b. Training/educational activity is documented in personnel or training records, and content material used for training is available for review
c. Process is in place to ensure new staff receive training
d. Process is in place to ensure all staff are kept apprised of changes in the PCMH and PCMH-N Interpretive Guidelines, and of the capabilities that have been implemented by the practice

4.2

Practice Unit has developed an integrated team of multi-disciplinary providers and a systematic approach is in place to deliver coordinated care management services that address patients' full range of health care needs for the patient population selected for initial focus

PCP and Specialist Guidelines:

a. The integrated team of multi-disciplinary providers must consist of at least 3 non-physician members, including an RN and at least 2 of the following (composition of team may vary depending on the needs of individual patients): certified diabetes educator, nutritionist (RD or Masters-trained nutritionist), respiratory therapist, PharmD or RPH, MSW, certified asthma health educator or other certified health educator specialist (Bachelor's degree or higher in Health Education), licensed professional counselor, licensed mental health counselor, or an NP and/or PA with training/experience in health education who is actively engaged in care coordination/self-management training separate from their office visit E&M duties
    i. When they are unable to include RNs or PharmDs in the multi-disciplinary care management team, individual practices may use LPNs or PharmD students, in which case these ancillary providers with lesser training must be actively supervised by the physician and/or by a supervising RN or PharmD, with regard to the educational and care management interventions provided to each individual patient. This supervision must be provided either directly in the practice (e.g., by the primary care physician) or by staff employed by the Physician Organization.
b. Practice unit team members hold regular team meetings and/or other structured communications about patients whose conditions are being actively managed.
c. All members of the team do not have to be at the same location or at the practice site, but care delivered by the team must be coordinated and integrated with the practice.
    i. When care is delivered by travel teams or at sites other than the practice:
        - The care must be fully coordinated by a practice team member or a health navigator who has ongoing communication with the practice
        - The PCMH/PCMH-N practice must be involved in ongoing monitoring, follow-up and reinforcement of health education/training received by patients at other sites
            - Monitoring includes proactive outreach to engage the patient in actively addressing ongoing health needs and health care goals on a longitudinal basis
    ii. The multi-disciplinary providers are not required to be employees of the PCMH/PCMH-N practice, but must have an ongoing relationship with, and communication with, the practice team members
        - Communication can be a combination of verbal, written, and electronic methods, preferably including some direct verbal communication and participation in in-person team meetings, although individual team members who are not on-site at a practice can make their information and perspective known to specific team members so that their information about individual patients is actively considered by the team as a routine part of case review and planning
    iii. The care management services must be coordinated and integrated with the patient's overall care plan

- The requirements for capability 4.2 can be met through referrals to hospital-based diabetes educators that take place in the context of an overall coordinated, integrated care plan and include bi-lateral communication between the diabetes educator and care management team, with individualized feedback provided to the care team following the diabetes education sessions. Diabetes educator and care team collaborate to ensure that referred patients receive needed services, and that patients understand that they should follow-up with PCMH practice regarding questions and concerns.
- Standard referrals to hospital-based diabetes educators with summary reports sent back to the PCP do not constitute care that is coordinated and integrated, and would not meet the requirements for capability 4.2

d. Tools such as Interactive Voice Response systems may be helpful in coordinating transition care and managing patients with chronic conditions.

4.3

Systematic approach is in place to ensure that evidence-based care guidelines are established and in use at the point of care by all team members of the Practice Unit

PCP Guidelines:

a. Guidelines are available and used at the point of care by all clinical staff in the Practice Unit
    i. Guidelines are activated and used regularly to provide alerts about gaps in care on the Point of Care report or in the EMR
b. All members in the practice, including front office staff who work with clinicians and patients, are knowledgeable about the type and length of appointments to book and their responsibilities for preparing resources for visits, based on the guidelines
    i. Guidelines are actively used to monitor, track, and conduct outreach to patients to schedule care as needed
c. Guidelines are used by PO to evaluate performance of physicians, Practice Units, and PO.

Specialist Guidelines:

a. Evidence-based care guidelines may be those developed by specialist societies
b. Guidelines are available and used at the point of care by all clinical staff in the Practice Unit
    i. Guidelines are activated and used regularly to provide alerts about gaps in care on the Point of Care report or in the EMR
c. All members in the practice, including front office staff who work with clinicians and patients, are knowledgeable about the type and length of appointments to book and their responsibilities for preparing resources for visits, based on the guidelines
    i. Guidelines are actively used to monitor, track, and conduct outreach to patients to schedule care as needed
d. Guidelines are used by PO to evaluate performance of physicians, Practice Units, and PO.

4.4

PCMH/PCMH-N patient satisfaction/office efficiency measures are systematically administered

PCP Guidelines:

a. Patient satisfaction and office efficiency measures (e.g., patient waiting time to obtain appointment, office visit cycle time, percentage of no-show appointments) are monitored
    i. Measures must be derived from surveys conducted by the office or from information provided by health plans, the PO, or other sources
        - Surveys do not need to focus on a specific chronic condition, provided they capture information relevant to all chronic conditions, such as asking about whether the primary practitioner discusses health care goals, diet and exercise, and supports the patient in achieving health management goals
    ii. Reference information at Institute for Healthcare Improvement: http://www.ihi.org/IHI/Topics/OfficePractices/Access/Measures/
    iii. Results must be quantified, aggregated, and tracked over time
b. If office is not meeting standards for patient-centered care, follow-up occurs (e.g., process improvements are implemented; efficiencies are improved; practice culture is addressed)

Specialist Guidelines:

a. Patient satisfaction and office efficiency measures (e.g., patient waiting time to obtain appointment, office visit cycle time, percentage of no-show appointments) are monitored
    i. Measures must be derived from surveys conducted by the office or from information provided by health plans, the PO, or other sources
    ii. Surveys should capture information relevant to all patients managed by the specialist
    iii. Reference information at Institute for Healthcare Improvement: http://www.ihi.org/IHI/Topics/OfficePractices/Access/Measures/
    iv. Results must be quantified, aggregated, and tracked over time
b. If office is not meeting standards for patient-centered care, follow-up occurs (e.g., process improvements are implemented; efficiencies are improved; practice culture is addressed)

[Please see Patient Registry** and **Performance Reporting Initiatives for clinical monitoring expectations]

4.5

Development and incorporation into the medical record of written action plan and goal-setting is systematically offered to the patient population selected for initial focus, with substantive patient-specific and patient-friendly documentation provided to the patient

PCP and Specialist Guidelines:

a. Physicians and other practice team members are actively involved in working with patients to use goal-setting techniques and develop action plans
    i. Goal-setting should focus on specific changes in behavior (e.g., walking around the block once a day) or concrete, tangible results (e.g., losing 2 pounds) rather than general clinical goals (such as lowering blood pressure or reducing LDL levels)
b. Patient-specific action plan and patient's individual goals must be documented in medical record, enabling providers to monitor and follow-up with patient during subsequent visits

c. Reference information provided at the Improving Chronic Illness Care website: http://www.improvingchroniccare.org/index.php?p=self-management_support&s=39

4.6

A systematic approach is in place for appointment tracking and generation of reminders for the patient population selected for initial focus

PCP and Specialist Guidelines:

a. Evidence-based guidelines are used systematically as a basis for:
    i. Conducting tracking and follow-up regarding missed appointments
    ii. Providing patients with mail and/or telephone reminders of upcoming appointments

4.7

A systematic approach is in place to ensure that follow-up for needed services is provided for the patient population selected for initial focus

PCP and Specialist Guidelines:

a. Evidence-based guidelines are used systematically as a basis for:
    i. Following up with patients to ensure that needed services, whether at the PCMH/PCMH-N practice site or at another care site, are obtained by the patients

4.8

Planned visits are offered to the patient population selected for initial focus

PCP and Specialist Guidelines:

a. Planned visits consist of a documented, proactive, comprehensive approach to ensure that patients receive needed care in an efficient and effective manner.
    i. Planned visits include the well-orchestrated, team-based approach to managing the patient's care during the visit, performed on a routine basis, as well as the tracking and scheduling of regular visits, and the guideline-based preparation that occurs prior to the visit.
b. Reference information provided at the Improving Chronic Illness Care website: http://www.improvingchroniccare.org/index.php?p=Planned_Visits&s=48
c. "Many healthcare providers believe themselves to already be doing 'planned' visits. They note that their patients with chronic conditions come back at defined intervals. Yet upon closer inspection, these visits may look a lot like acute care: the provider might lack necessary information about the patient's care needs; provider and patient might have different expectations for the visit; and staff may not be fully utilized to help with the organization of the visit and delivery of care. These "check-back" visits, while scheduled in advance, are often not efficient nor productive for the provider and patient.
d. Key Components of a Planned Visit
    i. Assign Team Roles and Responsibilities
        - For example, the following questions might need to be addressed: who is

going to call the patient to schedule the visit? Who will room the patient? If the patient has diabetes, who will remove her/his shoes and socks? Who

during the visit? All tasks need to be delegated to specific team members so that nothing is left to chance.

ii. Call a Patient in For a Visit
   - Develop a script for the call, and decide which team member will make the call. Set the tone and expectations for the issues addressed in the visit.
   - If you choose to mail an invitation to patients, be sure to track respondents. Typically, less than 50% of patients respond to a letter. You will need to plan an alternative method of contacting non-responders.

iii. Deliver Clinical Care and Self-Management Support
   - In preparation for the visit, print an encounter form from your registry or pull the chart in advance so that you can review the patient's care to date. Document what clinical care needs to be done during the visit.

iv. Until new roles are well integrated into the normal work flow, many practices have team huddles for 5-10 minutes…to review the schedule and identify chronic care patients coming in that day for an acute care visit. Decide how best to meet as a team to manage these patients. Determine the best intervals and timing for these meetings, and stick to them. The brief get-togethers help the team stay focused on practice redesign and create a spirit of 'one for all'."

4.9

Group visit option is available for the patient population selected for initial focus (as appropriate for the patient)

PCP and Specialist Guidelines:

a. Reference AAFP information on group visits at: http://www.aafp.org/fpm/20060100/37grou.html
b. Group visits are a form of office visit. (They are not the same as care coordination/care management services, which are follow-up services delivered by non-physician clinicians antecedent to an office visit at which individual treatment and/or health behavior goals have been established.)
c. Group visits include not only group education and interaction but also all essential elements of an individual patient visit, including but not limited to the collection of vital signs, history taking, relevant physical examination and clinical decision-making.
   i. Group visits differ from other forms of group interventions, such as support groups, which are generally led by peers and do not include one-on-one consultations with physicians.
d. The clinician is directly involved and meets with each patient individually
   i. NP or PA may conduct both the clinical and educational/group activity components of the group visit
e. Members of the care management team may take vital signs and other measurements and assist with individual encounters
f. Dietitians or pharmacists may lead educational sessions. Topics such as medication management, stress management, exercise and nutrition, and community resources, may be suggested by the group facilitator or by patients, who raise concerns, share information

and ask questions. In programs emphasizing self-management, physicians and patients work together to create behavior-change action plans, which detail achievable and behavior-specific goals that participants aim to accomplish by the next session. Once plans are set, the group discusses ways to overcome potential obstacles, which raises patients' self-efficacy and commitment to behavioral change. Patients' family members can also be included in these group sessions."

g. Group visits generally last from two to 2.5 hours and include no more than 20 patients at a time.
h. Group visits may be conducted in collaboration with other Practice Units

4.10

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

PCP Guidelines:

a. At a minimum, medication review and management is provided at every visit for all patients with chronic conditions.
    i. Chronic conditions under 4.10 are defined as any condition requiring maintenance drug therapy.
    ii. 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.

Specialist Guidelines:

a. At a minimum, medication review and management is provided at every visit for all patients with chronic conditions or when indicated given the patient's health status
    i. Chronic conditions under 4.10 are defined as any condition requiring maintenance drug therapy.
    ii. 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.

4.11

Development and incorporation into medical record of written action plans and goal-setting is systematically offered to all patients with chronic conditions or other complex health care needs prevalent in practice's patient population

PCP and Specialist Guidelines:

a. Reference 4.5

4.12

A systematic approach is in place for appointment tracking and generation of reminders for all patients

PCP and Specialist Guidelines:

a. Reference 4.6

4.13

A systematic approach is in place to ensure follow-up for needed services for all patients

PCP and Specialist Guidelines:

a. Reference 4.7

4.14

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

PCP and Specialist Guidelines:

a. Reference 4.8

4.15

Group visit option is available to all patients with chronic conditions (or, for some specialists, all sub-acute conditions) prevalent in practice population

PCP and Specialist Guidelines:

a. Reference 4.9

4.16

A systematic approach is in place for 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

PCP Guidelines:

a. PCP must have systematic process in place to communicate with specialists and identify who has lead responsibility for discussing and assisting each patient with advance care planning
    i. Training and information about advance care planning is available from the Centers for Disease Control and through a number of healthcare organizations
b. Provider with lead responsibility must ensure that all care partners are aware of and have copies of 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. Specialists are not expected to engage in advance care planning 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. Provider with lead responsibility must ensure that all care partners are aware of and have copies of advance care plan

4.17

A systematic approach is in place for developing a survivorship plan for patients once treatment is completed, including a copy of the survivorship plan in the patient's medical record, and ensuring that the plan is shared with the patient and the patient's providers

PCP and Specialist Guidelines:

a. PCP and specialist(s) must have systematic process in place to identify who has lead responsibility for developing each patient's individualized patient survivorship care plan that includes guidelines for monitoring and maintaining the health of patients who have completed treatment
    i. Information about survivorship plans can be accessed at: http://www.cancer.org/Treatment/SurvivorshipDuringandAfterTreatment/SurvivorshipCarePlans/index
b. Provider with lead responsibility must ensure that key care partners are aware of and have copies of the survivorship care plan

4.18

A systematic approach is in place for assessing patient palliative care needs and ensuring patients receive needed palliative care services

PCP and Specialist Guidelines:

a. PCP and specialists have systematic processes to identify patients who may have unmet needs related to serious illness. Potential identification triggers may include:
    i. Diagnosis or progression of serious illness such as advanced cancer, heart failure, COPD, or dementia
    ii. Multiple chronic illnesses with frequent hospitalizations
    iii. Significant scoring on risk stratification tools (e.g. LACE, PRISM, etc)
    iv. Answer of "no" to the 'surprise' question: Would you be surprised if this patient were to die in the next year?
b. PCP and specialist(s) have systematic process in place to identify who has lead responsibility for assessing and addressing the palliative care needs of patients with serious illness, and referring to other providers as appropriate, including:
    i. Advance care planning (including Durable Power of Attorney-HC designation, discussion and documentation of patient values and preferences)
    ii. Pain and physical symptom management
    iii. Psychological and emotional symptoms
    iv. Spiritual distress
    v. Caregiver stress
    vi. Home or community-based support services
    vii. Hospice eligibility
c. Provider with lead responsibility ensures that all care partners are aware that patient is receiving palliative care services
d. Palliative care services are made available as needed to patients with unmet needs at all stages of seriously illness, not only at time of terminal diagnosis

e. Reference http://www.nationalconsensusproject.org/Guidelines_Download2.aspx for definition of palliative care, and an overview of the domains that should be addressed in the delivery of comprehensive palliative care
f. Practice has established written protocols for determining when patients should be assessed for palliative care needs, based on accepted standards relevant to their patient population. Tools that can be used to support assessment and management of palliative care needs are available here:
    i. Brief, evidence-based educational reviews of key palliative care topics: https://www.capc.org/fast-facts/
    ii. Advance care planning: www.prepareforyourcare.org (available in multiple languages); www.makingyourwishesknown.com; State of Michigan advance directive documents available at: http://www.mibluecrosscomplete.com/resources/advance-directive.html
    iii. Pain and symptom management: http://www.palliative.org/newpc/professionals/tools/esas.html; https://www.capc.org/fast-facts/
    iv. Psychological and emotional symptoms: https://www.capc.org/fast-facts/7-depression-advanced-cancer/
    v. Spiritual distress: https://www.hpsm.org/documents/End_of_Life_Summit_FICA_References.pdf
    vi. Prognosis: http://eprognosis.ucsf.edu/
    vii. Hospice eligibility: http://geriatrics.uthscsa.edu/tools/Hospice_elegibility_card__Ross_and_Sanchez_Reilly_2008.pdf;
g. Options for delivery of palliative care include:
    i. Delivery within practice: At least one member of practice has received training through established palliative care training program, and has educated other practice staff. Examples of such training include:
        a. Hospice and Palliative Medicine Board Physician Certification (MD/DO)
        b. Hospice Medical Director Physician Certification (MD/DO)
        c. Palliative Care Nursing Certification for APRNs, RNs, LPNs, CNAs: http://hpcc.advancingexpertcare.org/competence/certifications-offered/
        d. Palliative Care Social Work Certification: http://www.socialworkers.org/credentials/credentials/achp.asp
        e. Professional Chaplaincy Certification: http://bcci.professionalchaplains.org/content.asp?admin=Y&pl=42&sl=42&contentid=45
        f. Education in Palliative and End of Life Care: www.epec.net – all health care professionals
        g. For domains that cannot be addressed directly by practice staff, practice has knowledge of community resources that will enable patient to receive palliative care across all domains (e.g., physical, emotional, spiritual, legal, ethical).
        h. Referrals: Practice maintains information on availability of comprehensive palliative care teams, and makes referrals as appropriate. Sources for referral can be found at http://www.mihospice.org/

4.19

Systematic process is in place to identify patients who would benefit from care management services based on clinical conditions and ED, inpatient, and other service use

PCP and Specialist Guidelines:

a. PCP and specialists must have systematic process in place to identify patients who are candidates for care management, and to document the results of the identification process
    i. PCPs should notify specialists when patient has care manager
    ii. Specialists should notify PCPs when specialist has care manager
    iii. When there is more than one care manager, the involved providers should coordinate to identify care manager with lead responsibility

4.20

Systematic process is in place to inform patients about availability of care management services

PCP and Specialist Guidelines:

a. PCP and specialist(s) must have systematic process in place to inform patients about availability of care management services, and to document the conversation and the patient's response

4.21

Inter-disciplinary team meetings are held regularly to conduct patient case reviews, with development and review of comprehensive care plans for medically complex patients

PCP and Specialist Guidelines:

a. PCP and specialist(s) must have systematic process in place to conduct and document regular patient case reviews, and develop and review comprehensive care plans for medically complex patients
b. Common elements of a comprehensive care management plan include:
    i. Full problem list
    ii. Expected outcome and prognosis
    iii. Measureable treatment goals
    iv. Symptom management
    v. Planned interventions
    vi. Medication management
        - Medication allergies
    vii. Community/social services ordered
    viii. Plan for directing/coordinating the services of agencies and specialists which are not connected to the practice
    ix. Identify individual who is responsible for each intervention