



BCBSM Physician Group Incentive Program 2012 Program Year

**Patient-Centered Medical Home
Linkage to Community Services**

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 Linkage to Community Services Initiative is to connect patients with community resources through a process of active coordination between the patient, health system, community service agencies, family, and caregivers.

The objective of the Linkage to Community Services 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 one or more chronic diseases often benefit from access to community services that exist outside of the primary care setting. Providing links to community resources is consistent with the whole-person orientation that is a hallmark of the patient-centered medical home concept.

Wagner's Chronic Care Model² identifies the need for community linkages within the primary care setting. Ideally, health care organizations should engage in focused collaborations with faith-based groups, schools, social service agencies, civic organizations and local businesses to enhance the quality of patient care. In a 1998 study of chronically ill older adults in Seattle, when primary care providers engaged in community-based collaboration, patient function improved and inpatient utilization decreased.³

Since the rise of Wagner's Chronic Care Model, linking patients to community resources has become more common. In a 2003 study of 1,104 physician organizations, 20 percent had written agreements in place with community service agencies in their area, while 31 percent had referral systems for linking patients with chronic conditions to resources in their community.⁴ Research from the *Annals of Family Medicine* in 2006 indicates similar figures; 21 percent of providers had agreements in place with community agencies while 33 percent had a referral system.⁵ As physician organizations integrate Wagner's Chronic Care Model into their organizational framework, linking

patients to community resources will become even more widespread, resulting in improved patient care.

Many community agencies – such as behavioral health organizations, low-cost clinics and faith-based groups - experience funding challenges that limit the ability to provide services to clients in a consistent way. It is common for social service programs to eliminate staff, decrease hours of operation, or discontinue operations in the face of budget reductions. Community resource listings must therefore be kept up-to-date to reflect the ever-changing nature of community-based services and programs.

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:

1. PCMH Related PGIP Initiatives: Opportunity to participate in Initiatives that support development of competency as a PCMH.
2. 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 connect patients with community resources through a process of active coordination between the patient, health system, community service agencies, family, and caregivers. Participants will receive financial incentive payments for implementing the capabilities listed 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 stated objectives. POs are responsible for providing leadership, support, coordination, and monitoring of Practice Unit practice transformation activity. POs are expected to maintain documentation 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. Documentation may be provided to BCBSM upon request and future practice audits are possible.

Table 1. Linkage to Community Services Initiative Tasks	
10.1	Physician Organization has conducted a comprehensive review of community resources for the geographic population that they serve, in conjunction with Practice Units
10.2	Physician Organization maintains a community resource database based on input from Practice Units that serves as a central repository of information for all Practice Units.
10.3	Physician Organization in conjunction with Practice Unit has established collaborative relationships with appropriate community-based agencies and organizations
10.4	All members of Practice Unit care team involved in establishing care treatment plans have received training on community resources so that they can identify and refer patients appropriately
10.5	Systematic approach is in place for evaluating all patients about community resources and assessing/discussing need for need for referral
10.6	Systematic approach is in place for referring patients to community resources
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
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

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:

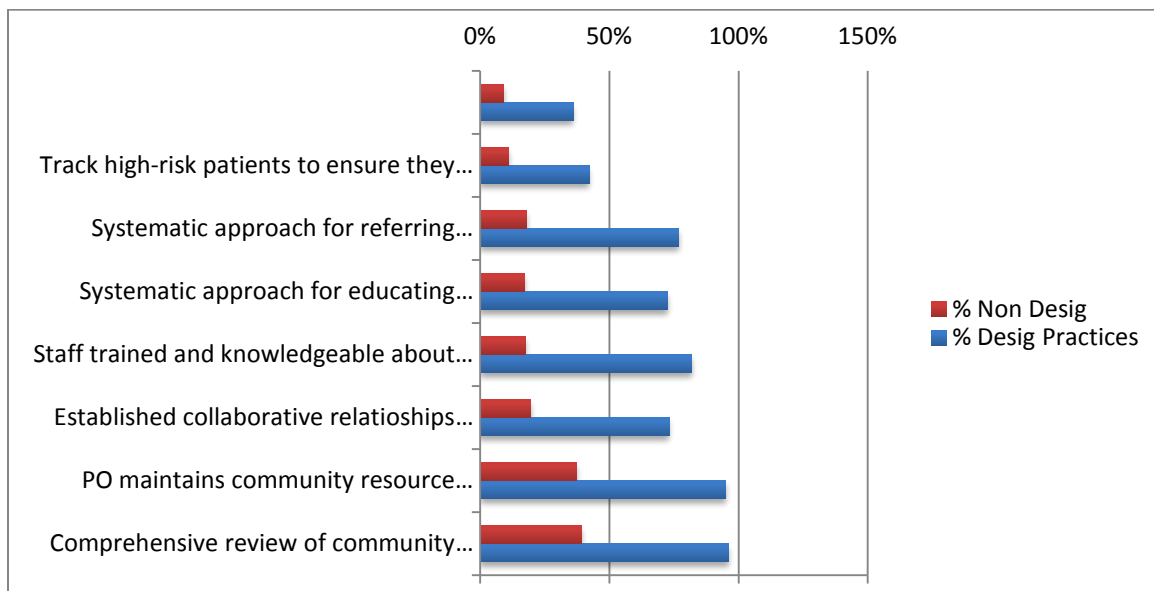
- Assess the rate of PCMH implementation to assist providers with understanding the level of commitment needed for long-term development of their medical home
- Determine whether the PCMH model is associated with more efficient utilization of services
- Determine whether the PCMH model is associated 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.

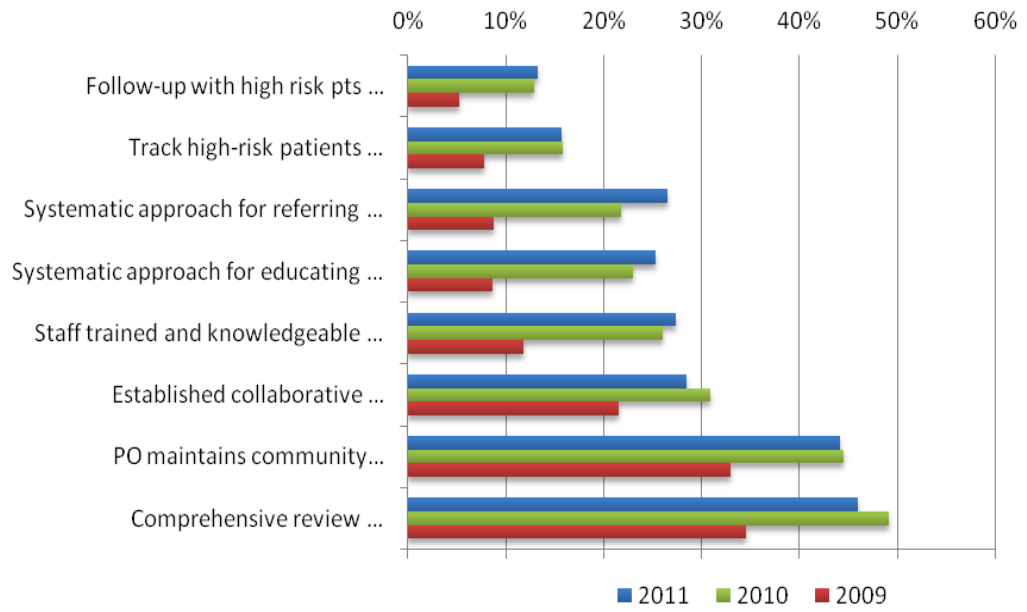
V. Results

The objective of the Linkage to Community Services 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 linking patients to community services.

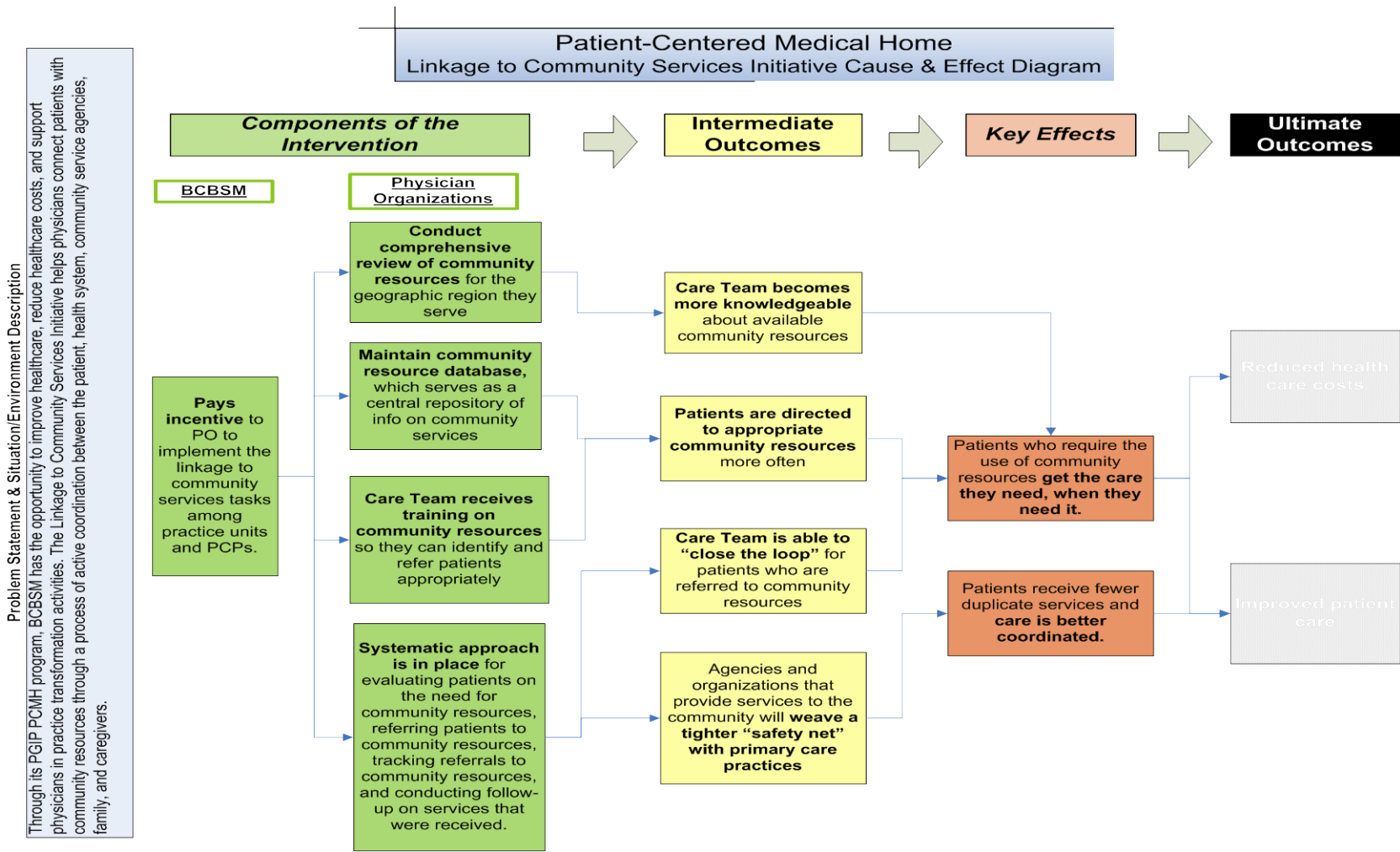


In general, the percentage of practice units that have implemented each capability associated with this Initiative has steadily increased over time, which shows that overall, PCMH-participating providers across the state are transforming their practices to become more patient-centered.

Linkage to Community Services



Appendix I: Cause and Effect Diagram



Appendix II: Additional Resources on Linkage to Community Services

1) MPCI List of Web Resources. Available at:
<http://www.mipci.org/resources/websites.cfm>

2) Policy Statement: Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening. *Pediatrics* July 2006; 118(1): 405-420.

3) Piette JD. Interactive Voice Response Systems in the Diagnosis and Management of Chronic Disease. *American Journal of Managed Care* 2000 Jul; 6(7): 817-27.

Appendix III: PGIP Initiative Contacts

For more information on the PCMH Linkages to Community Services 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 Developed by E. Wagner, MacColl Institute for Healthcare Innovation, Group Health Cooperative of Puget Sound. Available at:
<http://www.ihl.org/IHI/Topics/ChronicConditions/AllConditions/Changes>.

³ Leveille SG, Wagner EH, Davis C, Grothaus L, Wallace J, LoGerfo M, Kent D. Preventing Disability and Managing Chronic Illness in Frail Older Adults: A Randomized Trial of a Community-Based Partnership with Primary Care. *Journal of the American Geriatric Society* 1998 Oct;46(10):1191-8.

⁴ Wang MC, Rundall T, Shortell S. Factors Influencing the Development of Linkages Between Physician Organizations and Community Resources to Provide Care for Patients with Chronic Illness. Academy Health Meeting, Abstract no. 629. (2003).

⁵ Schmittdiel J, Shortell S, Rundall TG, Bodenheimer T, Selby J. Effect of Primary Care Orientation on Chronic Care Management. *Annals of Family Medicine* 2006;4:117-123.