VALUEPartnerships
Better Care. Better Outcomes. Better Value.

Blue Cross Blue Shield of Michigan

Interpretive Guideline 2016-2017
Updates

PGIP Field Team
Value Partnerships
Blue Cross Blue Shield of Michigan

Caveat Emptor

- 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 BCBSM is able to continue to incentivize capabilities, designate PCMH practices and offer the associated financial benefits.

Summary of Changes

- Six new capabilities added for upcoming program year, for a total of 155
  - 151 applicable to adult patients
  - 149 applicable to pediatric patients
- Added FAQ
- Clarified language
- Reinstated Domain 8

Note: New capabilities will be available for reporting beginning Jan 2017 for site visits in 2018.

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.

Introduction

- These PCMH capabilities are reported to BCBSM twice a year using the Self-Assessment Database.
- Change in terminology for specialist to Value Based Reimbursement.
- Note: Electronic prescribing is not a PCMH domain but it is included in the capability counts for PCMH Designation and so it part of the site visit review process. You may be asked to share information related to your electronic prescribing system.
- For capabilities referring to training, regular intervals are defined as a minimum of once per year. New staff must be trained at time of entry to practice.

Domain 1
Patient Provider Partnership

- Domain 1 requires an active conversation – Generic language across practices is not acceptable.
  - This has been a major weakness. Papers are thrown away –
    - How is the patient routinely educated about roles and responsibilities?
    - Is the office identifying patients that are not adhering to the PPA?
      - What does the follow up conversation look like?
    - What are the staff's individual roles and responsibilities in the PPA?
    - SCP – See next page for additional requirements

Domain 1 (continued)
Patient Provider Partnership

- 1.1 – PCP and SCP guidelines split
  - PCP
    - **Removed**: The patient-provider partnership must only be established one time per patient.
  - SCP:
    - **Added**: Conversation must include clear delineation of the specialist's role in caring for the patient, and the planned frequency and type of communication with the PCP.
      - **Active Jan. 2017**
    - The SCP PPA should outline specialty-specific role
      - **Grace period – Active Jan. 2018**

Domain 1 (continued)
Patient Provider Partnership

- 1.2 – If the practice has less than 100% acceptance of the PPA, then the practice must be actively reaching out to the remaining patients. This outreach must include information on the PPA, not just “come see us soon.”

Domain 2 -Patient Registry

- Important: Proof of outreach must be demonstrated at the site visit
- "Active use" is defined as using the key content of the registry to conduct outreach and proactively manage the patient population
    - Generating patient lists that are not being actively used to manage the patient population does not meet the intent of this capability

- It is our expectation that the POs are talking to the practices about the importance of using their own data for identifying patients in need of services. As we know, HeB Web has flaws and the prospective EBC is at least two months behind. The purpose of the all-patient, all-payer registry is to create a data source that the practices own that they trust and use. Too often we see practices demonstration how they would utilize their registry/EHR to outreach to patientS; but, in reality they focus solely on payer gap lists.

Domain 2 -Patient Registry

- For co-managed patients in a PCP registry where the specialist has primary lead responsibility, in order for the practice to claim the capability, it is our expectation that PCPs can demonstrate that the key clinical indicators/gaps in care are being fulfilled by the specialist. Where there are unfulfilled gaps, the office must act upon them either by contacting the patient or the specialist.
- If all the patients with a chronic condition are " completely handed off" to specialists, then the practice is not actively using the registry and the capability should not be in place.

Domain 3 - Performance Reporting

- Performance reports must be all-patient, all-payer and, where applicable, all physician.
- Reports should be based on practice/PO data sources.
- Individual payer performance reports do not meet this capability.

Domain 4
Individual Care Management

- 4.16: Updated: *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*
- Added: PCP must have systematic process in place to track care plans distributed to patients and returned to PCP, and where appropriate, to conduct periodic follow-up conversations with patients who have not yet executed an advance care plan
- Removed: Provider with lead responsibility must ensure that all care partners are aware of and have copies of advance care plan

Domain 4 (continued)
Individual Care Management

- 4.22 – New capability

  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
  - Reference language in 8.11

Additional Guidance:

- We require documentation that the advance care plan was shared with care partners or a systematic way to flag the completed advance care plan is in the EHR (Integrated Systems)

Domain 4 (continued)
Individual Care Management

4.23: New Capability - Practice has engaged in root cause analysis of any areas where there are significant opportunities for improvement in patient experience of care using tested methods such as Journey Mapping or LEAN techniques

PCP and Specialist Guidelines:

- Practice is currently or has within the past two years engaged in analysis of patient experience of care, using established methods such as Journey Mapping or LEAN
- Steps to address areas of concern or dissatisfaction have been identified.

Additional Guidance:

- Awaiting Tom's response for Journey Mapping

Domain 5
Extended Access

- 5.2 – Must have example of after-hours access to and updating of the EHR

Domain 5
Extended Access

After hours capabilities for specialist practice:

- There are two ways to meet afterhours capabilities:
  - (1) Specialty-appropriate clinic time: A clinician available beyond normal business hours (e.g., office provides hours before and/or after traditionally core business hours).
  - (2) Urgent care: Offices use defined protocol for those conditions for which urgent care is routinely appropriate and used.
- <u>If specialist practice is claiming access using urgent care:</u>
  - POs must assess the appropriateness of specialist use of urgent care.
  - Specialist must actively implement this protocol. One-off examples are insufficient.
  - If your specialists cannot provide you defined protocols and examples of urgent care use, then these capabilities are not applicable.

Domain 5
Extended Access

- 5.4 –Practice's patients should be aware of urgent care sites the practice recommends or with which it has a relationship. Practices should educate patients about why or why not to use certain urgent cares. This should take into account the geography of urgent care sites in their area regardless of affiliation or ownership (it is appropriate to educate patients as to why they might want to use an urgent care on a common platform with the practice).

- 5.7 – There was a 1-year grace period for a written policy and patient education for specialists in order that the patients not feel they are imposing on the practice. This will be enforced in 2017.

Domain 8 – eRX and EPCS

Domain 8 has been revitalized for the purposes of supporting BCBSM efforts to actively manage controlled substance prescriptions and address abuse. There are four new capabilities.

Note: New capabilities will be available for reporting beginning Jan 2017 for site visits in 2018.

Domain 8 – eRX and EPCS (cont'd)

- 8.8 – New capability - 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

Additional guidance:

- BCBSM will use EPCS reports to support practice's assertion of active use.
- 2018 PGIP Initiative Goal – 25%

Domain 8 – eRX and EPCS (cont'd)

- 8.9 – New Capability - Michigan Automated Prescription System (MAPS) reports are routinely run prior to prescribing controlled substances

PCP and Specialist Guidelines:

- All practitioners run MAPS reports prior to prescribing controlled substances, and follow-up with patient if any concerns are identified

Additional guidance:

- Practice Unit should have a standardized process for running MAPS reports (e.g., for patients on long term use without a history of abuse, reports could be run on a quarterly basis).
  - A written policy is strongly recommended!

Domain 8 – eRX and EPCS (cont'd)

- 8.10 – New Capability - Controlled Substance Agreements are in place for all patients with long-term controlled substance prescriptions

PCP and Specialist Guidelines:

- All practitioners ensure that patients with controlled substance prescriptions for longer than 30-60 days have a Controlled Substance Agreement in place
- Reference for sample forms http://www.naddi.org/aws/NADDI/asset_manager/get_file/32898/opioidagreements.pdf

Additional guidance:

- Controlled substance agreements should be reviewed and updated annually.

Domain 8 – eRX and EPCS (cont'd)

- 8.11 – New Capability - Controlled Substance Agreements are shared with all patient's care providers

PCP and Specialist Guidelines:

- All practitioners ensure that copies of Controlled Substance Agreements are given to all of the patient's care providers
- 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 a controlled substance agreement is in place

Additional Guidance:

- We require documentation that the Controlled Substance Agreements were shared with care partners or a systematic way to flag the Controlled Substance Agreement is in the EHR (Integrated Systems)

Domain 9 – Preventive Services

Definitions:

- *Primary prevention is defined as inhibiting the development of disease before it occurs, and is typically performed on the general patient population.*
- *Secondary prevention, also called "screening," refers to measures that detect disease before it is symptomatic.*
- *Tertiary prevention efforts focus on people already affected by disease and attempt to reduce resultant disability and restore functionality.*

Domain 9 – Preventive Services

- 9.7 - Secondary prevention program is in place to identify and treat asymptomatic persons who have already developed risk factors or pre-clinical disease, but in whom the disease itself has not become clinically apparent; or tertiary prevention to prevent worsening of clinically-established condition.

PCP and Specialist Guidelines:

System with guideline-based reminders for age-appropriate risk assessment and screening tests, including for depression, is in place.

Practice Unit may choose to implement tools such as checklists attached to the patient chart, tagged notes, computer generated encounter forms and prompting stickers.

Systematic process is in place for following up on any positive screening results (e.g., process is in place for managing positive depression screenings]

Mechanisms are established to identify asymptomatic at-risk patients and provide additional screenings

Practice systematically uses point of care alerts based on identified risk

Examples include accelerated regimen for colon and breast cancer screening in high risk patients

Practice systematically establishes or modifies existing point of care alerts based on identified risk (e.g., accelerated colonoscopy schedule for patients with polyps)

Domain 9 – Preventive Services

- 9.7 – continued

b. Mechanisms are established to identify asymptomatic at-risk patients and provide additional screenings

i. Practice systematically uses point of care alerts based on identified risk

This capability received a 1-yr grace period in 2016. This will be enforced in 2017.

Domain 10 – Community Services

Capabilities with 1-yr grace periods in 2016 that are now in effect:

- 10.3 – PO in conjunction with Practice Units has established collaborative relationships with appropriate community-based agencies and organizations
  - PO in conjunction with practice has conducted outreach to organizations and held in-person meetings or face-to-face events, at least annually, that facilitate interaction between practices and agencies where they discuss the needs of their patient population
- 10.5 - Systematic team approach is in place for educating all patients about availability of community resources and assessing and discussing the need for referral
  - Education process must include intake form and/or conversation in which patients are asked whether they are aware of or in need of community services
- 10.6 - Systematic approach is in place for referring patients to community resources
  - Assessments that identify a patient with need for referral are documented in the medical record to enable providers to follow-up during subsequent visits

Domain 11 – Self Management Support

- *11.2 - Structured self-management support is systematically offered to all patients in the patient population selected for initial focus (based on need, suitability, and patient interest)*
  - Update to letter d: Physicians may provide self-management support within the context of E&M services
    - At least one other trained member of the care team must be designated as a self-management support resource, with time allocated to work with patients

- 11.3/11.6 – updated to say the activities must be done at least monthly

- 11.8 – See capability for updates

Domain 12 – Patient Portal (cont'd)

- All capabilities were updated to add language about active use and remove language about "ability to."
- Demonstration of these capabilities for the practice site specifically requires examples or a usage log. If the office is unable to provide examples or a usage log the capabilities will not be found in place.

- 12. 7 - Providers are routinely using patient portal to electronically send automated care reminders and health education materials.
  - Used to be 4 of 5
  - Now just automated care reminders and health education materials. Must have both.

Domain 12 – Patient Portal

- 12.8 – Patient portal system has capability for patient to create and update personal health record

PCP and Specialist Guidelines:

- Personal health records are **created and maintained by patients** to improve their health care experience and reduce fragmentation of care, and typically include:
  - PCP name and phone number, allergies, including drug allergies, medications, including dosages, chronic health problems, major surgeries, living will or advance directive, family history, immunization history, results of screening tests, cholesterol level and blood pressure, exercise and dietary habits, health goals
  - Content of personal health record may be defined by patient and PO/Practice Unit, within context of patient portal system, but must contain at least some of the following patient-supplied elements
    - Chronic health problems, family history, exercise and dietary habits, health goals
- **Patients must be actively adding or augmenting existing health information in the portal**
  - The capability must exist for the patient to add the information themselves directly into the personal health record
    - If patient prefers, information may be given to provider to be entered

Domain 13 – Coordination of Care

- No changes

Domain 14 – Specialist Referral

- No changes
- 14.9 – Organization wide surveys will meet this capability if the SCP results are being shared with the PCPs.

Grace Period Capabilities

- The SCP PPA should outline specialty-specific role