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Blue Cross Blue Shield of Michigan

BCBSM Physician Group Incentive Program

Patient-Centered Medical Home and Patient-Centered Medical Home-Neighbor

Interpretive Guidelines
Specialist Edition

2016-2017

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READ ME FIRST: THE ESSENTIAL FAQS ABOUT THE PATIENT-CENTERED MEDICAL HOME AND PATIENT-CENTERED MEDICAL HOME-NEIGHBOR PROGRAM

1. What is the Patient-Centered Medical Home and Patient-Centered Medical Home-Neighbor?

The Patient-Centered Medical Home (PCMH) is a care delivery model in which patient treatment is coordinated through primary care physicians to ensure patients receive the necessary care when and where they need it, in a manner they can understand. The PCMH-Neighbor model enables specialists and sub-specialists, including behavioral health providers, to collaborate and coordinate with primary care physicians to create highly functioning systems of care.

The goals of the PCMH/PCMH-N model are to:

- Strengthen the role of the PCP in the delivery and coordination of health care
- Support population health management, which uses a variety of individual, organizational and cultural interventions to help improve the illness and injury burden and the health care use of defined populations.
- Ensure effective communication, coordination and integration among all PCP and specialist practices, including appropriate flow of patient care information, and clear definitions of roles and responsibilities

2. Why are there all these "capabilities?"

When BCBSM began developing its PCMH program in 2008 in collaboration with PGIP Physician Organizations (POs), it became clear that practices could not wave a wand and turn into a fully realized PCMH over night. In early demonstration projects, practices began suffering from transformation fatigue, in some cases leading to disillusionment with the PCMH model.

In partnership with the PGIP community, BCBSM decided to develop 12 initiatives to support incremental implementation of PCMH infrastructure and care processes. Each initiative focuses on a

PCMH domain of function and defines the set of capabilities that will enable practices to achieve the PCMH vision for that domain of function.

Initially, a 13th initiative was developed for electronic prescribing (domain 8), but then a separate e-prescribing incentive program was implemented, and e-prescribing was removed from the list of PCMH/PCMH-N domains. In the 2016-2017 version of the Interpretive Guidelines, domain 8 was resurrected in order to add capabilities related to electronic prescribing and management of controlled substance prescriptions.

3. *Why do we need "Interpretive Guidelines?"*

During the first round of site visits in 2009, we rapidly discovered that there were widely varying interpretations of nearly every term and concept in the PCMH model. We created the Interpretive Guidelines to provide definitions, examples, links to helpful resources, and also to address questions regarding extenuating circumstances.

4. *Why has the number of capabilities increased over time?*

Although the PCMH/PCMH-N model was designed to be highly aspirational, it also continues to evolve based on new research and insights about the delivery of optimal health care. Each year, BCBSM conducts a comprehensive review of the Interpretive Guidelines, incorporating input gathered from the PGIP community throughout the year as well as enhancements based on new findings.

5. *Who is responsible for reporting PCMH/PCMH-N capabilities to BCBSM?*

Physician Organizations are responsible for reporting PCMH/PCMH-N capabilities to BCBSM. Capabilities can be reported online at any time, using the Self-Assessment Database. Twice a year, in January and July, BCBSM takes a "snapshot" of the self-reported data.

It is not acceptable for a PO to request that practices simply self-report their capabilities. POs must be actively engaging and educating their practices about the PCMH/PCMH-N model, and must validate all capabilities before reporting them in place.

6. *Can we report a capability in place as soon as the practice has the ability to use it? Or what about when one physician or member starts using it?*

No and no. Any capability reported to BCBSM as "in place" must be fully 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 actively using the capability.

Some examples the field team has seen of capabilities that should not have been marked in place are:

- Patient portal capabilities reported as in place: Practice has patient portal implemented, but no providers or patients are using it.

- After hours/urgent care capabilities reported as in place for specialty practice: urgent care centers are identified in the PO's PCMH brochure the practice is giving to patients, but specialty practice says they don't use urgent care and do not counsel patients about how to receive after hours/urgent care, but instead direct patients to the ED.

7. *The PCPs in my PO are very familiar with the PCMH model, but our specialists hardly know what we're talking about. Some of them think they should be their patient's medical home, not the PCP. What should we do about this?*

It is critical that prior to reporting PCMH-N capabilities in place, POs ensure that both allopathic and non-allopathic specialists are aware of and in agreement with the PO's documented guidelines outlining basic expectations regarding the role of specialists in the PO and within the PCMH/PCMH-N model, including:

- Commitment to support the PCMH/PCMH-N model and the central role of the PCP in managing patient care and providing preventive and treatment services, including immunizations
- Willingness to actively engage with the PO to optimize cost/use of services
- Collaboration with PCPs and other specialists to coordinate care

In addition, POs should:

- Visit specialist practices to determine which capabilities are in place and actively in use. (The only exceptions would be those capabilities that are centrally deployed by the PO, such as generation of patient alerts and reminders.) POs should also ensure that specialist practices are aware of, and in agreement regarding, which PCMH-N capabilities are reported as in place for their practice.
- Hold forums and visit practices to educate the specialists and their teams about the PCMH-N model, and, importantly, emphasize the need for specialists to actively engage with the PO and their PCP colleagues to optimize individual patient care management and population level cost and quality performance.

Please remember that the point of the PCMH-N program is not to reward specialists for capabilities that just happen to be in place; the purpose is to enable POs to engage specialists in the PCMH-N model, with the goal of building an integrated, well-coordinated medical neighborhood.

As of 2017, if the field team finds during the course of a site visit that any of these elements are missing (e.g., the practice does not understand or support the PCMH/PCMH-N model, has not been visited/educated by the PO, is not aware of which capabilities have been reported in place, etc.), the field team reserves the right to suspend the site visit and find that none of the reported PCMH-N capabilities are in place.

8. *Why is it so important that the capabilities be reported accurately?*

Accurate reporting of PCMH-N capabilities is vital, for many reasons:

- The overall integrity of PGIP depends upon POs accurately reporting on their transformation efforts. The continued success of the program requires that BCBSM and PGIP POs are fully aligned in support of PGIP's goals, and that POs are committed to ensuring the accuracy of their self-reported data.
- Our PCMH/PCMH-N database is the source for extensive analytics and articles published in national peer-reviewed journals regarding the effectiveness of the PCMH and PCMH-N models.
- Inaccurate data will lead to misleading results, which could negatively affect the programmatic and financial viability of the PCMH/PCMH-N model.
- Inaccurate reporting of PCMH-N capabilities leads to inappropriate allocation of PGIP rewards, reducing the amount available to reward other key PGIP activities

9. *Do we have to implement the capabilities in order?*

Capabilities are not necessarily listed in sequential order (except for patient-provider partnership capabilities) and may be implemented in any sequence the PO and/or practice unit feels is most suitable to their practice transformation strategy.

10. *Don't you people know how to count? What happened to domain 7 and why does domain 8 start at 8.7?*

Sort of. Because we have amassed years of self-reported data based on numbered capabilities, we cannot reassign capability numbers. Domain 7 was previously used to collect evidence-based care data, and has been retired. In domain 8, capabilities 8.1 through 8.6 were related to incremental implementation of e-prescribing and have been retired.

11. *What does PCMH/PCMH-N have to do with Organized Systems of Care?*

In a word, everything. BCBSM's PCMH/PCMH-N program provides the foundation to build Organized Systems of Care (OSCs).

12. *Why does BCBSM do all those site visits and how should POs prepare practices?*

Site visits are a vital component of BCBSM's PCMH/PCMH-N program, and serve to:

- Educate POs and practice staff about the PCMH/PCMH-N Interpretive Guidelines and BCBSM expectations
- Enable the field team to gather questions and input to refine, clarify, and enhance the PCMH/PCMH-N Interpretive Guidelines
- Ensure that the PCMH/PCMH-N database is an accurate source for research as well as the PCMH Designation process

POs should inform practices that demonstration will be required for certain capabilities (please see site visit requirements table on p. 9). For example, 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.

13. *What do you mean by "co-management?"*

There are several types of co-management between PCPs and specialists, as well as other interactions, as defined in the table below.

Types of PCP/Specialist Clinical Interactions
Pre-consultation exchange - Expedite/prioritize care, clarify need for a referral, answer a clinical question and facilitate the diagnostic evaluation of the patient prior to specialty assessment
Formal consultation - Deal with a discrete question regarding a patient's diagnosis, diagnostic results, procedure, treatment or prognosis with the intention that the care of the patient will be transferred back to the PCMH/PCP after one or two visits.
Co-management • *Co-management with shared management for the disease* – specialist shares long-term management with the PCP for a patient's referred condition and provides advice, guidance and periodic follow-up for one specific condition. • *Co-management with principal care for the disease* – (referral) the specialist assumes responsibility for long-term, comprehensive management of a patient's referred medical/surgical condition; PCP receives consultation reports and provides input on secondary referrals and quality of life/treatment decisions; PCP continues to care for all other aspects of patient care and new or other unrelated health problems and remains first contact for patient. • *Co-management with principal care of the patient for a consuming illness for a limited period* – when, for a limited time due to the nature and impact of the disease, the specialist becomes first contact for care until the crisis or treatment has stabilized or completed. PCP remains active in bi-directional information and provides input on secondary referrals and other defined areas of care.
Transfer of patient to specialist - Transfer of patient to specialist for the entirety of care.

14. *You use the term "clinical practice unit teams" a lot. What does that mean?*

"Clinical Practice Unit teams" should be composed of "clinicians," defined as physicians, nurse practitioners, or physician assistants (unless otherwise specified in the guidelines).

15. Why aren't there any capabilities related to health literacy?

Health literacy should be considered across all relevant domains. All verbal and written communications with patients must be appropriate to the specific level of understanding and needs of the individual patient.

Overview: Capability Counts, Site Visit Requirements, and Predicate Logic

		Total Capabilities Applicable for Adult Patients	Total Capabilities Applicable for Pediatric Patients	Total Capabilities
1.0	Patient-Provider Partnership	10	10	10
2.0	Patient Registry	19	18	21
3.0	Performance Reporting	14	14	16
4.0	Individual Care Management	23	22	23
5.0	Extended Access	10	10	10
6.0	Test Tracking	9	9	9
8.0	Electronic Prescribing	5	5	5
9.0	Preventive Services	9	9	9
10.0	Linkage to Community Services	8	8	8
11.0	Self-Management Support	8	8	8
12.0	Patient Web Portal	13	13	13
13.0	Coordination of Care	12	12	12
14.0	Specialist Referral Process	11	11	11
	TOTAL	**151**	**149**	**155**

PCMH Domain		Site Visit Requirements	Predicate Logic
1.0 Patient-Provider Partnership			
Capability 1.1	Communication tools developed	Demonstration (Demo)	
Capability 1.2	Process underway	Demo	
Capability 1.3	Completed for 10% of patients	Demo & current reports	1.1
Capability 1.4-1.8	Completed for 30-90% of patients	Demo & current reports	All Prior
Capability 1.9	Patients informed that health information may be shared with care partners	Demo	
Capability 1.10	Establish process for repeating patient-provider partnership discussion	Demo	
2.0 Patient Registry			
Capability 2.1	Pt registry for diabetes or condition relevant to specialty	Demo & current reports	
Capability 2.2	Info on health care services at other sites	Demo & current reports	
Capability 2.3	Evidence-based care guidelines	Demo & current reports	
Capability 2.4	Point of care	Demo & current reports	
Capability 2.5	Attributed practitioner	Demo & current reports	
Capability 2.6	Gaps in care alerts to patients	Demo & current reports	
Capability 2.7	Gaps in care flags for all patients	Demo & current reports	

PCMH Domain		Site Visit Requirements	Predicate Logic
Capability 2.8	Patient demographics and clinical parameters	Demo & current reports	
Capability 2.9	Electronic	Demo & current reports	2.2
Capability 2.10	Asthma	Demo & current reports	
Capability 2.11	CAD (adult pts)	Demo & current reports	
Capability 2.12	CHF (adult pts)	Demo & current reports	
Capability 2.13	2 other chronic conditions	Demo & current reports	
Capability 2.14	Preventive services	Demo & current reports	
Capability 2.15	Assigned patients	Demo & current reports	
Capability 2.16	CKD	Demo & current reports	
Capability 2.17	Pediatric obesity (peds pts)	Demo & current reports	
Capability 2.18	Pediatric ADHD (peds pts)	Demo & current reports	
Capability 2.19	Care manager identified	Demo	
Capability 2.20	Advanced Patient Information	Demo	
Capability 2.21	Additional Advanced Patient Information	Demo	
3.0 Performance Reporting			
Capability 3.1	Diabetes	Demo & current reports	
Capability 3.2	PO/sub-PO, practice unit, and individual provider level	Demo & current reports	
Capability 3.3	2 other chronic conditions	Demo & current reports	
Capability 3.4	Data validated	Demo & current reports	
Capability 3.5	Trend reports	Demo & current reports	
Capability 3.6	Pediatric obesity	Demo & current reports	
Capability 3.7	All current patients	Demo & current reports	
Capability 3.8	Reports on health care services at other sites	Demo & current reports	
Capability 3.9	Specialists	Demo & current reports	
Capability 3.10	Asthma	Demo & current reports	
Capability 3.11	CAD	Demo & current reports	
Capability 3.12	CHF	Demo & current reports	
Capability 3.13	Pediatric ADHD	Demo & current reports	
Capability 3.14	Reports include care manager activity	Demo & current reports	
Capability 3.15	Quality metrics reported to external entities	Demo & current reports	
Capability 3.16	Track Choosing Wisely recommendations	Demo & current reports	
4.0 Individual Care Management			
Capability 4.1	PCMH training	Demo & Documentation	
Capability 4.2	Integrated team of multi-disciplinary providers	Demo	
Capability 4.3	Evidence-based care guidelines in use at point of care	Demo	
Capability 4.4	Patient satisfaction/office efficiency measured	Documentation of aggregated survey results	
Capability 4.5	Action plan and self-management goal-setting	Demo	
Capability 4.6	Appointment tracking and reminders – one chronic condition	Demo	

PCMH Domain		Site Visit Requirements	Predicate Logic
Capability 4.7	Follow-up for needed services – one chronic condition	Demo	
Capability 4.8	Planned visits – one chronic condition	Demo & Documentation	
Capability 4.9	Group visit	Documentation	
Capability 4.10	Medication review and management	Demo	
Capability 4.11	Action plan development and self-management goal-setting - all chronic conditions or other complex health care needs	Demo	4.5
Capability 4.12	Appointment tracking and reminders - all patients	Demo	4.6
Capability 4.13	Follow-up for needed services – all patients	Demo	4.7
Capability 4.14	Planned visits – all chronic conditions	Demo & Documentation	4.8
Capability 4.15	Group visit option - all chronic conditions	Documentation	4.9
Capability 4.16	Advance care planning	Demo & Documentation	
Capability 4.17	Survivorship Plan	Demo & Documentation	
Capability 4.18	Palliative Care	Demo & Documentation	
Capability 4.19	Identify candidates for care management	Demo & Documentation	
Capability 4.20	Inform patients about care management services	Demo	
Capability 4.21	Conduct regular case reviews	Demo	4.2
Capability 4.22	Provider initiating advance care plan ensures all care partners have copies of advance care plan	Demo	
Capability 4.23	Root cause analysis of areas of opportunity for improvement in patient experience of care	Demo	
5.0 Extended Access			
Capability 5.1	24-hour access to a clinical decision-maker by phone with feedback loop within 24 hours	Demo	
Capability 5.2	Clinical decision-maker has access to EHR or registry info during phone call	Demo	5.1
Capability 5.3	Access to non-ED after-hours provider for urgent care needs during at least 8 after-hours per week, with feedback loop	Demo	
Capability 5.4	All patients fully informed about after-hours care availability	Demo	
Capability 5.5	Access to non-ED after-hours provider for urgent care needs during at least 12 after-hours per week, with feedback loop	Demo	5.3
Capability 5.6	After-hours provider has access to EHR or patient's registry record during the visit	Demo	
Capability 5.7	Advanced access scheduling for at least 30% of appointments (tiered access for specialists)	Demo & Documentation	
Capability 5.8	Advanced access scheduling for at least 50% of appointments	Demo & Documentation	5.7
Capability 5.9	Practice unit has telephonic or other access to interpreters for all languages common to practice's established patients	Demo	
Capability 5.10	Patient education materials available in languages common to practice's established patients	Demo	
6.0 Test Results Tracking & Follow-Up			

PCMH Domain		Site Visit Requirements	Predicate Logic
Capability 6.1	Process/procedure documented	Demo & Documentation	
Capability 6.2	Ensure patients receive needed tests and practice obtains results	Demo & documentation	
Capability 6.3	Patient contact details are kept up to date	Demo & documentation	
Capability 6.4	Mechanism for patients to obtain information about normal tests	Demo	
Capability 6.5	Systematic approach to inform patients about abnormal test results	Demo	
Capability 6.6	Patients with abnormal results receive recommended follow-up care	Demo & documentation	6.5
Capability 6.7	All test tracking steps documented	Demo	
Capability 6.8	All clinicians and appropriate office staff trained	Demo & Documentation	
Capability 6.9	Computerized order entry integrated with automated test tracking system	Demo	
8.0 Electronic Prescribing			
Capability 8.7	Full e-prescribing system is in place and actively in use	Demo	
Capability 8.8	Electronic prescribing system is routinely used to prescribe controlled substances	Demo	
Capability 8.9	Michigan Automated Prescription System (MAPS) reports are routinely run prior to prescribing controlled substances	Demo	
Capability 8.10	Controlled Substance Agreements are in place for all patients with long-term controlled substance prescriptions	Demo	
Capability 8.11	Controlled Substance Agreements are shared with all patient's care providers	Demo	
9.0 Preventive services			
Capability 9.1	Primary prevention program	Demo	
Capability 9.2	Systematic approach to providing primary preventive services	Demo	
Capability 9.3	Outreach regarding ongoing well care visits and screenings	Demo	
Capability 9.4	Process in place to inquire and incorporate information about patient's outside health encounters	Demo	
Capability 9.5	Provision of tobacco use assessment tools and smoking cessation advice	Demo	
Capability 9.6	Written standing order protocols for preventive services without examination by a clinician	Demo & Documentation	
Capability 9.7	Secondary prevention program	Demo	
Capability 9.8	Staff training	Demo	
Capability 9.9	Planned visits for preventive services	Demo & Documentation	
10.0 Linkage to Community Services			
Capability 10.1	Comprehensive review	Demo	
Capability 10.2	PO maintains a community resource database	Demo	
Capability 10.3	Collaborative relationships with appropriate community-based agencies and organizations	Demo	
Capability 10.4	Staff training	Demo	
Capability 10.5	Systematic approach for educating all patients about community	Demo	

PCMH Domain		Site Visit Requirements	Predicate Logic
	resources and assessing/discussing need for referral		
Capability 10.6	Systematic approach for referring patients to community resources	Demo	
Capability 10.7	Systematic approach for tracking referrals of high-risk patients	Demo	
Capability 10.8	Systematic approach for conducting follow-up with high-risk patients	Demo	10.7
11.0 Self-Management Support			
Capability 11.1	Member of clinical care team or PO educated about and familiar with self-management support concepts and techniques	Demo & Documentation	
Capability 11.2	Self-management support – initial chronic condition	Demo	11.1
Capability 11.3	Follow-up to discuss action plans and goals and provide supportive reminders – initial chronic condition	Demo	11.1
Capability 11.4	Regular patient experience/satisfaction surveys of patients engaged in self-management support	Documentation of aggregated survey results	11.1, 11.2
Capability 11.5	Self-management support – all chronic conditions	Demo	11.1, 11.2
Capability 11.6	Follow-up to discuss action plans and goals and provide supportive reminders – all chronic conditions	Demo	11.1, 11.3
Capability 11.7	Self-management goal-setting - all patients	Demo	
Capability 11.8	One member of PO or practice unit is formally trained and regularly works with appropriate staff members	Demo & Documentation	
12.0 Patient Web Portal			
Capability 12.1	Available vendor options have been evaluated	Demo	
Capability 12.2	Liability and safety issues assessed	Demo	
Capability 12.3	Electronic appointment scheduling	Demo & documentation of recent (within past 3 months) active patient use (e.g., print-outs)	12.1, 12.2
Capability 12.4	Patients can log results of self-administered tests	Same as 12.3	12.1, 12.2
Capability 12.5	Automatic alerts for self-reported patient data that indicates a potential health issue	Same as 12.3	12.1, 12.2
Capability 12.6	E-visits	Same as 12.3	12.1, 12.2
Capability 12.7	Using patient portal to send automated care reminders, other info	Same as 12.3	12.1, 12.2
Capability 12.8	Capability for patient to create personal health record	Same as 12.3	12.1, 12.2
Capability 12.9	Ability for patients to review test results electronically	Same as 12.3	12.1, 12.2
Capability 12.10	Ability for patients to request prescription renewals electronically	Same as 12.3	12.1, 12.2
Capability 12.11	Ability for patients to graph and analyze results of self-administered tests	Same as 12.3	12.1, 12.2
Capability 12.12	Ability for patients to view registries, electronic health records online	Same as 12.3	12.1, 12.2
Capability 12.13	Ability to schedule appointments electronically	Same as 12.3	12.1, 12.2
13.0 Coordination of Care			
Capability 13.1	Notified of each patient admit and discharge - initial chronic condition	Demo	
Capability 13.2	Process for exchanging medical records – initial chronic condition	Demo	

PCMH Domain		Site Visit Requirements	Predicate Logic
Capability 13.3	Systematically track care coordination – initial chronic condition	Demo	
Capability 13.4	Flags for time-sensitive health issue – initial chronic condition	Demo	
Capability 13.5	Written transition plans for patients leaving the practice - initial chronic condition	Demo and Documentation	
Capability 13.6	Coordinate care with payer case manager	Demo	
Capability 13.7	Written procedures, team members trained	Demo & Documentation	
Capability 13.8	Capabilities 13.1-13.7 extended to all chronic conditions	Demo & Documentation	13.1 – 13.7
Capability 13.9	Capabilities 13.1-13.7 extended to all patients	Demo & Documentation	13.1 – 13.8
Capability 13.10	Discharge follow-up	Demo	
Capability 13.11	ADT Participant	Demo	
Capability 13.12	Actively participating in MI ADT Med Rec Use Case	Demo & Documentation	
14.0 Specialist Referral Process			
Capability 14.1	Documented procedures for preferred/high-volume specialists	Demo & Documentation	
Capability 14.2	Documented procedures for other key providers	Demo & Documentation	
Capability 14.3	Directory maintained	Demo	
Capability 14.4	Specialist referral materials	Demo	
Capability 14.5	Makes specialist appointments on behalf of patients	Demo	
Capability 14.6	Electronically-based tools and processes	Demo	
Capability 14.7	Process to monitor and confirm referrals and follow-up took place	Demo	
Capability 14.8	Staff trained	Demo & Documentation	
Capability 14.9	Practice unit regularly evaluates patient satisfaction	Documentation of aggregated survey results	
Capability 14.10	Phys-to-phys pre-referral communication	Demo & Documentation	
Capability 14.11	Specialist follows-up with PCP for self-referred patients	Demo	

PCMH/PCMH-N INTERPRETIVE GUIDELINES

1.0 Patient-Provider Partnership

Goal: Build provider care team and patient awareness of, and active engagement with, the PCMH model, clearly define provider and patient responsibilities, and strengthen the provider-patient relationship.

Capabilities 1.1-1.3 and 1.9 are applicable to specialists. For specialists, there are two ways to implement the patient-provider partnership capabilities: 1) specialist has patient-provider partnership discussion with "current" patients with whom the specialist has an ongoing treating relationship, which is defined as "having primary responsibility or co-management responsibility with PCP for patients with an established chronic condition"; 2) specialist has patient-provider partnership discussion with all patients at the onset of treatment.

1.1

Practice unit has developed PCMH-related patient communication tools, has trained staff, and is prepared to implement patient-provider partnership with each current patient, which may consist of a signed agreement or other documented patient communication process to establish patient-provider partnership

Specialist Guidelines:

a. Patient communication process must include a conversation between the patient and a member of the clinical practice unit team. In extenuating circumstances, well-trained Medical Assistants who are highly engaged with patient care may be considered a member of the clinical practice unit team.
b. 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
c. Documentation may consist of note in medical record, sticker placed on front of the chart, indicator in patient registry, patient log, or similar system that can be used to identify the percent of patients with whom the partnership has been discussed.
d. Documents and patient education tools are developed that explain PCMH concepts and outline patient's and specialist's roles and responsibilities.
e. Practice unit team members and all appropriate staff are educated/trained on patient-provider partnership concepts and patient communication processes
f. Process has been established for patients to receive PCMH information, and for practitioner to have conversation with patients about PCMH patient-provider partnership.
g. Mechanism and process has been developed to document establishment of patient-provider partnership in medical record or patient registry.

1.2

Process of reaching out to current patients is underway, and practice unit is using a systematic approach to inform patients about PCMH

Specialist Guidelines:

- i Examples of outreach include discussion at the time of visit, mailings, emails, telephone outreach, or other electronic means. Mass mailings do not meet the requirements for 1.3. Outreach materials should explain the PCMH/PCMH-N concept and patient-provider partnership, and the roles and responsibilities of the specialist provider, the PCP, and the patient.

1.3

Patient-provider agreement or other documented patient communication process is implemented and documented for at least 10% of current patients

Specialist Guidelines:

a. Evidence must be provided that patient-provider partnership conversations are occurring with, at a minimum, those patients for whom the specialist has primary responsibility or co-management responsibility with PCP
   - i It is not necessary to maintain a list for purposes of quantifying the percentage of patients engaged in patient-provider partnership conversations

b. Establishment of patient-provider partnership must include conversation between patient and a member of the practice unit clinical team
   i. In extenuating circumstances, well-trained Medical Assistants who are highly engaged with patient care may be considered a member of the clinical practice unit team.
   ii. Conversation should preferably take place in person, but may take place over phone in extenuating circumstances, for a limited number of patients
   iii. Other team members may begin the conversation, or follow-up after physician conversation with more detailed discussion/information, but a clinical team member must participate in at least part of the patient-provider partnership conversation

c. Conversation may be documented in medical record, patient registry, or other type of list

1.4

Patient-provider agreement or other documented patient communication process is implemented and documented for at least 30% of current patients

1.5

Patient-provider agreement or other documented patient communication process is implemented and documented for at least 50% of current patients

1.6

Patient-provider agreement or other documented patient communication process is implemented and documented for at least 60% of current patients

1.7

Patient-provider agreement or other documented patient communication process is implemented and documented for at least 80% of current patients

1.8

Patient-provider agreement or other documented patient communication process is implemented and documented for at least 90% of current patients

1.9

Providers ensure that patients are aware that as part of comprehensive, quality care and to support population management, health care information is shared among care partners as necessary.

PCP and Specialist Guidelines:

a. Providers ensure that patients are aware and clearly understand that in the course of providing care, providers will share patient information with other providers who are involved in the patient's care, as appropriate. The data-sharing may be through provision of written medical information or through electronic sharing of information (for example, electronic transmission of information about admits, discharges and transfers from/to hospital-based care settings).
b. Language regarding the sharing of health information with other providers can be added to the patient-provider partnership documentation, or it may be incorporated into the practice's existing HIPAA documentation, such as a "notice of privacy practices", in order to fulfill the requirement to inform patients.

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

2.0 Patient Registry

Goal: Enable providers to manage their patients both at the population level and at point of care through use of a comprehensive patient registry.

Applicable to specialists for the patients for whom they have primary or co-management responsibility (regardless of insurance coverage and including Medicare patients).

For all Patient Registry capabilities except 2.9, registry may be paper or electronic. A fully electronic registry may be the last capability to be implemented.

Nine of the Patient Registry capabilities identify the population of patients included in the registry (2.1, 2.10, 2.11, 2.12, 2.13, 2.15, 2.16, 2.17, and 2.18). The other twelve Patient Registry capabilities pertain to registry functionality (2.2, 2.3, 2.4, 2.5, 2.6., 2.7, 2.8, 2.9, 2.14, 2.19, 2.20, and 2.21). All capabilities pertaining to functionality that are marked as in place must be in place for each population of patients marked as "included" in the registry.

2.1

A paper or electronic all-payer registry is being used to manage all established patients in the Practice Unit with: Diabetes

(For specialists, relevant patient population selected for initial focus and not addressed in other 2.0 capabilities)

Specialist Guidelines:

a. Active use is defined as using the key content of the registry to conduct outreach and proactively manage the patient population
    i Generating patient lists that are not being actively used to manage the patient population does not meet the intent of this capability
b. A patient registry is a database that enables population-level management in addition to generating point of care information, and allows providers to view patterns of care and gaps in care across their patient population. A registry contains several dimensions of clinical data on patients to enable providers to manage and improve the health of their population of patients.
c. Relevant clinical information that is the focus of attention in generally accepted guidelines and is incorporated in common quality measures pertinent to the patient population must be incorporated in the registry (e.g., physiologic parameters, lab results, medication use, physical findings, and patient behaviors such as peak flow meter use or daily salt intake).
d. Registry data must be in the form of data fields that are accessible for tabulation and population management.
e. Registry must include all established patients for which the specialist has ongoing primary or co-management responsibility with the condition referenced in the capability, regardless of insurance coverage (including Medicare patients)
    i For ER physicians, a registry that tracks frequent ER users, or patients with drug-seeking behavior, may qualify
f. Patients assigned by managed care organizations do not have to be included in registry if they are not established patients (reference 2.15).
g. Patient information may be entered by the practice, populated from EHR or other electronic or manual sources, or populated with payer-provided data
    i Registry must include data pertinent to key clinical performance measures (e.g., BCBSM-provided data or similar data from other sources)
h. Registry may initially be a component of EHR for basic-level functioning, as long as the practice or the PO has the capability to use the EHR to generate routine population-level performance reports and reports on subsets of patients requiring active management.
    i Subsets of patients requiring active management refers to those patients with particular management needs including but not limited to those who have physiologic parameters out of control or who have not received specified, essential services

ii For example, for behavioral health providers, i.e., psychologists and psychiatrists, common relevant conditions would be depression and anxiety

i. Reference AAFP article for additional information on creating a registry: http://www.aafp.org/fpm/20060400/47usin.html

2.2

Registry incorporates patient clinical information, for all established patients in the registry, for a substantial majority of health care services <u>received at other sites</u> that are necessary to manage the population

<u>Specialist Guidelines:</u>

a. Registry may be paper or electronic
b. "All patients in the registry" may consist of patients relevant to the specialty type, if practice unit has only implemented capability 2.1.
c. The registry is not expected to contain clinical information on all health care services received at any site for 100% of patients in the registry, but is expected to contain a critical mass of information from various relevant sources, including the PO's or practice unit's own practice management system, and electronic or other records from facilities with which the PO or practice unit is affiliated
d. Other sites and service types are defined as labs, inpatient admissions, ER, urgent care and pharmaceuticals (with dates and diagnoses where applicable), when relevant to the condition being managed by the specialist,
e. The definition of "substantial majority of health care services" is three-quarters of relevant services rendered to patients.
f. If registry is paper, information may be extracted from records and recorded in registry manually, and must be in the form of an accessible data field for population level management of patients

2.3

Registry incorporates evidence-based care guidelines

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

a. Registry functionality may be paper or electronic.
b. Guidelines should be drawn from recognized, validated sources at the state or national level (e.g., MQIC Guidelines, USPSTF).
c. Determination of which evidence-based care guidelines to use should be based on judgment of practice leaders.

2.4

Registry information is available and in use by the Practice Unit team at the point of care

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

a. Registry functionality may be paper or electronic.
b. Practice unit has and is fully using the capability to generate up-to-date, integrated individual patient reports at the point of care to be used during the visit.

c. EHR would meet the requirements of this capability provided it contains evidence-based guidelines, and relevant information is identified and imported into screens or reports that facilitate easy access to all relevant data elements particular to the conditions under management, for the purpose of guiding point of care services.

2.5

Registry contains information on the individual practitioner for every patient currently in the registry who is an established patient in the practice unit

Specialist Guidelines:

a. Registry may be paper or electronic
b. The individual practitioner responsible for the care of each patient is identified in the registry
    i Registry should contain information on both specialist and patient's primary care physician
    ii Exceptions may be granted when patient does not want to identify provider, e.g., behavioral health providers
    i. Occasional gaps in information about some patients' individual attributed practitioner due to changes in medical personnel are acceptable

2.6

Registry is being used to generate routine, systematic communication to patients regarding gaps in care

PCP and Specialist Guidelines:

a. Registry may be paper or electronic.
b. Communications may be manual, provided there is a systematic process in place and in use for generation of regular and timely communications to patients.
c. Communications may be sent to patients via email, fax, regular mail, text messaging, or phone messaging.

2.7

Registry is being used to flag gaps in care for every patient currently in the registry

PCP and Specialist Guidelines:

a. Registry may be paper or electronic.
b. Registry must have capability to identify all patients with gaps in care based on evidence-based guidelines incorporated in the registry.
c. EHR would meet the requirements of this capability if it can be used to produce population level information on gaps in care for chronic condition patients.

2.8

Registry incorporates information on patient demographics for all patients currently in the registry

PCP and Specialist Guidelines:

a. Registry may be paper or electronic.
b. Registry contains basic patient demographics, including name, gender, date of birth.

2.9
Registry is fully electronic, comprehensive and integrated, with analytic capabilities

PCP and Specialist Guidelines:

a. Practice unit must have capability 2.2 in place in order to receive credit for 2.9
b. All data entities must flow electronically into the registry
c. Data is housed electronically
d. Linkages to other sources of information (as defined in 2.2) are electronic for all facilities and other health care providers with whom the practice unit regularly shares responsibility for health care.
e. Registry has population-level database and capability to electronically produce comprehensive analytic integrated reports that facilitate management of the entire population of the Practice Unit's patients.

2.10
Registry is being used to manage all patients with: Persistent Asthma

PCP and Specialist Guidelines:

a. Reference 2.1(a)-(g).

2.11
Registry is being used to manage all patients with Coronary Artery Disease (CAD)

PCP and Specialist Guidelines:

b. Reference 2.1(a)-(g).

2.12
Registry is being used to manage all patients with: Congestive Heart Failure (CHF)

PCP and Specialist Guidelines:

a. Reference 2.1(a)-(g).

2.13
Registry includes at least 2 other conditions

Specialist Guidelines:

a. Reference 2.1(a)-(g).
b. Registry is being used to manage all patients with at least 2 other conditions relevant to the specialist's practice for which there are evidence-based guidelines and the need for ongoing population and patient management, and which are sufficiently prevalent in the practice to warrant inclusion in the registry based on the judgment of the practice leaders

2.14

Registry incorporates preventive services guidelines and is being used to generate routine, systematic communication to all patients in the practice regarding needed preventive services

2.15

Registry incorporates patients who are assigned by managed care plans and are not established patients in the practice

2.16

Registry is being used to manage all patients with: Chronic Kidney Disease

PCP and Specialist Guidelines:

a. Reference 2.1(a)-(g).

2.17

Registry is being used to manage all patients with: Pediatric Obesity

PCP and Specialist Guidelines:

a. Reference 2.1(a)-(g).

2.18

Registry is being used to manage all patients with: Pediatric ADD/ADHD

PCP and Specialist Guidelines:

a. Reference 2.1(a)-(g).

2.19

Registry contains information identifying the individual care manager for every patient currently in the registry who has an assigned care manager

PCP and Specialist Guidelines:

a. Registry may be paper or electronic
b. Registry includes name of the care manager for each patient with an assigned care manager
c. Where a patient has more than one care manager, registry must identify which care manager is the lead care manager

2.20

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

PCP and Specialist Guidelines:

a. Registry may be paper or electronic.
    i. Registry contains advanced patient demographics to enable practices to identify vulnerable patient populations, including race and ethnicity, and also including data elements such as:

1. primary/preferred language
2. measures of social support (e.g., caretaker for disability, family network)
3. disability status
4. health literacy limitations
5. type of payer (e.g., uninsured, Medicaid)
6. relevant behavioral health information (e.g., date of depression screening and result)
7. social determinants of health such as housing instability, transportation limitations, food insufficiency, risk of exposure to violence

2.21

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

PCP and Specialist Guidelines:

b. Registry may be paper or electronic.
   ii. Registry contains advanced patient demographics to enable them to identify vulnerable patient populations, including:
      1. gender identity
      2. sexual orientation

3.0 Performance Reporting

Goal: Generate all-patient/payer reports enabling POs and providers to monitor their population level performance over time, close gaps in care, and improve patient outcomes.

Applicable to specialists for the patients for whom they have primary or co-management responsibility regardless of insurance coverage and including Medicare patients.

Seven of the Performance Reporting capabilities identify the population(s) of patients included in the reports (3.1, 3.3, 3.6, 3.10, 3.11, 3.12, and 3.13). The other Performance Reporting capabilities pertain to report attributes (3.2, 3.4, 3.5, 3.7, 3.8, 3.9, 3.14, 3.15, and 3.16). All capabilities pertaining to report attributes that are marked as in place must be in place for each population of patients marked as included in the reports.

3.1

Performance reports that allow tracking and comparison of results at a specific point in time across the population of patients are generated for: Diabetes (or, for specialists, relevant patient population selected for initial focus and not addressed in other 3.0 capabilities)

Specialist Guidelines:

a. Performance reports are systematic, routine, aggregate-level reports that provide current, clinically meaningful health care information on the population of patients that are included

in the relevant registry, allowing comparison of a population of patients at a single point in time
    i The registry may be a population registry, or a clinical registry, such as the ones surgical specialties use to track and address complications
b. The performance reports must be actively analyzed and used in self-assessment of provider performance
c. The reports must contain several dimensions of clinical data on patients to enable providers to manage their population of patients. Relevant clinical information that is the focus of attention in established, generally accepted guidelines, and is incorporated in common quality measures pertinent to the chronic illness, must be incorporated in the reports (i.e., physiologic parameters, lab results, medication use, physical findings, and patient behaviors such as peak flow meter use or daily salt intake)
d. It is acceptable for the performance reports to be produced and distributed on a regular basis by the PO or sub-PO, as long as the practice units have the capability to request and receive reports on a timely basis.

3.2
Performance reports are generated at the population level, Practice Unit, and individual provider level

Specialist Guidelines:

a. Population level optimally consists of PO and/or sub-PO population, but alternatively, as the PO works toward implementing registry capabilities across all practice units, the population level report may be based on a meaningful subset of relevant aggregated practice unit performance
b. Performance reports provide information and allow comparison at the population, practice unit, and individual provider level where feasible (i.e., PO has multiple specialist practices of same type) for all patients currently in the registry, regardless of insurance coverage and including Medicare patients

3.3
Performance reports include at least 2 other conditions

PCP and Specialist Guidelines:

a. Reference 2.13
b. Performance reports are being generated for at least 2 other **chronic conditions** (or for specialists, 2 other conditions relevant to the specialist's practice) not addressed in other 3.0 capabilities for which there are evidence-based guidelines and the need for ongoing population and patient management, and which are sufficiently prevalent in the practice to warrant inclusion in the registry based on the judgment of the practice leaders (regardless of insurance coverage and including Medicare patients).

3.4

Data contained in performance reports has been fully validated and reconciled to ensure accuracy

PCP and Specialist Guidelines:

a. The practice and PO have process to ensure that data in the registry are representative of the data in the patient's medical record
    i For example, where a test result is needed for management, evidence of the test being ordered should not be used as evidence that test was conducted, absent a test result report being received and entered in the record.

3.5

Trend reports are generated, enabling physicians and their POs/sub-POs to track, compare and manage performance results for their population of patients over time

Specialist Guidelines:

a. Performance reports include both current and past health care information for the population of patients currently in the registry (regardless of insurance coverage and including Medicare patients), allowing analysis and comparison of results across time (e.g., quarter to quarter, year to year).
b. Population level optimally consists of PO and/or sub-PO population where feasible (i.e., PO has multiple specialist practices of same type) but alternatively, as the PO works towards implementing registry capabilities across all practice units, the population level report may be based on a meaningful subset of relevant aggregated practice unit performance

3.6

Performance reports are generated for the population of patients with: Pediatric Obesity

PCP and Specialist Guidelines:

a. Reference 3.1.

3.7

Performance reports include all current patients in the practice, including well patients, and include data on preventive services

3.8

Performance reports include patient clinical information for a substantial majority of health care services received at other sites that are necessary to manage the patient population

PCP and Specialist Guidelines:

a. Reference guidelines for Capability 2.2
b. For all established patients in the registry, the performance reports are expected to include treatment information pertinent to standard quality metrics (e.g., use of beta blockers following AMI), but are not expected to contain comprehensive treatment information as this level of information is often contained in detailed narrative text in clinical notes.

c. Reportable items could include information about encounters (including observation bed stays, frequent ED visits), diagnosis and associated labs, physiologic parameters such as blood pressure, medications, or diagnostic services provided during the encounter.

3.9

Performance reports include information on services provided by specialists or sub-specialists

PCP and Specialist Guidelines:

a. Reference 3.1
b. Information on key preventive or disease specific services provided by specialists or sub-specialists is incorporated into performance reports.

3.10

Performance reports are generated for the population of patients with: Persistent Asthma

PCP and Specialist Guidelines:

a. Reference 3.1

3.11

Performance reports are generated for the population of patients with: Coronary Artery Disease [not applicable to pediatric practices]

PCP and Specialist Guidelines:

a. Reference 3.1

3.12

Performance reports are generated for the population of patients with: Congestive Heart Failure [not applicable to pediatric practices]

PCP and Specialist Guidelines:

a. Reference 3.1

3.13

Performance reports are generated for the population of patients with: Pediatric ADD/ADHD

PCP and Specialist Guidelines:

a. Reference 3.1

3.14

Performance reports include care management activity

PCP and Specialist Guidelines:

a. Care management activity should include the following information for each member of the care management team:
    i Patient caseload (number of unique patients)
    ii Number of in-person encounters

iii Number of telephonic encounters

3.15

Key clinical indicators are tracked and reported to external entities to which practices are accountable for quality measurement

Specialist Guidelines:

a. Practices or POs are tracking and reporting on key clinical indicators relevant to their practices, such as those outlined in HEDIS, PQRS and Meaningful Use standards

3.16

Performance reports are generated to track one or more Choosing Wisely recommendations relevant to scope of practice

PCP and Specialist Guidelines:

a. Practices or POs are tracking and reporting on one or more Choosing Wisely recommendations relevant to scope of practice for all patients, regardless of payer

4.0 Individual Care Management

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

Applicable to 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, 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

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/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 (Bachelors 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

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

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 EHR
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

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 Agency for Healthcare Research and Quality about CAHPS: http://www.ahrq.gov/cahps/index.html
    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. "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 or productive for the provider and patient.
c. 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 will examine the feet? Who will prepare the patient encounter form for use 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

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 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

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
a. Specialist must have systematic process in place to track care plans distributed to patients and returned to specialist, and where appropriate, to conduct periodic follow-up conversations with patients who have not yet executed an 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 for example:
    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 for example:
    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. 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
    ii. Spiritual distress: https://www.hpsm.org/documents/End_of_Life_Summit_FICA_References.pdf
    iii. Prognosis: http://eprognosis.ucsf.edu/
    iv. 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, family members, and caregivers about availability of care management services, and to document the conversation and the patient, family member, or caregiver response.

4.21

Multi-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

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:

a. Provider with lead responsibility must ensure that all care partners are aware of and have copies of advance care plan
b. Reference language in 8.11

4.23

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:

a. 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
b. Steps to address areas of concern or dissatisfaction have been identified.

5.0 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

Applicable to specialists.

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:

a. Clinical decision-maker must be an M.D., D.O., P.A., or N.P. If not M.D. or D.O., clinical-decision maker must have ability to contact supervising M.D. or D.O. on an immediate basis if needed

i. Clinical decision-maker may be, but is not required to be, the patient's primary care provider

b. Clinical decision-maker has the ability to direct the patient regarding self-care or to an appropriate level of care.
    i. When reason for patient contact is not relevant to provider's domain of care, provider will ensure that patient is able to contact PCP or other relevant provider
c. Clinical decision-maker communicates all clinically relevant information via phone conversation directly to patient's primary physician, by email, by automated notification in an EHR system, or by faxing directly to primary physician regarding the interaction within 24 hours (or next business day) of the interaction
d. For after-hour calls, clinical decision-maker responds to patient inquiry in a timely manner (generally 15-30 minutes, and no later than 60 minutes after initial patient inquiry)
    i. For urgent calls, clinical decision-maker responds to patient inquiry in a timely manner (generally 15-30 minutes, and no later than 60 minutes after initial patient inquiry)
    ii. For non-urgent calls during office hours, patients may be given response by phone before end of business day, or offered appointments in a timeframe appropriate to their health care needs

5.2
Clinical decision-maker accesses and updates patient's EHR or registry info during the phone call

PCP and Specialist Guidelines:

a. Clinical decision-maker (as defined in 5.1) must routinely have access to and update patient's EHR or registry information during all calls
    i. Occasional technical problems, such as failure of internet service in rural areas, may occur and would not constitute failure to meet the requirements of 5.2 as long as access to the EHR or registry is typically and routinely available
b. In circumstances where the patient is personally well known to clinician or the condition is non-urgent and easily managed, the clinician may not always need to access the EHR or registry during the call, and may update the record after the call

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

Specialist Guidelines:

a. Feedback from urgent care center is only required when the care provided to the patient is relevant to the condition being managed by the specialist
    i. For patients who do not reside within the specialist's geographic vicinity, establishment of a feedback loop may not always be possible
b. After-hours is defined as office visit availability during weekday evening (e.g., 5-8 pm) and/or early morning hours (e.g., 7-9 am) and/or weekend hours (e.g., Saturday 9-12),

sufficient to reduce patients' use of ED for non-ED care. After-hours provider may be at Practice Unit site or may be in a physically separate location (e.g., an urgent care location or a separate physician office) as long as it is within 30 minutes travel time of the PCMH
    i. Services provided by the after-hours provider must be billable as an office visit or an urgent care visit, not as an ER visit
c. If after-hours provider is different from Practice Unit (e.g., they are an urgent care center or a physician who shares on-call responsibilities), there must be an established arrangement for after-hours coverage, and the after-hours provider must be able to provide feedback regarding care encounter to the patient's Practice Unit within 24 hours or on the next business day
d. Practice Units may team with other practice units/physicians to provide after-hours urgent care
a. Patient referral to specialists, high tech imaging, and inpatient admissions recommended by urgent care providers should be made by or coordinated with PCP Provider who places high priority on avoiding unnecessary ED visits, and is routinely and systematically directing patients to after-hours care whenever appropriate
    i. If patient would have been brought into office during normal business hours, but is being sent to ED after-hours, this would not meet the requirements for this capability

5.4

A systematic approach is in place to ensure that all patients are fully informed about after-hours care availability and location, at the PCMH site as well as other after-hours care sites, including urgent care facilities, if applicable

PCP and Specialist Guidelines:

a. Providers should ensure patients know how to contact them during after-hours, and should ensure patients are aware of location of urgent care centers, when applicable
b. Where PCPs and specialists are in the same medical neighborhood, they should be aware of urgent care centers commonly used by care partners
    i. Specialists are encouraged to work with the PCP community to identify appropriate urgent care sites with whom they share clinical information

5.5

Practice Unit has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs (as defined under 5.3) during at least 12 after-hours per week

PCP and Specialist Guidelines:

a. Reference 5.3

5.6

Non-ED after-hours provider for urgent care accesses and updates the patient's EHR or patient's registry record during the visit

PCP and Specialist Guidelines:

a. Reference 5.3 for definition of non-ED after-hours provider for urgent care needs

b. Clinical decision-maker must routinely have access to and update patient's EHR or registry information during all visits
    i. Occasional technical problems, such as failure of internet service in rural areas, may occur and would not constitute failure to meet the requirements of 5.6 as long as access to the EHR or registry is typically and routinely available

5.7

Advanced access scheduling is in place: for PCPs, at least 30% of appointments are reserved for same-day appointments for acute and routine care (i.e., any elective non-acute/urgent need, including physical exams and planned chronic care services, for established patients); for specialists, tiered access is in place

Specialist Guidelines:

a. Specialists must establish tiered access system to address needs of sub-acute, chronic, and routine patients
    i. Same day appointments available for urgent patients
    ii. Appointments within 1-3 weeks available for sub-acute patients
b. Written policy for advanced access is available
    i. Patients are aware of policy and are not discouraged from requesting appointments

{Capability 5.8 need not be implemented by specialists}

5.9

Practice unit has telephonic or other access to interpreter(s) for all languages common to practice's established patients.

PCP and Specialist Guidelines:

a. Languages common to practice are defined as languages identified as primary by at least 5% of the established patient population
b. Language services may consist of third-party interpretation services or multi-lingual staff
c. Asking a friend or family member to interpret does not meet the intent of this capability

5.10

Patient education materials and patient forms are available in languages common to practice's established patients

PCP and Specialist Guidelines:

a. Languages common to practice are defined as languages identified as primary by at least 5% of the established patient population
b. Not applicable to practices where English is the primary language for 95% or more of the practice's established patient population

6.0 Test Results Tracking & Follow-up

Goal: Practice uses a standardized tracking system to ensure needed tests are received, results are communicated in a timely manner, and follow-up care is received

Applicable to specialists.

Provider ordering the test is responsible for following up to clearly communicate information about test orders and test results to partner provider, or to patient when indicated. When specialist recommends tests for co-managed patient, ordering PCP is responsible for all follow-up and for clearly communicating test orders and test results to partner provider.

6.1

Practice has test tracking process/procedure documented, which requires tracking and follow-up for all tests and test results, with identified timeframes for notifying patients of results

PCP and Specialist Guidelines:

a. Test tracking procedure must be in writing and identify all steps in process and timeframes
b. Procedure document must be reviewed and updated as needed annually

6.2

Systematic approach and identified timeframes are in place for ensuring patients receive needed tests and practice obtains results

PCP and Specialist Guidelines:

a. Follow-up occurs with patients to ensure necessary tests are performed
b. Communication processes are in place with testing entities as necessary, to ensure results are received
c. Results are reviewed, signed, and dated by the physician and noted in the patient's medical record

6.3

Process is in place for ensuring patient contact details are kept up to date

PCP and Specialist Guidelines:

a. Patients are asked at every visit to confirm that address and phone numbers are current

6.4

Mechanism is in place for patients to obtain information about normal tests

PCP and Specialist Guidelines:

a. Patients are informed about how to access normal test results
b. Process may use any of the following mechanisms:
    i. Patient phone call to specific phone number at practice, with instructions to patient on when to call
    ii. Phone call, text, or other secured messaging from practice to patient
    iii. Mail from practice

iv. Direct conversation with patient
v. Patient access via secure web portal (in conjunction with one of the above options for patients without internet access)
vi. Telling patients that "No news is good news" does not meet the intent of this capability. Patients must have clear understanding of how to obtain information about normal test results.

6.5
Systematic approach is used to inform patients about all abnormal test results

PCP and Specialist Guidelines:

a. Systematic approach is in place to flag as high priority results where follow-up is essential and the risk of not following up is high, i.e., tissue biopsies, diagnostic mammograms, INR tests
b. For high priority results, patient is contacted by phone (repeated attempts at different times of day, on different days if necessary; if necessary and acceptable to patient, email or patient portal may be used to request the patient call office; as a last resort, results may be sent by registered mail)
    i. For low priority results, such as minor lab abnormalities, contact may also be by letter
c. Systematic approach is in place to ensure that practice is aware of and communicates to patients about all abnormal test results for all patients, in a timely manner, and that patient communication process is clear and patients understand implications of test results

6.6
Systematic approach is used to communicate with patients with abnormal results regarding receiving the recommended follow-up care within defined timeframes.

PCP and Specialist Guidelines:

a. Patients requiring follow-up are flagged and follow-up timeframes are specified
    i. Provider makes at least 2 attempts to contact patient; for serious conditions, third attempt is made by certified mail
        - Communication attempts are documented in patient's medical record
b. Cancellations and no-show appointments are tracked and assessed to determine whether any patients require follow-up
c. Outcomes of follow-up action are filed in patient's medical record

6.7
Systematic approach is used to document all test tracking steps in the patient's medical record

PCP and Specialist Guidelines:

a. All phone calls, letters, and other communications with patient regarding testing and test results are documented in the patient's medical record

6.8

All clinicians and appropriate office staff are trained to ensure adherence to the test-tracking procedures; all training is documented either in personnel file or in training logs or records

PCP and Specialist Guidelines:

a. Practice unit or PO maintains record of training and can provide training content for review
b. Training occurs at time of hire for new staff, and is repeated at least annually for all staff

6.9

Practice has Computerized Order Entry integrated with automated test tracking system

PCP and Specialist Guidelines:

a. Test-tracking system has Computerized Order Entry system structured to log all test orders and is linked to automated tracking system that supports caregiver follow-up
b. Test tracking system has the ability to electronically receive and track results

8.0 Electronic Prescribing and Management of Controlled Substance Prescriptions

Goal: All providers use electronic prescribing and actively manage controlled substance prescriptions

8.7.

Full e-prescribing system is in place and actively in use by all physicians

PCP and Specialist Guidelines:

a. All practitioners routinely use an e-prescribing system for all prescriptions for non-controlled substances
b. E-prescribing system meets Medicare requirement standards

8.8

Electronic prescribing system is routinely used to prescribe controlled substances

PCP and Specialist Guidelines:

c. All practitioners routinely use an e-prescribing system to prescribe controlled substances

8.9

Michigan Automated Prescription System (MAPS) reports are routinely run prior to prescribing controlled substances

PCP and Specialist Guidelines:

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

8.10

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

PCP and Specialist Guidelines:

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

8.11

Controlled Substance Agreements are shared with all patient's care providers

PCP and Specialist Guidelines:

a. All practitioners ensure that copies of Controlled Substance Agreements are given to all of the patient's care providers
b. 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

9.0 Preventive Services

Goal: Actively screen, educate, and counsel patients on preventive care and health behaviors

Applicable to specialists.

When patient is co-managed by PCP and specialist, roles must be clearly defined regarding who is responsible for ensuring patients receive needed preventive services.
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.

9.1

Primary prevention program is in place that focuses on identifying and educating patients about personal health behaviors to reduce their risk of disease and injury.

PCP and Specialist Guidelines: Patient questionnaire or other mechanism is used to elicit information about personal health behaviors that may be contributing to disease risk

i. During well-visit exam and initial intake for new patients
ii. During other visits when behavior may be relevant to acute concern (e.g., tobacco use when patient presents with cough)

b. Patient assessment addresses personal health behaviors and disease risk factors, based on age, gender, health issues
    i. Behaviors and risks assessed should include a majority of the following (or other primary prevention procedures) as appropriate to the patient population: Alcohol and Drug Use, Breast Self-Examination, Awareness of Lead Exposure, Low Fat Diet and Exercise, Use of Sunscreen, Safe Sex, Testicular Self-Examination, Tobacco Avoidance, and Flu Vaccine

9.2
A systematic approach is in place to providing primary preventive services

PCP and Specialist Guidelines:

a. Preventive care guidelines are integrated into clinical practice (e.g., Michigan Quality Improvement Consortium - www.mqic.org). Examples of appropriate Guidelines include:
    i. Adult Preventive Services Guideline 18-49 Yrs
    ii. Adult Preventive Services Guideline 50-65 Yrs
    iii. Childhood Overweight Prevention Guideline
    iv. Prevention of Unintended Pregnancy in Adults
    v. Preventive Service for Children & Adolescents Ages Birth – 24 Months
    vi. Preventive Service for Children and Adolescents Ages 2-18 Yrs
    vii. Tobacco Control Guideline
b. Systematic appointment tracking system (implemented as part of Individual Care Management Initiative) is in place. 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).

9.3
Strategies are in place to promote and conduct outreach regarding ongoing well care visits and screenings for all populations, consistent with guidelines for such age and gender-appropriate services promulgated by credible national organizations

PCP and Specialist Guidelines:

a. Systematic reminder system is in place and incorporates the following elements:
    i. Age appropriate health reminders (e.g., annual physicals).
    ii. Age appropriate immunization information consistent with most current evidence-based guidelines
    iii. If reminders are generated by PO, offices should have knowledge of the process
b. For children and adolescents from birth to 18 years of age examples of outreach strategies may include birthday reminders for well-visits, kindergarten round-up, flu vaccine reminders, health fairs, brochures, school physical fairs
c. For adults, examples of outreach strategies may include annual health maintenance examination reminders, and age and gender-appropriate reminders about recommended screenings (e.g., mammograms)
d. Outreach should be systematic and consistent with evidence-based guidelines

9.4

Practice has process in place to inquire about a patient's outside health encounters and has capability to incorporate information in patient tracking system or medical record

PCP and Specialist Guidelines:

a. "Outside health encounter information" includes services such as immunizations provided at health fairs
b. Practice unit should include actual/estimated date of service in the medical record whenever possible
c. Information may be included in historical section of record

9.5

Practice has a systematic approach in place to ensure the provision/documentation of tobacco use assessment tools and advice regarding smoking cessation

PCP and Specialist Guidelines:

a. Examples may include yearly assessment sheet, tobacco use intervention programs

9.6

Written standing order protocols are in place allowing Practice Unit care team members to authorize and deliver preventive services according to physician-approved protocol without examination by a clinician

PCP and Specialist Guidelines:

a. Standing orders are orders for office personnel that are signed in advance by the physician authorizing the provision of specified services under certain clinical circumstances, and are reviewed/updated on a regular basis
b. Examples include vaccinations, fecal occult blood tests and mammogram orders, medication intensification algorithm for patients with lipid disorder or high blood pressure

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:

a. System with guideline-based reminders for age-appropriate risk assessment and screening tests, including for depression, is in place.
    i. Practice Unit may choose to implement tools such as checklists attached to the patient chart, tagged notes, computer generated encounter forms and prompting stickers.
    ii. Systematic process is in place for following up on any positive screening results (e.g., process is in place for managing positive depression screenings]
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
ii. Examples include accelerated regimen for colon and breast cancer screening in high risk patients

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

9.8

Staff receives regular training and/or communications and updates regarding health promotion and disease prevention and incorporates preventive-focused practices into ongoing administrative operations

PCP and Specialist Guidelines:

a. Applicable to either primary or secondary preventive services
b. Practice unit staff has received training or educational material regarding a full range of preventive services and health promotion issues
c. Training occurs at time of hire for new staff, and is repeated at least annually for all staff
    i. Educational material is circulated or posted when guidelines change
        - For example, PO or practice unit staff person may be assigned to update clinical personnel on standards and guidelines such as AHRQ newsletter updates, the immunization schedule & standards issued by the Advisory Committee on Immunization Practices, Alliance of Immunization in Michigan, or Centers for Disease Control and Prevention.
        - For example, information may be provided to practice units educating them on appropriate billing and ICD-9 codes in order to ensure accurate reporting for preventive medicine services (including use of the correct ICD-9 code for a physical)
d. Staff is trained (as appropriate to patient population) regarding consistently using and entering information into the Michigan Care Improvement Registry (MCIR)

9.9

Planned visits are offered as a means of providing preventive services in the context of structured health maintenance exams for which the practice team and patient are prepared in advance of the date of service

PCP and Specialist Guidelines:

a. Reference 4.8 for requirements of planned visit

10.0 Linkage to Community Services

Goal: Expand the PCMH-Neighborhood to include community resources. Incorporate use of community resources into patients' care plans and assist patients in accessing community services.

Applicable to specialists.

When patient is co-managed by PCP and specialist, roles must be clearly defined regarding who is responsible for ensuring patients receive needed community services.

10.1
PO has conducted a comprehensive review of community resources for the geographic population that they serve, in conjunction with Practice Units

PCP and Specialist Guidelines:

a. The review may take place within the context of a multi-PO effort
b. Review should include health care, social, pharmaceutical, mental health, and rare disease support associations
    i. If comprehensive community resource database has already been developed (e.g., by hospital, United Way) then further review by PO is not necessary
    ii. Review may include survey of practice units to assist in identifying local community resources

10.2
PO maintains a community resource database based on input from Practice Units that serves as a central repository of information for all Practice Units.

PCP and Specialist Guidelines:

a. The database may include resources such as the United Way's 2-1-1 hotline, and links to online resources.
b. At least one staff person in the PO is responsible for conducting a semiannual update of the database and verifying local resource listings (PO may coordinate with Practice Unit staff to ensure resource reliability)
    i. During the update process, consideration may be given to including new, innovative community resources such as Southeast Michigan Beacon Community's Text4Health program
    ii. It is acceptable for staff to not verify aggregate listings (such as 2-1-1) if they are able to document how often the listings are updated by the resource administrator
c. Resource databases are shared with other POs, particularly in overlapping geographic regions
d. Portion of database includes self-management training programs available in the community

10.3
PO in conjunction with Practice Units has established collaborative relationships with appropriate community-based agencies and organizations

PCP and Specialist Guidelines:

a. PO or practice is able to provide a list of organizations providing services relevant to their patient population in which collaborative, ongoing relationships are directly established
    i. 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

b. Collaborative relationships must be established with selected agencies with relevance to patients' needs
c. Collaborative relationships need to be established directly with the individual agencies (not via 2-1-1) and involve ongoing substantive dialogue

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

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

PCP and Specialist Guidelines:

a. Systematic process is in place for the practice unit team to educate new patients and all patients during annual exam (or other visits, as appropriate) about availability of community resources, and assessing and discussing the need for referral
    i. 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
    ii. Practice support staff are empowered to alert practice unit staff to possible psychosocial and other needs
    iii. For example, Practice Units may develop an algorithm (or series of algorithms) to guide the assessment and referral process
    iv. Additional information about available community resources should be disseminated via language added to patient-provider partnership documents, PO or Practice Unit website, brochures, waiting room signage, county resource booklets at check-out desk, or other similar mechanisms

10.6

Systematic approach is in place for referring patients to community resources

PCP and Specialist Guidelines:

a. Practice Unit must be able to verbally describe or provide written evidence of systematic process for referring patients to community resources.
    i. For example, systematic process may consist of standardized patient referral materials such as a "prescription form", computer-generated printout that details appropriate sources of community-based care, or other documented process or tools.
    ii. Assessments that identify a patient with need for referral are documented in the medical record to enable providers to follow-up during subsequent visits
    iii. Patients should have access to national and local resources that are appropriate for their ethnicity, gender orientation, ability status, age, and religious preference, including resources that are available in other languages such as Spanish, Arabic, and American Sign Language.
    iv. For example, if Practice Units within a PO have a great deal of diversity within their patient population, the PO may amass specific information about services for those diverse patient groups. Practice Units may also share information about resources for diverse groups.

10.7

Systematic approach is in place for tracking referrals of high-risk patients to community resources made by the care team, and making every effort to ensure that patients complete the referral activity

Specialist Guidelines:

a. Practice units have the responsibility to identify those patients who are at high risk of complications/decompensation for whom referral to a particular agency is critical to reaching established health and treatment goals.
b. Referrals to community resources should be tracked for high-risk patients. Practice Units are encouraged to create a hierarchy to ensure that vital services (such as referrals to mental health providers) are being tracked appropriately.
c. Specialists must ensure that PCPs are notified about referrals to community resources for high-risk patients.
d. The purpose of tracking the referrals is to ensure that these high-risk patients receive the services they need.

10.8

Systematic approach is in place for conducting follow-up with high-risk patients regarding any indicated next steps as an outcome of their referral to a community-based program or agency.

PCP and Specialist Guidelines:

a. Patients may be held partially responsible for the tracking process. For example, Practice Units may use technology such as Interactive Voice Response (IVR) for patients to report

initial contact and completion, develop a "passport" that patients can have stamped when they complete trainings or attend a support group, or use existing disease registries such as WellCentive to track community-based referral activities.

b. Process includes mechanism to track patients who decline care and obtain information about reasons care was not sought.

11.0 Self-Management Support

Goal: Systematic approach to empowering patients to understand their central role in effectively managing their illness, making informed decisions about care, and engaging in healthy behaviors.

Applicable to specialists. When patient is co-managed by PCP and specialist, roles must be clearly defined regarding which provider is responsible for leading self-management support activities and which provider is responsible for reinforcing self-management support activities.

To receive credit for a self-management support capability, basic self-management support delivered in the context of office visits must be available to all patients. Advanced self-management support, 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.

11.1

Clinician who is member of care team or PO staffperson is educated about and familiar with self-management support concepts and techniques and works with appropriate staff members at the practice unit at regular intervals to ensure they are educated in and able to actively use self-management support concepts and techniques.

PCP and Specialist Guidelines:

a. The intent of this capability is to actively empower the staff within the practice unit to incorporate self-management support efforts into routine clinic process.
b. Regular intervals are defined as a minimum of once per year
    i. New staff must be trained at time of entry to practice
c. Self-management support uses a team-based, systematic, model-driven (including behavioral and clinical dimensions) approach to actively motivating and engaging the patient in effective self-care for identified chronic conditions; must extend beyond usual care such as encouragement to follow instructions
d. Level, type, and intensity of training, education, and expertise may vary, depending upon team members' roles and responsibilities in the Practice Unit
    i. Education must be substantive and in-depth and focus on a particular model of self-management support and not consist of only a brief introduction to the concept. Recommended sites for more information include:
        - IHI Partnering in Self-Management Support: A Toolkit for Clinicians
            - http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx
        - Self-Management Support Information for Patients and Families:

http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforPatientsFamilies.aspx

- California Health Care Foundation Self-Management
  - http://www.chcf.org/publications/2009/09/selfmanagement-support-training-materials
- Flinders Self-Management Model: http://www.flinders.edu.au/medicine/fms/sites/FHBHRU/documents/publications/FLINDERS%20PROGRAM%20INFORMATION%20PAPER%20FINAL_M.pdf
- Motivational Interviewing
  - http://www.motivationalinterviewing.org/

e. Education of practice unit staff members may be provided by PO staff person if the PO staff person has adequate time to provide comprehensive, meaningful education; otherwise, practice unit is responsible for identifying a member of the practice's clinical care team to receive education in self-management support concepts and techniques

f. Appropriate team members should have awareness of self-management concepts and techniques, including:
   i. Motivational interviewing
   ii. Health literacy/identification of health literacy barriers
   iii. Use of teach-back techniques
   iv. Identification of medical obstacles to self-management
   v. Establishing problem-solving strategies to overcome barriers of immediate concern to patients
   vi. Systematic follow-up with patients

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)

PCP and Specialist Guidelines:

a. Self-management support is assisting patients in implementing their action plan through face-to-face interactions and/or phone outreach in between visits.
b. Self-management support services may be provided in the context of a planned visit
c. An action plan is a patient-specific goal statement that incorporates treatment goals including aspects of treatment that involve self-management. It is not an action step; it is a goal statement.
d. Physicians may provide self-management support within the context of E&M services
   i. 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

Systematic follow-up occurs for all patients in the patient population selected for initial focus who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders

PCP and Specialist Guidelines:

a. Follow-up may occur via phone, email, patient portal, or in person, and must occur at least monthly.

11.4

Regular patient experience/satisfaction surveys are conducted for patients engaged in self-management support, to identify areas for improvement in the self-management support efforts

PCP and Specialist Guidelines:

a. Surveys may be administered electronically, via phone, mail, or in person
b. Results must be quantified, aggregated, and tracked over time
c. Self-management support survey questions may be added to regular patient satisfaction surveys providing sampling is structured to ensure adequate responses from those who actually received self-management support services
d. If survey results identify areas for improvement, timely follow-up occurs (e.g., self-management support efforts are systematized to assure they are available on a timely basis to all patients for whom they are appropriate)

11.5

Self-management support is offered to multiple populations of patients within the practice's patient population (based on need, suitability and patient interest)

11.6

Systematic follow-up occurs for multiple populations of patients within the practice's patient population who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders

PCP and Specialist Guidelines:

a. Follow-up may occur via phone, email, patient portal, or in person, and must occur at least monthly.

11.7

Support and guidance in establishing and working towards a self-management goal is offered to every patient, including well patients (e.g., asking well patients about health goals)

PCP and Specialist Guidelines:

a. Self-management goal is developed collaboratively with the patient and is specific and reflective of the patient's interests and motivation

11.8

At least one member of PO or practice unit is formally trained through completion of a nationally or internationally-accredited program in self-management support concepts and techniques, and regularly works with appropriate staff members at the practice unit to educate them so they are able to actively use self-management support concepts and techniques.

PCP and Specialist Guidelines:

a. Training for self-management techniques should include:
    i. Motivational interviewing
    ii. Health literacy/identification of health literacy barriers
    iii. Use of teach-back techniques
    iv. Identification of medical obstacles to self-management
    v. Establishment of problem-solving strategies to overcome barriers of immediate concern to patients
    vi. Systematic follow-up with patients
b. Practices should seek structured information/approaches/processes, which can be from any legitimate source
c. Self-management training of the practice unit staff must be provided directly by the individual(s) certified as completing the formal self-management training
    i. A "train the trainer" model, where, for example, a PO staffperson who has completed a formal self-management training program trains practice consultants , who in turn train practice unit staff, does not meet the requirements for this capability.
    ii. Examples of training programs that meet the criteria are available from the PGIP Care Management Resource Center at http://micmrc.org/system/files/micmrc-approved-self-management-support-mcm-program-summary-v12a.pdf
    iii. Such programs must be sufficiently robust that they provide ample opportunities for learners to practice new self management support skills with individualized feedback as part of the practice experience.

12.0 Patient Web Portal

Goal: Patients have access to a web portal enabling patients to access medical information and to have electronic communication with providers

Applicable to specialists.
Patient web portal is a system that supports two-way, secure, compliant communication between the practice and the patient. For capabilities pertaining to patient's use of portal, practice unit staff must be trained in and have implemented this capability, and patients must be able to use it currently.

12.1
Available vendor options for purchasing and implementing a patient web portal system have been evaluated

PCP and Specialist Guidelines:

a. Assessment of vendor options may be conducted by PO or Practice Unit.

12.2

PO or Practice Unit has assessed liability and safety issues involved in maintaining a patient web portal at any level and developed policies that allow for a safe and efficient exchange of information

PCP and Specialist Guidelines:

a. Safety issues may include prohibiting electronic communication for emergency situations, etc.
b. All messages exchanged must be secure and HIPAA compliant.
c. Attestation of PO is acceptable

12.3

Patients actively request appointments electronically

PCP and Specialist Guidelines: Practice schedules patients and notifies them of their appointment time

12.4

Patients actively log and/or graph results of self-administered tests (e.g., daily blood glucose levels)

PCP and Specialist Guidelines:

a. Option should be available to patients, recognizing that not all patients will choose to use these tools. Demonstration of use is required

12.5

Providers are automatically alerted by system regarding self-reported patient data that indicates a potential health issue

PCP and Specialist Guidelines:

a. "Flags" may be set using customized parameters for individuals based on their care needs.

12.6

Patients actively participate in E-visits

PCP and Specialist Guidelines:

a. POs and/or Practice Units have developed and implemented protocol for responding to patient messages/requests for e-visits in a consistent and timely manner (e.g., a triage system), using structured online tools.
b. Please refer to the AAFP guidelines for e-visits for more information. The guidelines are available here: http://www.aafp.org/online/en/home/policy/policies/e/evisits.html

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)

12.8

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

PCP and Specialist Guidelines:

a. Personal health records are created and maintained by patients to improve their health care experience and reduce fragmentation of care, and typically include:
    i. 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
    ii. 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
b. Patients must be actively adding or augmenting existing health information in the portal
    i. 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

12.9

Patients actively review test results electronically

12.10

Patients actively request prescription renewals electronically

12.11

Patients actively graph and analyze results of self-administered tests for self-management support

PCP and Specialist Guidelines:

a. Option should be available to patients, recognizing that not all patients will choose to use these tools

12.12

Patients actively view registries and/or electronic health records online that contain patient personal health information that has been reviewed and released by the provider and/or practice

12.13

Patients actively schedule appointments electronically through an interactive calendar

PCP and Specialist Guidelines:

a. Patients should have the ability to see currently available appointments and insert themselves into the schedule of the practice. Time slot is then reserved for patient.
    1. May be subject to final confirmation by practice

13.0 Coordination of Care

Goal: Patient transitions are well-managed and patient care is coordinated across health care settings through a process of active communication and collaboration among providers, patients and their caregivers

When patient is co-managed by PCP and specialist, roles must be clearly defined regarding which provider is responsible for leading care coordination activities.
Applicable to specialists for patients for whom the specialist has lead care management responsibility or when the admission is relevant to the condition being managed by specialist.

13.1

For patient population selected for initial focus, mechanism is established for being notified of each patient admit and discharge or other type of encounter, at facilities with which the physician has admitting privileges or other ongoing relationships

PCP and Specialist Guidelines:

a. Standards for information exchange have been established among participating organizations to enable timely follow-up with patients.
b. Facilities must include hospitals, and may include long-term care facilities, home health care, and other ancillary providers.

13.2

Process is in place for exchanging necessary medical records and discussing continued care arrangements with other providers, including facilities, for patient population selected for initial focus

Specialist Guidelines:

a. Specialists systematically request that patients provide name of PCP
b. Patients are encouraged to request that their PCP be notified of any encounter they may have with other health care facilities and providers (for example, SNFs, rehab facilities, non-primary hospitals)
c. Practice units are responsible for ensuring that other providers have relevant medical information in a timely manner necessary to make care decisions

13.3

Approach is in place to systematically track care coordination activities for patient population selected for initial focus.

PCP and Specialist Guidelines:

a. Processes are structured to allow care coordination across other settings of care, and may include:
    i. Facility name
    ii. Admit date
    iii. Origin of admit (ED, referring physician, etc.)
    iv. Attending physician (if someone other than PCP)
    v. Discharge date
    vi. Diagnostic findings
    vii. Pending tests
    viii. Treatment plans
    ix. Complications at discharge

13.4

Process is in place to systematically flag for immediate attention any patient issue that indicates a potentially time-sensitive health issue for patient population selected for initial focus

PCP and Specialist Guidelines:

a. For example, home monitoring of CHF patient indicates weight gain, or diabetes patient is treated for cellulitis in ER, or a CHF patient has a change in mental health status

13.5

Process is in place to ensure that written transition plans are developed, in collaboration with patient and caregivers, where appropriate, for patients in patient population selected for initial focus who are leaving the practice (i.e., because they are moving, going into a long-term care facility, or choosing to leave the practice).

PCP and Specialist Guidelines:

a. Caregivers may include nurse, social workers, or other individuals involved in the patient's care
b. Practice units are responsible for ensuring that written transition plan is provided in a timely manner so that patient can receive needed care
c. Transition plan must consist of either a written summary or clear, concise excerpts from the medical record containing diagnoses, procedures, current medications, and other information relevant during the transition period (e.g., upcoming needed services, prescription refills)
d. A copy of the transition plan must be provided to the patient
e. Inability to develop collaborative plan due to voluntary, precipitous departure of patient from the practice, or unwillingness of the patient to participate, would not constitute failure to meet the requirements of 13.5

13.6

Process is in place to coordinate care with payer case manager for patients with complex or catastrophic conditions

PCP and Specialist Guidelines:

a. Process may be directed by PO or practice unit
b. Process should include ability to respond to and coordinate with payor case managers when the patient is enrolled in formal case management program
c. Process should include ability to contact health plan case managers when, in the clinician's judgment, unusual circumstances may warrant the coverage of non-covered services, particularly to avoid inpatient admissions or use of other higher-cost services

13.7

Practice has written procedures and/or guidelines on care coordination processes, and appropriate members of care team are trained on care coordination processes and have clearly defined roles within that process

PCP and Specialist Guidelines:

a. Written procedures and/or guidelines are developed for each phase of the care coordination process
b. The procedures or guidelines are developed by either the PO or practice unit
c. Training/education of members of care team are conducted by either the PO or practice
d. Training occurs at time of hire for new staff, and is repeated at least annually for all staff

13.8

Care coordination capabilities as defined in 13.1-13.7 are in place and extended to multiple patient populations that need care coordination assistance

Specialist Guidelines:

a. Applicable to multiple patient populations relevant to the practice
b. Written procedures and/or guidelines on care coordination processes may be developed by the PO or practice

13.9

Coordination capabilities as defined in 13.1-13.7 are in place and extended to all patients that need care coordination assistance

PCP and Specialist Guidelines:

a. Written procedures and/or guidelines on care coordination processes may be developed by the PO or practice

13.10

Following hospital discharge, a tracking method is in place to apply the practice's defined hospital discharge follow-up criteria, and those patients who are eligible receive individualized transition of care phone call or face-to-face visit within 24-48 hours

PCP and Specialist Guidelines:

a. PCP and specialists should coordinate to determine which physician(s) is/are most appropriate for follow-up
b. Hospital discharge follow-up criteria is defined by the practice

13.11
Practice is actively participating in the Michigan Admission, Discharge, Transfer (ADT) Initiative

PCP and Specialist Guidelines:

a. Practice maintains an all-patient list that has been sent to MiHIN's Active Care Relationship File in accordance with all MiHIN's specifications
b. The practice maintains an active and compliant status with the statewide health information exchange (HIE) system.
c. The practice has a process for managing protected health information in compliance with applicable standards for privacy and security.
d. The practice connects information received through the HIE process with clinical processes, such as transition of care management following hospitalization.

13.12
Practice is actively participating in the Michigan Admission, Discharge, Transfer (ADT) Medication Reconciliation Use Case

PCP and Specialist Guidelines:

a. The practice connects medication reconciliation information received through the HIE process with clinical processes, such as transition of care management following hospitalization, and a process exists for updating patient medical records

14.0 Specialist Pre-Consultation and Referral Process

Goal: Process of referring patients from PCPs to specialists, and from specialists to sub-specialists, is well coordinated and patient-centered, and all providers have timely access to information needed to provide optimal care

Applicable to specialists.

14.1
Documented procedures are in place to guide each phase of the specialist referral process – including desired timeframes for appointment and information exchange - for preferred or high volume providers

Specialist Guidelines:

a. Practice unit has defined parameters for specialist referral process, including when patient is being referred from PCP to specialist, and when specialist is referring to another sub-specialty, for preferred and high-volume providers

i. Parameters must define timeframes, scheduling process, transfer of patient information from referring physician to specialist, and reporting of results
ii. Parameters include procedures to ensure that PCPs are aware of what information is needed by specialist prior to appointments
iii. Parameters include procedures to ensure that when specialist is referring to a different specialist, the referring physician provides information needed prior to appointments

14.2

Documented procedures are in place to guide each phase of the specialist referral process – including desired timeframes for appointment and information exchange – for other key providers

Specialist Guidelines:

a. Other key providers are defined as PCPs who refer patients for management of an uncommon condition of special importance to the patient's well-being

14.3

Directory is maintained listing specialists to whom patients are routinely referred

Specialist Guidelines:

a. For PCPs with whom the specialist shares a meaningful number of patients, specialists will provide PCPs or POs with information needed to maintain the PCP's directory
    i. Information should include current contact information (phone, address, fax, list of key contacts: office manager, appt scheduler), provider updates (new providers or if providers left practice), new procedures/techniques available, any insurance changes, and a summary of any other key changes in the practice (EHR, patient portal)
    ii. Specialist must contact PCP or PO to validate information at least annually and update when necessary

14.4

PO or Practice Unit has developed specialist referral materials supportive of process and individual patient needs

Specialist Guidelines:

a. Processes are in place to ensure PCP referral materials are used appropriately by the specialist and other team members in the specialist office
a. Specialist practice must provide patient with a summary of the specialist appointment, including:
    i. Diagnosis, medication changes, plan of care
    i. Expected duration of specialist involvement
    ii. When the patient should return to the specialist and when the patient should return to the PCP
b. Visit information must be provided to patient in writing at time of visit

14.5

Practice Unit or designee routinely makes specialist appointments on behalf of patients

Specialist Guidelines:

a. Specialist coordinates with PCPs to make appointments for patients when requested to do so by PCP
b. Responsibility for notifying patient of appointment date and time is clearly established
c. Specialists schedule any out of office or sub-specialist referrals and notifies PCP of these appointments

14.6

Each facet of the interaction between preferred/high volume specialists and the PCPs at the Practice Unit level is automated by using bi-directional electronically-based tools and processes to avoid duplication of testing and prescribing across multiple care settings

Specialist Guidelines:

a. Specialist has capability to accept electronically-generated referrals via patient registry, portal system, or EHR, or other tools (e.g. Fusion by CareFX)
b. Policies have been developed to ensure safe, HIPAA compliant information exchange for all information related to the specialist referral process

14.7

For all specialist and sub-specialist visits deemed important to the patient's well-being, process is in place to determine whether or not patients completed the specialist referral in a timely manner, reasons they did not seek care if applicable, additional sub-specialist visits that occurred, specialist recommendations, and whether patients received recommended services

Specialist Guidelines:

a. System is in place to inform PCPs when patients are seen, identify what was done or recommended and whether the recommendations, including testing, procedures or follow up visits, occurred.
    i. If patient is not seen, specialist conducts outreach to patient and PCP is notified

14.8

Appropriate Practice Unit staff are trained on all aspects of the specialist referral process

PCP and Specialist Guidelines:

a. Training occurs at time of hire for new staff, and is repeated at least annually for all staff

14.9

Practice Unit regularly evaluates patient satisfaction with most commonly used specialists, to ensure physicians are referring patients to specialists that meet their standards for patient-centered care

Specialist Guidelines:

a. Specialist conducts patient satisfaction survey and provides results to referring PCPs

14.10

Physician-to-physician pre-consultation exchanges are used to clarify need for referral and enable PCP to obtain guidance from specialists and subspecialists, ensuring optimal and efficient patient care

Specialist Guidelines:

a. Specialist practice has mechanism in place to ensure PCP access to timely pre-consultation exchanges

14.11

When patient has self-referred to specialist, specialist obtains information from patient about PCP and informs PCP of patient's visit so PCP follow-up can be conducted

Specialist Guidelines:

a. Specialist routinely notifies PCP of visits when patients have self-referred

Addendum to PCMH and PCMH-N Interpretive Guidelines: Physician Group Incentive Program Glossary

This Glossary is a list of acronyms and terms used within the PGIP and PCMH programs

ACSC *Ambulatory Care Sensitive Conditions* Illnesses that generally do not result in hospitalization if managed properly (e.g., diabetes, asthma). In PGIP specifically, it is part of our inpatient dashboard, and defined as, "a subset of admissions designated by the Agency for Healthcare Research and Quality (AHRQ) that determines which admissions could be avoided with early intervention and good outpatient care."

CCM *Chronic Care Model* A framework created by Ed Wagner that summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels. The model draws on best practices and provides a foundation for collaborative programs, tools, and research aimed at improving care for the chronically ill.

CDR *Chronic Disease Registry* Database that aids in the collection of clinical data for patients with a specific disease (e.g., diabetes, asthma), or tracks specific medical tests (pap smear, mammogram). Also referred to as **patient registries,** CDRs facilitate population-based care management for physician practices.

CEB *Clinical Epidemiology and Biostatistics* A BCBSM department that provides analytic support for the Health Care Value division, of which PGIP is a part. The department conducts exploratory analyses, creates predictive models, and designs and conducts evaluations of PGIP programs.

EBCR *Evidence Based Care Report* A quarterly report provided by BCBSM to PGIP POs. The EBCR establishes a baseline snapshot of key clinical quality metrics for chronic conditions and preventive services for BCBSM members. The EBCR contains validated effectiveness of care measures based on HEDIS, MQIC, and BCBSM's own quality measures.

EHR/EMR *Electronic Health Records/Electronic Medical Records* An individual patient medical record in digital format.

E&M *Evaluation and Management* A set of professional procedure codes most simply categorized as a physician office visit.

E&M Uplift PCMH designated physicians receive enhanced fees for E&M codes billed to BCBSM. Eligibility for these "fee uplifts" is generally evaluated on an annual basis and is distributed at the practitioner level (specialist physicians are also eligible for fee uplifts, but theirs are for all RVU-based codes).

GDR *Generic Dispensing Rate* The rate (proportion of total adjusted prescriptions) at

which a less expensive generic drug is dispensed in lieu of the more expensive brand-name drug.

Initiative A PGIP program designed to improve health care. PGIP Initiatives may focus on a specific condition or service, and are chosen by each physician organization annually to help facilitate improvement opportunities throughout the health system.

IP *Inpatient* A person receiving medical treatment that requires a hospital stay.

IPA *Independent Practice Association* A group of independent physicians who work in their own private practices, but join together to pursue mutual interests, such as contracting collectively with payers.

Lean Thinking *Lean Thinking* or *Lean Manufacturing* *A model promoting a*n optimal way of producing goods through the removal of waste and inefficiency. Although Lean principles were developed in the manufacturing sector, there is increasing interest in its application to the field of healthcare

MI *Medical Informatics* A BCBSM department that provides support by developing statistical tools, reports, and models for PGIP-related initiatives. This department works closely with CEB.

OP *Outpatient* A person receiving medical treatment that does not require a hospital stay.

OSC *Organized Systems of Care* Highly functioning groups of primary care and specialty physicians affiliated with facility-based provider organizations who accept responsibility for collectively managing a shared population of patients. Based on the patient-centered medical home model, OSCs serve the needs of patients in an effective and efficient manner across multiple care settings, eliminating fragmentation and waste in the health care system.

OSCs are similar to **Accountable Care Organizations**, where a community of caregivers accepts accountability for a specific patient population, but have a broader focus on establishing health care systems that work for patients.

PCMH *Patient Centered Medical Home* A patient-centered medical home is an approach to providing comprehensive primary care for people of all ages and medical conditions. It is a way for a physician-led medical practice, chosen by the patient, to integrate health care services for that patient. There are two ways for providers to participate in BCBSM's PCMH Initiatives:

- Implementing PCMH capabilities in our 12 initiatives
  - Physician organizations receive incentive dollars for capability implementation within their practices
    - Practices can be either PCPs or specialists
- Becoming PCMH Designated

- Designation takes place at practice unit level
- Occurs annually, for PCPs only
- Providers receive enhanced fee for office-based E&M codes

PCMH-N *Patient Centered Medical Home Neighbor* Patient Centered Medical Home Neighbors are specialist physicians, and the "neighborhood" is BCBSM's way of integrating specialist providers into the PCMH model. The PCMH-N Interpretive Guidelines are the vehicle for describing how to operationalize that process.

PCLC *Primary Care Leadership Committee* BCBSM-appointed representatives from physician organizations, who provide guidance to BCBSM regarding current initiatives and the future direction of the PGIP program.

PCP *Primary Care Physician* In the Physician Group Incentive Program, we define this as a physician who is licensed in the state of Michigan in one of the following medical fields: internal medicine, family practice, general practice, pediatrics, and internal medicine/pediatrics.

PCS *Primary Care Sensitive* This term refers to an algorithm created by NYU that classifies types of emergency department visits. In PGIP specifically, it is a metric in the Emergency Department dashboard, defined as the first three New York University categories of emergency department use: non-emergent, emergent/primary care-treatable, and emergent-ED needed-preventable.

PGIP *Physician Group Incentive Program* A voluntary program for physician organizations, who are rewarded based upon performance improvement and participation in selected initiatives. This is BCBSM's primary approach to pay-for-performance.

PHO *Physician-Hospital Organization* A legal entity formed and owned by one or more hospitals and physician groups.

PHR *Personal Health Record* A health record that is initiated and maintained by an individual. An ideal PHR would provide a complete and accurate summary of the health and medical history of an individual by gathering data from many sources and making this information accessible online to anyone who has the necessary electronic credentials to view the information.

PMPM *Per Member Per Month* A method of expressing the cost of services and products. The PMPM cost is the total monthly cost divided by the number of members over which the cost is spread, or the total yearly cost divided by the number of members times 12.

PMS *Practice Management Software* A type of software that deals with the day-to-day operations of a medical practice. Such software frequently allows users to capture patient demographics, schedule appointments, maintain lists of insurance payers, perform billing tasks, and generate reports.

PO	*Physician Organization* A physician group composed of primary care and specialist physicians, which may be owned by physicians.
Population Health Management	An approach to health that aims to improve the health of an entire human population. Elements of population health management are embedded in each component of the PGIP program, including the PCMH and OSC models; one of the most common tools used to promote population health management is the chronic disease registry.
Practice Unit (PU)	The basic element of PGIP data collected through the PGIP Physician List process. A Practice Unit is one or more physician(s) within a PGIP PO who share clinical responsibility for a group of patients and are formally organized to provide medical care, consultation, and diagnosis/treatment through joint use of clinical information and care processes. In the majority of practice units this collaboration occurs in the context of shared facilities/equipment/personnel.
Sub-PO	A subdivision within a physician organization that is defined by the PO. These entities are larger than a Practice Unit, and also referred to as “sub-groups” or “physician groups.” Sub-POs assist POs in administering the elements of PGIP (e.g., tracking process improvements, parsing BCBSM datasets, distributing PGIP funds, etc.).