



BCBSM Physician Group Incentive Program 2012 Program Year

**Patient-Centered Medical Home
Extended Access**

Initiative Plan



I. Initiative Overview

The Blue Cross Blue Shield of Michigan (BCBSM) Patient-Centered Medical Home Initiatives are part of the Physician Group Incentive Program (PGIP). Since its inception in 2005, PGIP has supported and facilitated practice transformation using a wide variety of initiatives to reward physician organizations (POs) for improved performance in health care delivery. As of September 2011, PGIP includes 40 POs from across the state of Michigan, representing nearly 15,000 primary care and specialty physicians who are members of the BCBSM TRUST PPO and/or Traditional Networks. These physicians provide care to nearly two million BCBSM members.

BCBSM's Physician Group Incentive Program encourages all payer collaboration, catalyzing all payer system development, rather than payer-specific system development. Through PGIP, BCBSM is helping to improve the quality of care for all Michigan residents. Patients throughout the state, regardless of payer, benefit from the improved care processes developed through the PGIP provider community. Developing systems of care which are used for all patients helps assure that providers don't have to alter care processes based on whether patients have insurance, or which insurance they have. This is an important factor in ensuring that the best practices and care processes are reliably provided to all patients, all of the time. This all-payer approach to practice transformation is good for patients with coverage from BCBSM and BCN and helps further BCBSM's social mission of cultivating a healthier future for all Michigan residents.

BCBSM's PCMH program has provided the foundation to build Organized Systems of Care (OSCs). An Organized System of Care (OSC) is a community of caregivers consisting of primary care practices, specialists/subspecialists, hospitals and other providers that measure performance, set goals, track progress, and coordinate care across the continuum for the primary care-attributed patient population. The OSC assumes responsibility for establishing shared information systems and care processes, and accepts accountability for delivering effective and efficient patient care over time and across settings of care.

Specialty and sub-specialty practices affiliated with the OSC are expected to engage in care processes consistent with the principles of the Patient-Centered Medical Home Neighbor (PCMH-N) model¹:

- Ensure effective communication, coordination, and integration with PCMH practices
- Provide appropriate and timely consultations and referrals that complement the aims of the PCMH practice(s)
- Confirm the appropriate flow of necessary patient and care information
- Determine responsibility for all types of clinical interactions, in accordance with the definitions listed below
- Support patient-centered care, enhanced care access, and high-quality, safe care
- Recognize the PCMH practice as the provider of the patient's primary care
- Understand that the PCMH practice has overall responsibility for coordination and integration of care provided to the patient

For more information about Organized Systems of Care and the specialist role within the PCMH model, please see the Organized Systems of Care Initiative Plan.

Goals and Objectives

The goal of the Extended Access Initiative is to ensure that all patients have comprehensive and timely access to health care services that are patient-centered, culturally sensitive, and delivered in the least intensive and most appropriate setting based on the patient's needs. Ultimately, implementation of this Initiative will lead to reduced non-emergent Emergency Department visits, improved practice efficiency and increased patient satisfaction.

The objective of the Extended Access Initiative is to annually increase the percentage of PGIP practice units that have implemented the capabilities associated with this Initiative.

Summary of Results

For details on progress being made by Physician Organizations participating in this Initiative, please refer to the *Results* section of this Initiative plan.

In 2012, BCBSM will continue to engage participating POs in their efforts to implement the tasks associated with this Initiative, offering assistance as needed. BCBSM will also update the *PCMH Interpretive Guidelines* annually, based on PO feedback and clarification about the Initiative tasks.

II. Background

Health Problem and Significance

Patients who have adequate access to primary care are more likely to be satisfied with the health care they receive, and to have better health status and lower rates of inpatient, specialist and emergency department use. Multiple studies have found that patients who have a regular source of care and continuous care with the same physician over time, have higher rates of preventive screening,² better health, and lower overall costs of care.³ Communities with sufficient numbers of primary care providers have less disparity in health outcomes for socially disadvantaged subpopulations and healthier populations overall.⁴

Researchers report that only 27% of adults (and 12% of low-income Americans) have full access to a well-organized source of health care.⁵ Studies have found that as many as 50% of ED visits are for non-emergent problems that could have been handled in a primary care setting.⁶

Solo or smaller practices may find it impractical to provide 24/7 phone coverage or urgent care access on their own. Arrangements may be made with other practices to share extended access responsibilities, or with free-standing urgent care centers that are reasonably close by.

III. Initiative Description

To support and promote the concept of the Patient-Centered Medical Home (PCMH), and in recognition of the challenges associated with transitioning to a PCMH model, BCBSM invites PGIP-participating POs to collaborate with us in a two-pronged PCMH approach:

- I. PCMH Related PGIP Initiatives: Opportunity to participate in Initiatives that support development of competency as a PCMH.
- II. PCMH Designation Program: Implementation of differential reimbursement for PGIP physicians who meet criteria for BCBSM designation as a PCMH

Both opportunities are optional for providers. In addition, POs and their Practice Units do not have to apply for PCMH Designation to participate in the PCMH Initiatives.

POs that choose to participate in PCMH Initiatives will receive incentive rewards commensurate with their performance and participation in their selected Initiatives.

Specific Area of Focus

Participants in this Initiative will ensure that all patients have comprehensive and timely access to health care services that are patient-centered, culturally sensitive, and delivered in the least intensive and most appropriate setting based on the patient’s needs. Participants will receive incentive payments for implementing the capabilities listed in Table 1 below, and meeting the stated goals and objectives of this Initiative plan.

Consistent with the overall design of PGIP, an integral part of this Initiative is that PO-identified Practice Units will work to implement capabilities to successfully accomplish the stated objectives. POs are responsible for providing leadership, support, coordination, and monitoring of Practice Unit practice transformation activity. POs will be expected to maintain documentation, which can be provided to BCBSM upon request, regarding the capabilities that Practice Units implement during the course of their participation in the PCMH Initiatives, and which Practice Units identify as being “fully in place” on the PCMH self-assessment survey. Future practice audits are possible.

TABLE 1. Extended Access Initiative Capabilities	
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
5.2	Clinical decision-maker accesses and updates patient's EMR or registry info during the phone 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 PCP office, after-hours provider has a feedback loop within 24 hours or next business day to the patient's PCMH
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
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
5.6	Non ED after-hours provider for urgent care accesses and updates the patient's EMR or patient's registry record during the visit
5.7	Advanced access scheduling is in place, reserving at least 30% of appointments 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)
5.8	Advanced access scheduling is in place reserving at least 50% of appointments for same-day appointments for routine and acute care (i.e., any elective non-acute/urgent need, including physical exams and planned chronic care services, for established patients)
5.9	Practice Unit has telephonic or other access to interpreter(s) for all languages common to practice's established patients.

Criteria for Participation

To participate in this Initiative, POs must currently participate in the Physician Group Incentive Program.

BCBSM Deliverables

BCBSM will provide PCMH Interpretive Guidelines to participating POs, and update the guidelines at least annually based on PO and practice questions and feedback. The Interpretive Guidelines provide detailed descriptions of each capability associated with each PCMH Initiative to deepen PO and practice unit understanding of program expectations and the PCMH model.

BCBSM will also conduct site visits to enrich PO and practice unit understanding of the Patient-Centered Medical Home Initiatives.

In addition, BCBSM will provide semi-annual Progress Report templates and a database for the collection of Self-Reported PCMH data, so that POs can adequately fulfill their reporting requirements.

PO Expectations

POs are expected to complete all reporting requirements, including self-reported data about practice unit performance on PCMH capabilities, twice per year. POs are also strongly encouraged to participate in workgroups and webinars related to their PCMH involvement, and to collaborate with their fellow POs to share best practices.

Incentive Model & Payment Methodology

This Initiative will have 2 Incentive Payment periods:

- January 1 – June 30 (6 months)
- July 1 – December 31 (6 months)

Physician Organizations will receive incentive payments commensurate with their performance on implementing PCMH capabilities during the six-month incentive payment period. POs will be expected to complete the following reporting requirements in a timely manner:

- At the end of each six-month incentive payment period, update PCMH self-reported data, identifying all tasks implemented by each participating Practice Unit
- Once per year, complete the PCMH progress reports, identifying best practice accomplishments, challenges encountered, and outlining plans to overcome barriers to success

POs are encouraged to maintain high-level implementation plans to assist them in tracking progress and recording key milestones related to the PCMH Initiatives.

Performance payments will reflect the percent of the PO's total practice units that implement an Initiative capability. POs employing a phased approach to practice unit involvement in an Initiative will not be financially penalized since there is no time limit for implementation of PCMH capabilities.

Note: BCBSM reserves the right to modify its evaluative and administrative processes related to the Initiative at any time.

IV. Evaluation

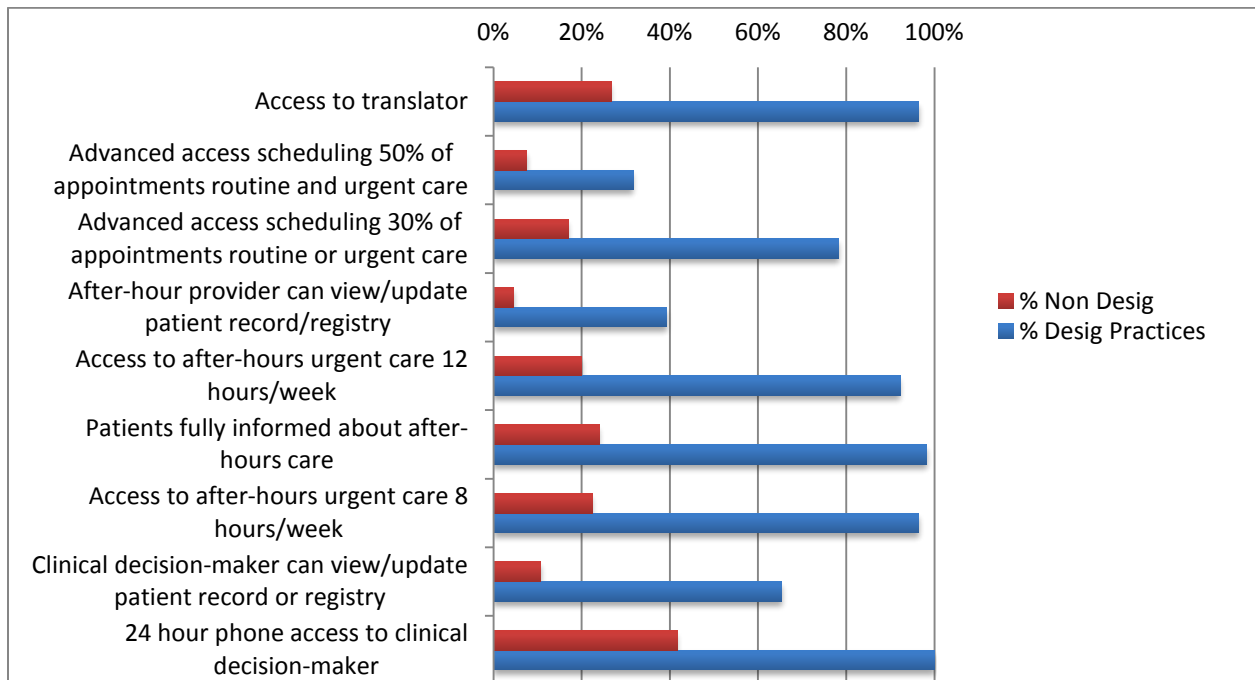
A long-term evaluation of the Patient-Centered Medical Home Program is currently underway. Objectives of the evaluation are as follows:

- Assess the rate of PCMH implementation to assist providers with understanding the level of commitment needed for long-term development of their medical home
- Determine whether the PCMH model is associated with more efficient utilization of services
- Determine whether the PCMH model is associated with improved performance in evidence-based care
- Determine whether the PCMH model is associated with lower overall medical and pharmacy costs
- Estimate savings, if any, generated from the PCMH program and its associated Initiatives
- Determine whether members who obtain care in a patient-centered medical home are more likely to have a continuous source of care than members who obtain care in practices without patient-centered medical home capabilities
- Determine stakeholder awareness of and satisfaction with the PCMH program
- Determine whether the PCMH model is associated with improved patient satisfaction with their medical care.

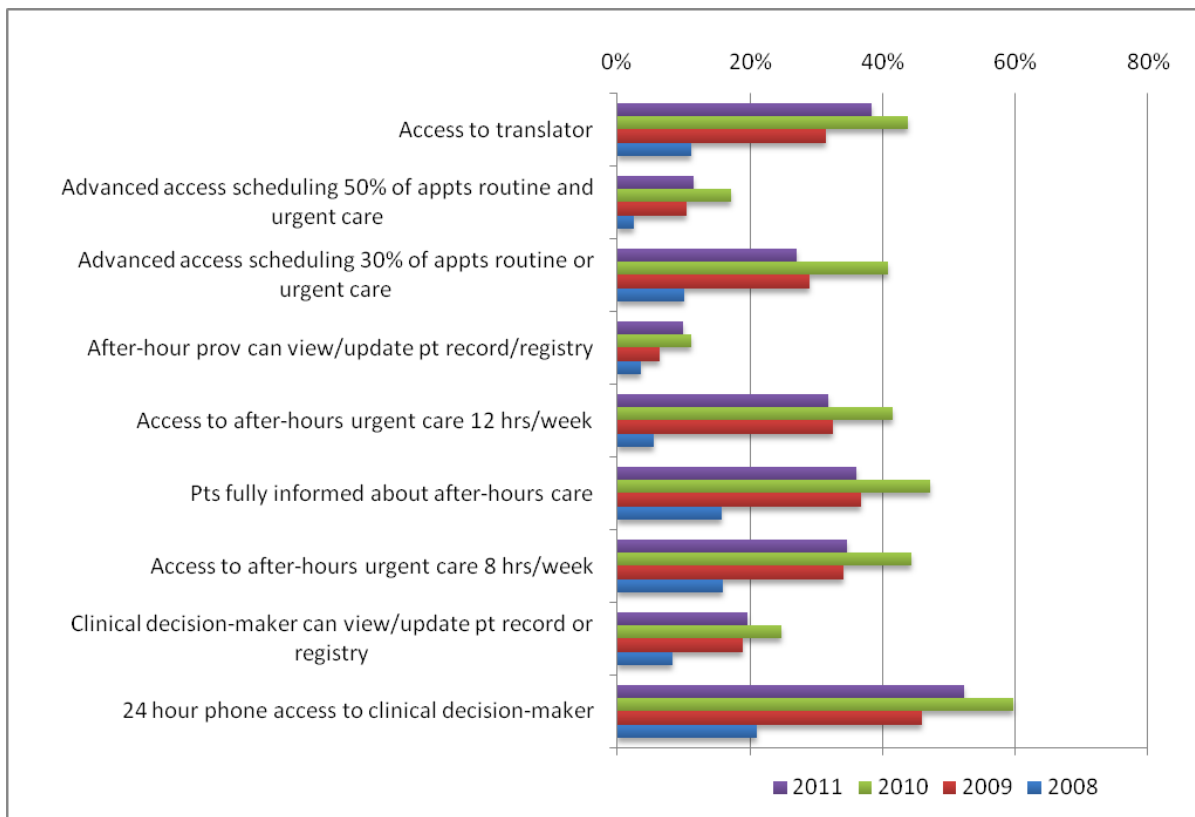
Findings from the long-term evaluation will be available on a rolling basis, beginning in the 2012 program year.

V. Results

The objective of the Extended Access Initiative is to annually increase the percentage of PGIP practice units that have implemented the capabilities associated with this Initiative. As our recent program results show, both designated and non-designated providers are actively implementing capabilities related to extended access.



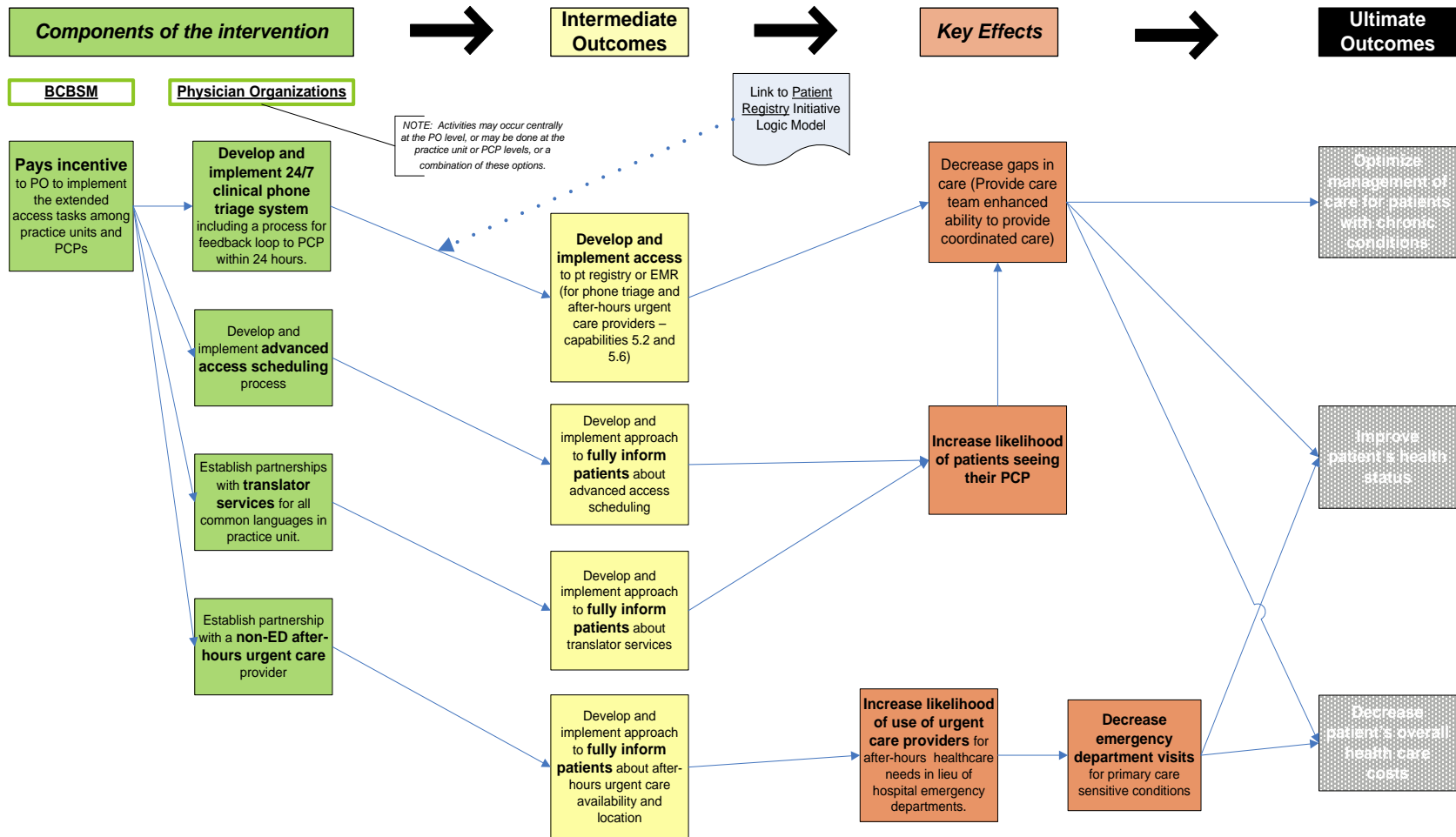
In general, the percentage of practice units that have implemented each capability associated with this Initiative has steadily increased over time, which shows that overall, PCMH-participating providers across the state are transforming their practices to become more patient-centered.



Appendix I: Cause and Effect Diagram

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Patient Centered Medical Home Extended Access Initiative Logic Model



Appendix II: Additional Resources on Extended Access

AAFP website: tools, resources, articles on open access scheduling. Available at:
<http://www.aafp.org/online/en/home/publications/journals/fpm/collections/transformation.html#Parsys0003>

American Academy of Urgent Care Medicine – available at:
<http://www.aaucm.org/viewpoints.asp>

Resources for multi-lingual materials:

www.immunize.org offers multi-lingual materials reviewed for technical accuracy by the Centers for Disease Control (Arabic, Armenian, Cambodian, Chinese, Farsi, Hmong, Japanese, Korean, Laotian, Portuguese, Romanian, Russian, Samoan, Somali, Spanish, Tagalog and Vietnamese.) The site also provides immunization updates, guidelines and answers to difficult questions.

www.noah-health.org provides information on AIDS, cancer, heart disease, stroke and other health topics in Spanish.

www.familydoctor.org provides information on numerous health topics in Spanish.

Appendix III: PGIP Initiative Contacts

For more information on the PCMH Extended Access Initiative, please contact one of the following individuals:

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Endnotes

¹ American College of Physicians Policy Paper, "The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices", October 2010.

² Jennifer E. DeVoe, MD, DPhil, George E. Fryer, PhD, Robert Phillips, MD, MSPH and Larry Green, MD. Receipt of Preventive Care Among Adults: Insurance Status and Usual Source of Care. *American Journal of Public Health*, 2003; 93(5):786-91.

³ Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *The Milbank Quarterly*. 2005;83(3):457-502.

⁴ Starfield, B, Shi L. The medical home, access to care, and insurance: a review of the evidence. *Pediatrics* Vol. 113 No. 5 May 2004, pp. 1493-1498.

⁵Health Care Quality Survey, *Commonwealth Fund*, 2006.

⁶ McCaig LF, Nawar EN. National Hospital Ambulatory Medical Care Survey: 2004 emergency department summary. Advance data from vital and health statistics; no. 372. Hyattsville, MD: *National Center for Health Statistics*. 2006.