



BCBSM Physician Group Incentive Program 2012 Program Year

**Patient-Centered Medical Home
Individual Care Management**

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 Individual Care Management Initiative is to ensure that patients with chronic conditions receive organized, planned care that empowers patients to take greater responsibility for their health, thereby improving the patients' overall health status and decreasing health care costs.

The objective of the Individual Care Management 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

Wagner's Chronic Care Model was developed as an alternative to the processes physicians use to provide care for acute conditions. Under the acute care model, chronic illness care is often a marginally connected string of episodes initiated by patients. The phenomenon, well known to family physicians, has been described as "the tyranny of the urgent."²

Researchers report that only 56% of those with chronic disease receive clinically appropriate care, and only 27% of adults (and 12% of low-income Americans) report having full access to a well-organized source of health care.³ The most common chronic diseases cost the economy more than \$1 trillion annually, and costs are projected to rise as high as \$6 trillion by 2050. Michigan ranks 28 out of 50 in incidence of chronic disease. In 2003, chronic disease treatment cost Michigan residents \$10.6B in direct costs and \$37.9B in lost productivity.⁴

As envisioned in the Chronic Care Model, individual care management consists of planned, productive interactions between informed, motivated patients and prepared physicians, who use self-management support techniques to empower patients to take greater responsibility for their own health.

The implementation of individual care management capabilities will require substantial transformation of care processes, staff responsibility, information access/flow, and patient expectations. Practices report that the key to practice transformation is a strong, highly functioning team.

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 patients with chronic conditions receive organized, planned care that empowers patients to take greater responsibility for their health. Participants will receive incentive payments for implementing the capabilities listed in Table 1 below, and for 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. Individual Care Management Initiative Tasks⁴	
4.1	Practice Unit leaders and staff have been trained/educated and have comprehensive knowledge of the Patient-Centered Medical Home model, the Chronic Care model, and practice transformation concepts
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 at least one chronic condition
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
4.4	PCMH patient satisfaction/office efficiency measures are systematically administered
4.5	Development of written action plan and goal-setting is systematically offered to all patients with the chronic condition selected for initial focus, with substantive patient-specific and patient-friendly documentation provided to the patient
4.6	A systematic approach is in place for appointment tracking, generation of reminders for all patients with the chronic condition selected for initial focus

TABLE 1. Individual Care Management Initiative Tasks⁴	
4.7	A systematic approach is in place to ensure that follow-up for needed services is provided for all patients with the chronic condition selected for initial focus
4.8	Planned visits are offered to all patients with the chronic condition selected for initial focus
4.9	Group visit option is available for all patients in the Practice Unit with the chronic condition selected for initial focus (as appropriate for the patient)
4.10	Medication review and management is provided at every visit for all patients with chronic conditions
4.11	Action plan development and goal-setting is systematically offered to all patients with chronic conditions or other complex health care needs, prevalent in the practice's patient population.
4.12	A systematic approach is in place for appointment tracking and generation of reminders for all patients
4.13	A systematic approach is in place to ensure follow-up for needed services for all patients
4.14	Planned visits are offered to all patients with chronic conditions prevalent in the practice population
4.15	Group visit option is available to all patients with chronic conditions prevalent in the practice population

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

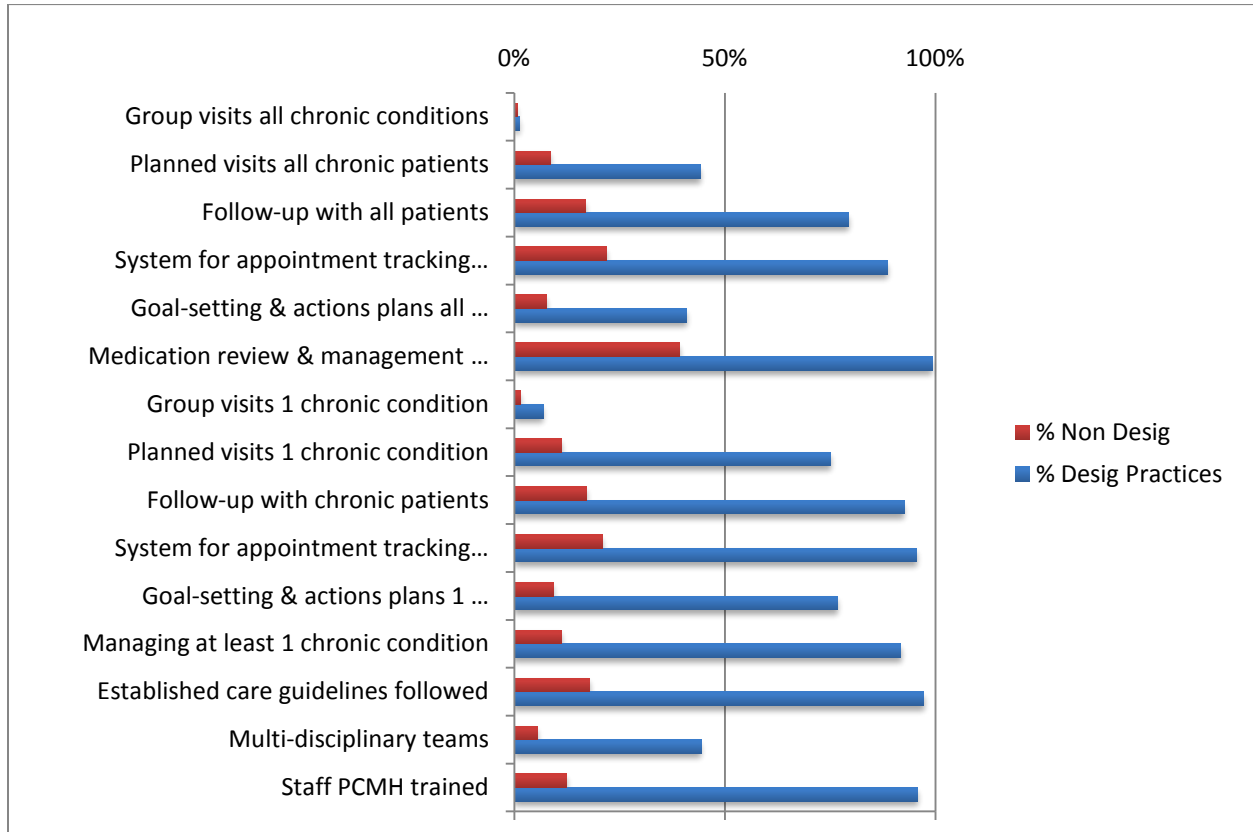
A long-term evaluation of the Patient-Centered Medical Home Program is currently underway. Objectives of the evaluation are as follows:

- 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.

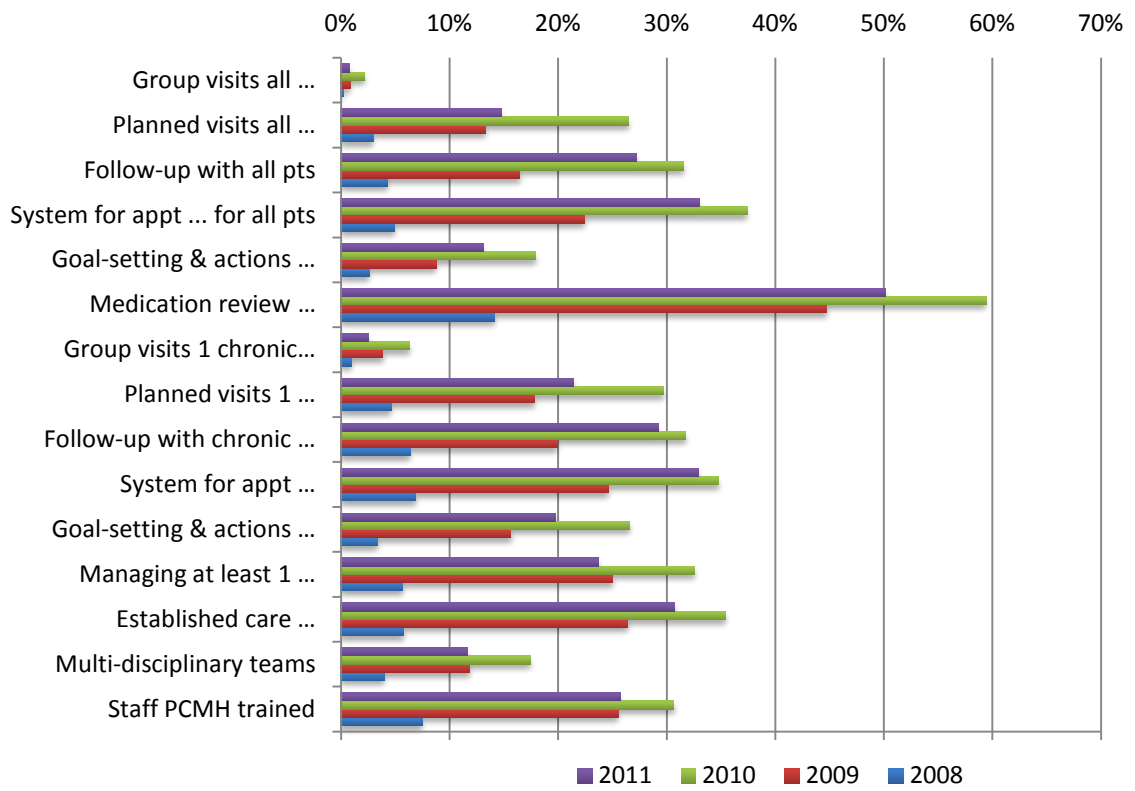
V. Results

The objective of the Individual Care Management 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 individual care management.



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.

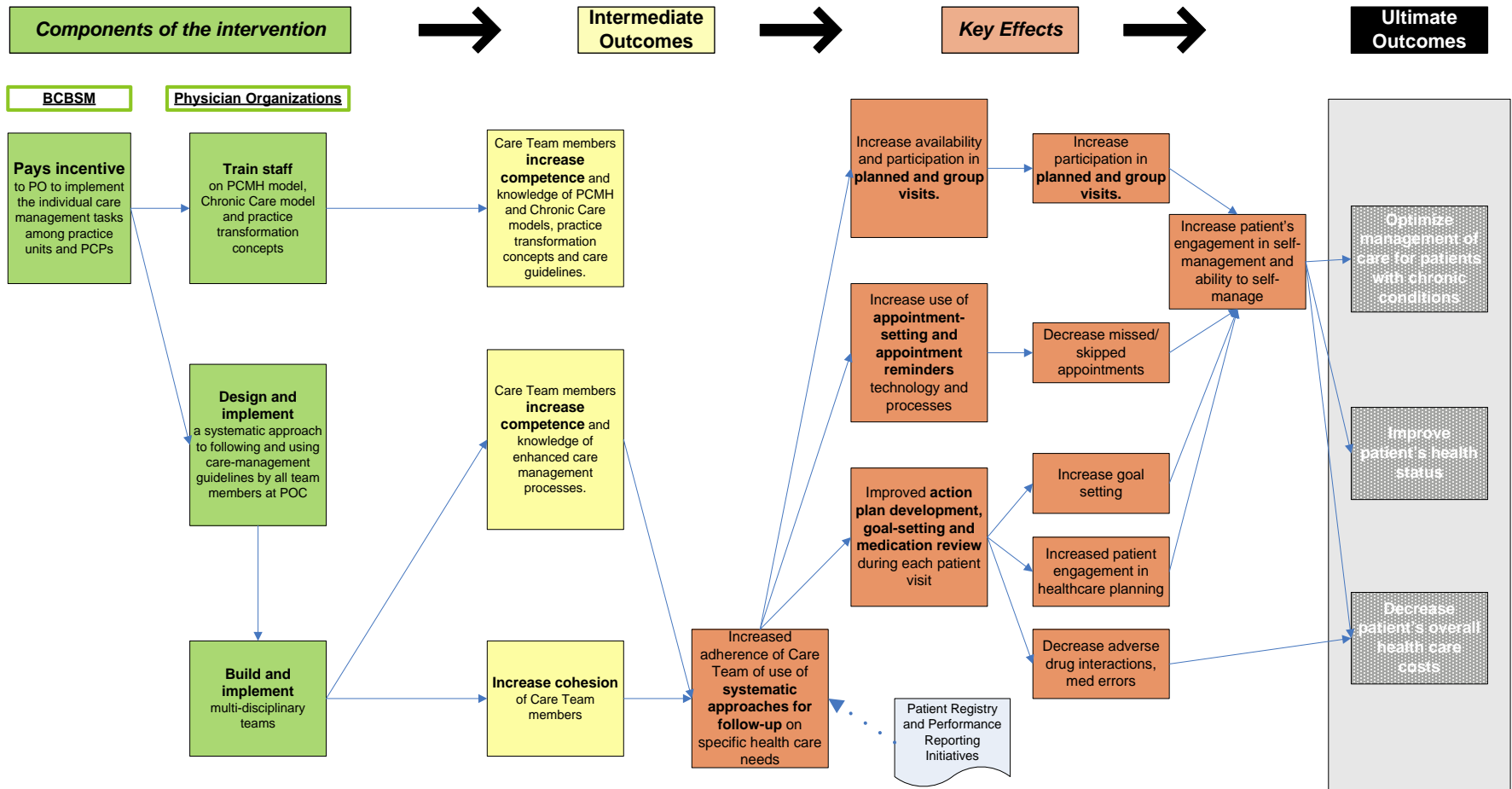
Individual Care Management



Appendix I: Cause and Effect Diagram

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Patient Centered Medical Home Individual Care Management Initiative



Appendix II: Additional Resources on Individual Care Management

ICIC: tools, resources, articles on the Chronic Care Model, clinical practice change, actions plans. Available at:

http://www.improvingchroniccare.org/index.php?p=Clinical_Practice_Change&s=3

AAFP website: tools, resources, articles on group visits, individual care management, patient-centered care. Available at:

<http://www.aafp.org/online/en/home/publications/journals/fpm/collections/transformation.html>

Appendix III: PGIP Initiative Contacts

For more information on the PCMH Individual Care Management 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 Philip J. Mohler, MD, and Nancy B. Mohler, RD, MS, CDE, Improving Chronic Illness Care: Lessons Learned in a Private Practice, *Family Practice Management*, Nov-Dec 2005.

³Health Care Quality Survey, *Commonwealth Fund*, 2006.

⁴ DeVol R, Bedroussian A. An Unhealthy America: The Economic Burden of Chronic Disease, *Milken Institute*, October 2007.