**This is the 2019 Revised PCMH Changes**

**Anything in Red was changed by BCBSM**

**BCBSM Physician Group Incentive Program**

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

**Interpretive Guidelines 2018-2019**

**V12.1**

    

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**Blue Cross Blue Shield of Michigan**

**Physician Group Incentive Program**

**Patient-Centered Medical Home**

**And Patient-Centered Medical Home-Neighbor Interpretive Guidelines**

***READ ME FIRST: Introduction***

***Everyone needs to read these into pages***

**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 overnight. 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 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 to address questions regarding extenuating circumstances.

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

4. ***Why have new capabilities been added over time, and why are some capabilities being retired?***

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, and new capabilities are added as needed based on new findings.

Starting in 2017, capabilities are retired when they no longer require substantive time and or resources to implement, due to the evolution of practice transformation.

**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, andmodel 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 take other remedial steps as deemed appropriate.

**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 and the PCMH Designation Program depends upon POs accurately reporting on their transformation efforts. Currently, a minimum of 50 PCMH capabilities must be in place for a practice to be designated. 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, anddata 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 Physician Organizations 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. 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.  All requested documentation must be available and provided **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. |

  

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| **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.

**Capabilities Overview**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | |
|  |  | **Required Capabilities** | **Retired Capabilities** | **Total Active Caps Applicable for Adult Patients** | **Total Active Caps Applicable for Pediatric Patients** | **Total Number of Capabilities** | **Total # Active Capabilities** |
| 1.0 | PPP | 1.1 | 1.9 | 11 | 11 | 120 | 119 |
| 2.0 | Patient Registry |  | 2.5 | 18 | 20 | 231 | 220 |
| 3.0 | Performance Reporting |  |  | 15 | 17 | 186 | 186 |
| 4.0 | Individual Care Management | 4.6 |  | 28 | 28 | 283 | 283 |
| 5.0 | Extended Access | 5.1 |  | 10 | 10 | 10 | 10 |
| 6.0 | Test Tracking | 6.2 6.5 | 6.3 | 8 | 8 | 9 | 8 |

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | |
| 8.0 | Electronic Prescribing |  |  | 5 | 5 | 5 | 5 |
| 9.0 | Preventive Services |  |  | 9 | 9 | 9 | 9 |
| 10.0 | Linkage to Community Services | 10.2 |  | 8 | 8 | 8 | 8 |
| 11.0 | Self- Management Support |  |  | 8 | 8 | 8 | 8 |
| 12.0 | Patient Web Portal |  | 12.1, 12.2, 12.8 | 11 | 11 | 14 | 112 |
| 13.0 | Coordination of Care |  |  | 12 | 12 | 12 | 12 |
| 14.0 | Specialist Referral Process |  | 14.3, 14.5, 14.10 | 8 | 8 | 11 | 810 |
|  | **TOTAL NUMBER** | **6** | **96** | **151** | **155** | **16756** | **1580** |
|  | | | | | | | |

**PCMH/PCMH-N INTERPRETIVE GUIDELINES**

1. **Patient-Provider Partnership**

**Start of the Changes**

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.

120 total capabilities; 1 retired; 1 required. All capabilities applicable to: Adult and Peds Patients

* 1. ***- Required***

***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***

*BCBSM PCMH and PCMH-N Interpretive Guidelines 2018-2019V12.1– 2017-2018*

*PCP Guidelines:*

1. Documentation does not need to be on paper. It 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.

*Specialist Guidelines:*

* 1. c. Documentation does not need to be on paper. It 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.

     

|  |  |
| --- | --- |
| **Required for PCMH Designation: YES** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| * Current documentation required (examples include flyer, tablet, patient brochure, etc.) * Demo of communication process includes conversation with patients and member of PU team using available tools to educate on PCMH * Demo of the documentation of partnership within the EMR or registry * All staff trained on PCMH model | |



1. Practice must also have mechanism to track percent of patients that have established  partnership, andpartnership and be able to provide data during site visit showing denominator (total number of “current” patients in the practice) and numerator (total number of patients in the denominator with whom conversations have been held and partnerships established at any point in the past).

*Specialist Guidelines:*

***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***

*PCP Guidelines:*

***1.9 Retired***

***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***

*PCP and Specialist Guidelines:*

1. 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 to fulfill the requirement to inform patients.

***1.10***

***Providers have an established process for repeating Patient-Provider Partnership discussion***

*PCP and Specialist Guidelines:*

***1.11***   **RETIRED**

***Practice has a regularly scheduled in-person new patient orientation that is distinct from a regularly scheduled visit, to set expectations about being a patient within that practice, and provide education about the value of a patient-centered medical home model.***

*PCP and Specialist Guidelines:*

a. Orientation can be in a group setting and led by a mid-level provider or nurse

|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: 1.1, 1.3-1.7** |
| **PCMH Validation Notes for Site Visits *necessary.*** | |
| • Most recent report that details the numerator, denominator and the percentage of active patients that have the PCMH agreement | |

    

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| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |

  

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| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |

  

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| **PCMH Validation Notes for Site Visits** |
| • Show agendas, patient handouts, meeting schedules for new patient orientation |
|  |

***1.12***

***Practice establishes a Patient and Family Advisory Council to better understand patient and caregiver perspectives, and how those perspectives can be used to optimize patient care.***

*PCP and Specialist Guidelines:*

1. For more information on creating a Patient and Family Advisory Council, review this module from the American Medical Association: https://www.stepsforward.org/modules/pfac
2. Cannot be solely hospital-based
3. Patients on committee must be current patients of the practice or their family members

**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.

231 total capabilities; 1 retired. Capabilities 2.11, 2.12 and 2.16 applicable to: Adult Patients only Capabilities 2.17, and 2.18, 2.22, and 2.23 applicable to: Peds Patients only

*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; however, to report capabilities as in place within this domain, the registry must be fully in place and routinely utilized.*

*Eleven not 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, 2.22, and 2.23). 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.*

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| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| * Show agendas, meeting schedules, attendee list for PFAC * Show examples of patient feedback collected from PFAC and demonstrate  how change was enacted based on feedback | |

***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)***

*PCP Guidelines:*

  

1. Reference AAFP article for additional information on Reference article on creating a simple disease 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 received at other sites that are necessary to manage the population***

*PCP Guidelines: Specialist Guidelines:*

***2.3***

***Registry incorporates evidence-based care guidelines***

*PCP and Specialist Guidelines:*

 

1. 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***

*PCP and Specialist Guidelines:*

***2.5* RETIRED**

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

 *PCP 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. Occasional gaps in information about some patients’ individual attributed practitioner due to changes in medical personnel are acceptable

*Specialist Guidelines:*

c.  Registry may be paper or electronic   

* 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

iii. 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:*

***2.7***

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

*PCP and Specialist Guidelines:*

***2.8***

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

*PCP and Specialist Guidelines:*

***2.9***

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

*PCP and Specialist Guidelines:*

***2.10***

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

*PCP and Specialist Guidelines:*  

***2.11***

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

*PCP and Specialist Guidelines:*

***2.12***

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

*PCP and Specialist Guidelines:*

***2.13***

***Registry includes at least 2 other conditions***

*PCP Guidelines:*

a. Reference 2.1(a)-(g). b. Registry includes at least 2 other **chronic conditions not addressed in other 2.0 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

i Examples of other chronic conditions include (but are not limited to) depression in adults, or sickle cell anemia, hypertension, anxiety

*Specialist Guidelines:*

***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***

*PCP Guidelines:*

***2.15***

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

*PCP Guidelines:*

a. Active outreach should be conducted to engage patients assigned by managed care plans a.b. Patients assigned by managed care plans s who are not established patients should must be included in the registry once they are established in the practice, and active outreach conducted to engage them as established patients 

***2.16***

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

*PCP and Specialist Guidelines:*

***2.17***

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

*PCP and Specialist Guidelines:*

***2.18***

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

*PCP and Specialist Guidelines:* 

***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:*

***2.20***

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

*PCP and Specialist Guidelines:*

***2.21***

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

*PCP and Specialist Guidelines:*

**2.22**

***Registry is being used to manage all patients with: pediatric autism***

*PCP and Specialist Guidelines:*

a. Reference 2.1(a)-(g). b. Information about screening tools for autism is available here: https://www.cdc.gov/ncbddd/autism/hcp-screening.html

      

|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| * Demo the process of using the registry tool to identify the patient population * Registry should contain relevant clinical info such as which screening tool was used to identify condition and related results from screening, along with next  steps/treatment plan which may include, but is not limited to, speech therapy,  occupational therapy, etc. * How is the info entered in the registry? * What do you do with it when you receive it, how do you address gaps in care | |

***2.23***

***Registry is being used to manage pediatric behavioral health disorders, which may include depression, anxiety, and/or eating disorders***

*PCP and Specialist Guidelines:*

a. Reference 2.1(a)-(g). b. If currently using depression for capability 2.13, a different condition other than depression must be used for this capability c. Examples of behavioral health screening tools include the PHQ2/9, Postpartum Depression Screening and GAD (Generalized Anxiety Disorder) scale

 

|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| * Demo the process of using the registry tool to identify the patient population * Registry should contain relevant clinical info such as which screening tool was used to identify condition and related results from screening, along with next  steps/treatment plan * How is the info entered in the registry? * What do you do with it when you receive it, how do you address gaps in care? | |
|  | |

**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.

186 total capabilities Capabilities 3.11 and 3.12 applicable to: Adult patients only Capabilities 3.6 ,and 3.13, 3.17, and 3.18 applicable to: Peds patients only *Applicable to PCPs; and to specialists for the patients for whom they have primary or co- management responsibility regardless of insurance coverage and including Medicare patients.*

***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)***

*PCP Guidelines:*

1. Performance reports are systematic, routine, aggregate-level reports that provide current, clinically meaningful health care information on the entire population of patients of all ages that are included in the registry (e.g., all diabetics, regardless of payor and including Medicare patients), allowing comparison across the population of patients, at a single point in time.

*Specialist Guidelines:*

|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| • The practice must demo how they are using these performance reports to improve population management.  • Steps: 1) For each cChronic cCondition, do they have are the relevant measures  included in the their performance reports? 2) What sort of review is being done with these reports? 3) What actions are taken? | |

***3.2***

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

*PCP Guidelines:*  

*Specialist Guidelines:*

***3.3***

***Performance reports include at least 2 other conditions***

*PCP and Specialist Guidelines:*

***3.4***

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

*PCP and Specialist Guidelines:*

  

***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***

*PCP Guidelines:*

*Specialist Guidelines:*

***3.6***

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

 

*PCP and Specialist Guidelines:*      

|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| • The practice must demo how they are using these performance reports to improve population management  1) For each cChronic cCondition, are do they have the relevant measures included in their performance reports?  2) What sort of review is being done with these reports?  3) What actions are taken? | |
|  | |

***3.7***

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

*PCP Guidelines:*

***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

|  |  |
| --- | --- |
|  | |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a2.2** |

***3.9***

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

*PCP and Specialist Guidelines:*

|  |
| --- |
| • The practice must demo how they are using these performance reports to improve population management.  • Steps: 1) For each cChronic cCondition, do they have are the relevant measures  included in their performance reports? 2) What sort of review is being done with these reports? 3) What actions are taken? |

***3.10***

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

*PCP and Specialist Guidelines:*

a. Reference 3.1



|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| • The practice must demo how they are using these performance reports to improve population management.  • Steps: 1) For each cChronic cCondition, do they have are the relevant measures  included in their performance reports?  2) What sort of review is being done with these reports?  3) What actions are taken? | |

***3.11***

***Performance reports are generated for the population of patients with: Coronary Artery Disease***

*PCP and Specialist Guidelines:*

a. Reference 3.1   

**PCMH Validation Notes for Site Visits**

• Steps: 1) For each cChronic cCondition, do they have are the relevant measures

included in their performance reports? 2) What sort of review is being done with these reports? 3) What actions are taken?

***3.12***

***Performance reports are generated for the population of patients with: Congestive Heart Failure***

*PCP and Specialist Guidelines:*

a. Reference 3.1



|  |
| --- |
| • The practice must demo how they are using these performance reports to improve population management.  • Steps: 1) For each cChronic cCondition, do they have are the relevant measures  included in their performance reports? 2) What sort of review is being done with these reports? 3) What actions are taken? |

***3.13***

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

*PCP and Specialist Guidelines:*

a. Reference 3.1



|  |
| --- |
| • The practice must demo how they are using these performance reports to improve population management.  • Steps: 1) For each cChronic cCondition, do they have are the relevant measures  included in their performance reports? 2) What sort of review is being done with these reports? 3) What actions are taken? |

***3.14***

***Performance reports include care management activity***

*PCP and Specialist Guidelines:*

***3.15***

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

*PCP Guidelines: Specialist Guidelines:*

***3.16***

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

*PCP and Specialist Guidelines:*

***3.17 Performance reports are generated for the population of patients with: Pediatric autism***    

|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| • The practice must demo how they are using these performance reports to improve population management.  • Steps: 1) For each chronic condition, are the relevant measures included in the performance reports?  2) What sort of review is being done with these reports?  3) What actions are taken? | |

***3.18***

Performance reports are generated for the population of patients with: ***pediatric behavioral***

***health disorders, which may include depression, anxiety, and/or eating disorders***

*PCP and Specialist Guidelines:* 

c. Reference 3.1



|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| • The practice must demo how they are using these performance reports to improve population management.  • Steps: 1) For each chronic condition, are the relevant measures included in the performance reports?  2) What sort of review is being done with these reports?  3) What actions are taken? | |

**4.0**

**Individual Care Management**

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

2823 total capabilities; 1 required All capabilities applicable to: Adult and Peds patients 

***4.1***

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

*PCP Guidelines:*

Website http://www.improvingchroniccare.org

*Specialist Guidelines:*

website: http://www.improvingchroniccare.org

***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:*

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.

|  |
| --- |
| * Multidisciplinary team (include RN, DM educators, etc.), regular team meetings, travel teams, ongoing communication w/ PU * Have oOffice describes team and condition addressed * Must be a multi-disciplinary team (min of 3 with RN). Examples of structured  communication between team -members aton planned intervals. |

***4.3***

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

*PCP Guidelines:*

*Specialist Guidelines:*

***4.4***

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

*PCP Guidelines: Specialist Guidelines:*

***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:*

***4.6- Required***

***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:*

***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:*

***4.8***

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

*PCP and Specialist Guidelines:*

 

1. Develop a script for the call, and then decide which team member will make the call. Set the tone and expectations for the issues addressed in the visit.

***4.9***

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

*PCP and Specialist Guidelines:* 

|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| * Group visit (2 hrs, no more than 20 pts), must include 1 on 1 with clinical decision-maker. MD * Discuss patient selection process, walk through group visit: Who attended the group visit? How did practice reach out to patients? Can practice identify group visits now occurring? | |

***4.10***

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

*PCP Guidelines:*

a. At a minimum, medication review and management is are provided by clinical decision- maker at every visit for all patients with chronic conditions.

*Specialist Guidelines:*

a. At a minimum, medication review and management is are provided at every visit for all patients with chronic conditions or when indicated given the patient’s health status

***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:*

***4.12***

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

*PCP and Specialist Guidelines:*

***4.13***

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

*PCP and Specialist Guidelines:*

Appointment tracking and reminder for ALL pts

***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:*

 ***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:*

***4.16***

* Group visit (2 hrs, no more than 20 pts), must include 1 on 1 with MD/NP/PA

*PCP Guidelines:*

b.c.If patient is not ready to sign an advance care plan, document in medical record and address at next health maintenance exam

*Specialist Guidelines:*

***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:*

***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:*

* 1. 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
  2.  Spiritual distress: https://www.hpsm.org/documents/End\_of\_Life\_Summit\_FICA\_References.pdf
  3. c) Palliative Care education for chaplaincy, nurses, social workers, and other  health professionals: https://csupalliativecare.org/programs/ Nursing Certification for APRNs, RNs, LPNs, CNAs: http://advancingexpertcare.org/certifications-handbooks-applications
  4. d) Palliative Care Social Work Certification: https://www.socialworkers.org/Careers/CredentialsCertifications
  5. e) Professional Chaplaincy Certification: http://bcci.professionalchaplains.org/content.asp?admin=Y&pl=42&sl=42&c ontentid=45
  6. f)c) Education in Palliative and End of Life Care: www.epec.net – all health care professionals

***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:*

***4.20***

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

*PCP and Specialist Guidelines:*

***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:*



***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:*

***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:*

Test of change? Outcome?  ***4.24 Physician organization and/or practice unit standardizes, develops and maintains care***  ***management processes and workflows, to ensure efficient delivery of care management services in the practices for whom they coordinate/administer care management.***

*PCP and Specialist Guidelines:*

a. This capability should be marked as “in-place” only for practices with whom the PO has worked to implement care management. Practice participation in care management may be verified using PDCM claims data.

***4.25***

***Physician organization ensures that care managers are trained, onboarded, and integrated into their practice(s) effectively. Includes ensuring training requirements are completed, creating process for “warm handoffs” from physician to care manager to facilitate strong uptake of care management services by patients, as well as development of communication materials to promote care manager as integral part of practice staff (i.e., flier about care manager role, business cards for care manager).***

*PCP and Specialist Guidelines:*

a. This capability should be marked as “in-place” only for practices with whom the PO has worked to implement care management. Practice participation in care management may be verified using PDCM claims data.

***4.26***

***Physician organization supports care management billing process for practices engaged in care management. PO may assist practice billing/coding staff with understanding care management billing process, and ensuring the appropriate training resources are utilized for billing.*** 

|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a4.24** |
| **PCMH Validation Notes for Site Visits** | |
| • PO or practice provides documentation about general policies related to care management delivery and examples of care management workflows | |

*  

|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a4.24** |
| **PCMH Validation Notes for Site Visits** | |
| • PO provides documentation on care manager training materials, care management training trackers, processes for ensuring warm handoffs, and/or practice materials used to introduce care manager to patients and caregivers | |



*PCP and Specialist Guidelines:*

a. This capability should be marked as “in-place” only for practices with whom the PO has worked to implement care management. Practice participation in care management may be verified using PDCM claims data.

***4.27***

***Physician organization assists practices with integrating and analyzing data related to effective care management, including the PDCM monthly member lists, and reports for tracking PDCM Engagement Initiative, to ensure optimal care management engagement and targeting***

*PCP and Specialist Guidelines:*

a. This capability should be marked as “in-place” only for practices with whom the PO has worked to implement care management. Practice participation in care management may be verified using PDCM claims data.



|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a4.24** |
| **PCMH Validation Notes for Site Visits** | |
| * PO or practice provides care management billing training/reference materials/job aids * PO or practice demonstrates billing of care management codes | |

 

|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a4.24** |
| **PCMH Validation Notes for Site Visits** | |
| * PO demonstrates procedure for processing/disseminating care management data to practices, including monthly patient lists and routine engagement reports and routine claims reports verified through health plan claims data * PO demonstrates how they assist practices in targeting high-risk patients | |

***4.28***

***Physician organizations assist practices with seeking waiver for offering Medication Assisted Treatment (MAT) as needed/desired to reduce opioid dependency in the practice’s patient population. Practices that seek waiver must be both willing and able to deliver medication assisted treatment to their patients.***

*PCP and Specialist Guidelines:*

a. For more information on medication-assisted treatment, refer to the following websites: https://www.samhsa.gov/medication-assisted-treatment and https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm600092.htm 

b. For more information on the waiver process, visit this site: https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training- materials-resources/buprenorphine-waiver 

|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| • Physician can provide evidence that they have successfully received waiver to deliver medication assisted treatment, and can also demonstrate that they have delivered medication assisted treatment to relevant patients through documentation in medical record. | |

**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. Practice must be routinely referring non-emergent patients to after-hours care, whether located at the practice site or another urgent care center (i.e., specialist practices that always send patients to ED do not meet the criteria for having after-hours care capabilities in place).

10 total capabilities; 1 required All capabilities applicable to: Adult and Peds patients

*Applicable to PCPs and specialists.*

***5.1 Required***

***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., D.C., licensed psychologist, P.A., or N.P. If not M.D. or D.O., clinical-decision maker must have ability to contact supervising 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 another 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

***5.2***

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

*PCP and Specialist Guidelines:*

***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***

*PCP Guidelines:*

  

*Specialist Guidelines:*

***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:*

***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:*

***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***

*PCP Guidelines:*

  

1. http://www.managedcaremag.com/archives/2002/12/same-day-appointments- promise-increased-productivity
2. Reference Institute for Healthcare Improvement articles at http://www.ihi.org/Topics/PrimaryCareAccess/Pages/default.aspx for information on implementing advanced access

*Specialist Guidelines:*

***5.8***

***Advanced access scheduling is in place reserving at least 50% of appointments for same-day appointment for acute and routine care (i.e., any elective non-acute/urgent need, including physical exams and planned chronic care services, for established patients)* [Applicable to PCPs only]**

*PCP Guidelines:*

***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:*

Languages common to practice are defined as languages identified as primary by at least 5% of the established patient population (\*Note – 5% is not required for 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.a. Not applicable to practices where English is the only language ?primary language for 95% or more of the practice’s established patient population ?

|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| * Practice shows examples of patient education materials in other languages * Languages common to practice are defined as languages identified as  primary  by at least 5% of the 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 9 total capabilities; 1 retired; 2 required. All capabilities applicable to: Adult and Peds patients

***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:*

***6.2 Required***

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

*PCP and Specialist Guidelines:*



|  |  |
| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| • Documented process required that includes time frames for notification. | |

 

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

***All 6.3* RETIRED**

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

|  |  |
| --- | --- |
| **Required for PCMH Designation: YES** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| • Demo the process of identifying follow-up for necessary test. | |

*PCP and Specialist Guidelines:*



a. Patients are asked at every visit address phone number are current

***6.4***

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

*PCP and Specialist Guidelines:*

i. Patient phone call to specific phone number at practice, with instructions to patient on when to call

1. Mail from practice   Reminder card from practice ???

vi. Telling patients that “No news is good news” does not meet the intent of this verbally telling patients to call a number without providing written instructions does not meet the intent of this capability. Patients must have clear understanding of how to obtain information about normal test results.



***6.5 Required***

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

*PCP and Specialist Guidelines:*

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 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:*

***6.7***

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

*PCP and Specialist Guidelines:*

***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:*

***6.9***

***Practice has Computerized Order Entry integrated with automated test tracking system***

*PCP and Specialist Guidelines:*

**8.0**

**Electronic Prescribing and Management of Controlled Substance Prescriptions**

Adult and Peds patients

***8.7***

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

*PCP and Specialist Guidelines:*

1. When possible, EHR or other automated system should be set to default to e-prescribing. E- prescribing system meets Medicare requirement standards

b.c.“ Actively in use” is defined as greater than 75% should we raise this to 75% or more? of non- controlled prescriptions prescribed by the practice

***8.8***

***Electronic prescribing system is routinely used to prescribe controlled substances***

*PCP and Specialist Guidelines:*

 

ii. Greater thanAt least 75% of controlled substance prescriptions prescribed by tge practice should be electronic

**\*\*\*2018 GRACE PERIOD – EVALUATED AT 50%+**

***8.9***

***Michigan Automated Prescription System (renamed “PMP AWARxE”) reports are routinely run prior to prescribing controlled substances***

*PCP and Specialist Guidelines:*

***8.10***

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

*PCP and Specialist Guidelines:*

https://www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForm s.pdf http://www.naddi.org/aws/NADDI/asset\_manager/get\_file/32898/opioidagreemen ts.pdf 

***8.11***

***Controlled Substance Agreements are shared with all patient’s care providers***

*PCP and Specialist Guidelines:*

**9.0**

**Preventive Services**

Goal: Actively screen, educate, and counsel patients on preventive care and health behaviors 9 total capabilities All capabilities applicable to: Adult and Peds patients. *Applicable to PCPs and select specialists managing the full scope of preventive services. 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:*

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

  

|  |
| --- |
| * Provide a copy of the patient intake form & discuss the process for identifying patients in need of preventive services * Counseling on isolated elements of prevention, such as tobacco cessation, does not meet the intent of this capability; only comprehensive primary prevention meets the intent |

***9.2***

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

*PCP and Specialist Guidelines:*

***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:*

  

***9.4***

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

*PCP and Specialist Guidelines:*

***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:*

***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:*

***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:*

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

May not be applicable to some specialty types

     

***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:*

***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:*

**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.

8 total capabilities; 1 required All capabilities applicable to: Adult and Peds patients

***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:*

***10.2 - Required***

***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:*

1. The database may include resources such as the United Way’s 2-1-1 hotline, and links to online resources such as www.auntbertha.com.
2. 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)
   1. During the update process, consideration may be given to including new, innovative community resources such as Southeast Michigan Beacon Community’s Text4Health program
   2. 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
3. Resource databases are shared with other POs, particularly in overlapping geographic regions
4. Portion of database includes self-management training programs available in the community



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| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| * Discuss review process with PO representation at the visit. * United Way or other formal databases will count | |

  

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| **Required for PCMH Designation: YES** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| • Demo examples in the database | |



***10.3***

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

*PCP and Specialist Guidelines:*

***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:* 

***10.5***

***Systematic team approach is in place for assessing and educating all patients about availability of community resources and assessing and discussing the need for referral***  *PCP and Specialist Guidelines:*

***10.6***

***Systematic approach is in place for referring patients to community resources***

*PCP and Specialist Guidelines:*



***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***

*PCP Guidelines:*

1. 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.

*Specialist Guidelines:*

1. 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.  ???

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| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| * What does the referral process look like and who is involved? * Are appointments made for patients? (Dedicated staff member) | |

 

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| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| • Demo how follow-up occurs with high-risk patients. What are examples of “high-risk” regarding community resources for the practice? | |

***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:*

**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.  8 total capabilities All capabilities applicable to: Adult and Peds patients

***11.1***

***Clinician who is member of care team or PO staff person 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:*

1. The expectation intent of this capability is that POs areo actively empowering the staff within the practice unit to incorporate self-management support efforts into routine clinic process.

 • http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolki

tforClinicians.aspx

Self-Management Support Information for Patients and Families:

http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforPatientsF amilies.aspx

California Health Care Foundation Self-Management http://www.chcf.org/publicatins/2009/09/selfmanagement-support-training-materials

Flinders Self-Management Model: http://www.flinders.edu.au/medicine/fms/sites/FHBHRU/documents/publi cations/FLINDERS%20PROGRAM%20INFORMATION%20PAPER%20FINAL\_M. pdf

* South West Self-Management Program: http://www.swselfmanagement.ca/smtoolkit/
* • http://www.motivationalinterviewing.org/

***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:*

***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:*

***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:*



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| **Required for PCMH Designation: NO** | **Predicate Logic: 11.1, 11.2** |
| **PCMH Validation Notes for Site Visits** | |
| * Documented survey results * Demonstrate examples of areas of improvement and action taken based on  survey results * Have results improved based on actions taken? | |

***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***

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| **Required for PCMH Designation: NO** | **Predicate Logic: 11.1, 11.2** |
| **PCMH Validation Notes for Site Visits** | |
| * How do you engage patients in self-mgmt? * What tools are you using? * What chronic condition/s have you chosen for self-management? | |



*PCP and Specialist Guidelines:*

***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:*  

* 1. A “train the trainer” model, where, for example, a PO staff person who has  completed a formal self-management training program subsequently trains practice consultants, who in turn train practice unit staff, does not meet the requirements for this capability.
  2. 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

**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

14 total capabilities; 32 retired.

All capabilities applicable to: Adult and Peds patients

***12.1* RETIRED**

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

*PCP and Specialist Guidelines:*

***12.2* RETIRED**

***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:*

***12.3***

***Patients actively request appointments electronically***

a. *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, blood pressure, weight)***

*PCP and Specialist Guidelines:*

***12.5***

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

*PCP and Specialist Guidelines:*

***12.6***

***Patients actively participate in E-visits***

*PCP and Specialist Guidelines:*

Please refer to the AAFP guidelines for e-visits for more information. The guidelines are available here: https://www.aafp.org/about/policies/all/virtual-visits.html 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:*

 

***12.8* RETIRED**

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

*PCP and Specialist Guidelines:*

***12.9***

***Patients actively review test results electronically***

***12.10***

***Patients actively request prescription renewals electronically***

  

**PCMH Validation Notes for Site Visits**

***12.11***

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

*PCP and Specialist Guidelines:*

***12.12***

***Patients actively view visit summaries 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***

    

 

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| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| * Demo of how the patient accesses the medical record & what info is available to them * Elements must include, at a minimum: active diagnoses, current medications, allergies, treatment plan, next steps/follow-up | |

***12.13***

***Patients actively schedule appointments electronically through an interactive calendar***

*PCP and Specialist Guidelines:*

***12.14***

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

**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  12 total capabilities All capabilities applicable to: Adult and Ped Pediatrics patients  Applicable to PCPs. 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:*

***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***  *PCP Guidelines:*

*Specialist Guidelines:*

***13.3***

***Approach is in place to systematically track patient population selected for initial focus.***

*PCP and Specialist Guidelines:*

**PCMH Validation Notes for Site Visits**

***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:*

***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:*

***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 judgment, unusual circumstances may warrant the coverage of non-covered services, particularly to avoid inpatient admissions or use of other higher-cost services the patient is enrolled in formal case management program

***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:*

***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***

*PCP Guidelines:*



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| --- | --- |
| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| * Process for case management coordination: BCN is 800-775-2283392-2512, BCBSM is 800-845-5982, Blue Cross Complete is 800-228-8554 * Discuss process for referrals to case managers | |

 

*Specialist Guidelines:*

***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:*

***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:*

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| **Required for PCMH Designation: NO** | **Predicate Logic: 13.1-13.8** |
| **PCMH Validation Notes for Site Visits** | |
| * Must have 13.1-13.7 in place before 13.9 * Written procedures and/or guidelines on care coordination processes may be  developed by the PO or practice | |



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| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| * Documentation required for tracking process * PCP and specialists should coordinate to determine which physician(s) is/are  most appropriate for follow-up * Who at the PU contacts the patient for the Transition of Care (TOC) visit? * What is the time frame for patient contact (e.g. 24-48 hours?) * Are same day appointments held for TOC visits? | |

***13.11***

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

*PCP and Specialist Guidelines:*

1. Practice maintains an all-patient list that has been sent to MiHIN’s Active Care Relationship (ACRS) File in accordance with all MiHIN’s specifications

  

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| **Required for PCMH Designation: NO** | **Predicate Logic: n/a** |
| **PCMH Validation Notes for Site Visits** | |
| * Practice maintains an all-patient list that has been sent to MiHIN’s Active Care Relationship (ACRS) File in accordance with all MiHIN’s specifications * The practice maintains an active and compliant status with the statewide HIE system. * The practice has a process for managing protected health information in compliance with applicable standards for privacy and security. * The practice connects information received through the HIE process with clinical processes, such as transition of care management following hospitalization. * Who at the PU has access to the ADT information and how is the information used? * How often do you access the ADT? * What is your patient outreach process after an ED visit or IP visit (include  timeframe)? | |



***13.12***

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

*PCP and Specialist Guidelines:*

**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

11 total capabilities; 31 retired. All capabilities applicable to: Adult and Peds patients

*Applicable to PCPs and 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***

*PCP Guidelines:*         

*Specialist Guidelines:*

• Please reference introduction, p. 72-3

***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***

*PCP Guidelines:*

*Specialist Guidelines:*

14.3 RETIRED

***Directory is maintained listing specialists to whom patients are routinely referred***

*PCP Guidelines*

*Specialist Guidelines:*

  

**PCMH Validation Notes for Site Visits**

***14.4***

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

*PCP Guidelines:*

*Specialist Guidelines:*

***14.5***   **RETIRED**

***Practice Unit or designee ensures patients are scheduled for specialist appointments in timely manner***

    

*PCP Guidelines:*  

*Specialist Guidelines:*

***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***

*PCP Guidelines: Specialist Guidelines:*

1. Specialist has capability to accept electronically-generated referrals via patient registry, portal system, or EHR, or other tools (e.g. Fusion by CareFX)

***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***

*PCP Guidelines:*

  

*Specialist Guidelines:*

***14.8***

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

*PCP and Specialist Guidelines:*

***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***

*PCP Guidelines:*

*Specialist Guidelines:*

  

***14.10* RETIRED**

***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***

*PCP Guidelines:*

*Specialist Guidelines:*

***14.11***

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

*PCP Guidelines: Specialist Guidelines:*

 

 

    