



BCBSM Physician Group Incentive Program 2012 Program Year

**Patient-Centered Medical Home
Patient-Provider Partnership**

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 Patient-Provider Partnership Initiative is to improve the quality of patient care by expanding patient awareness of the Patient-Centered Medical Home model and strengthening the bond between patients and their care-giving team.

The objective of the Patient-Provider Partnership 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

The current United States health care system is increasingly regarded as having reached a state of crisis. The U.S. spends more money on health care than any of the 30 other countries in the Organization for Economic Cooperation and Development (OECD) (most of which are considered the most economically advanced countries in the world), yet consistently ranks low in international comparisons.²

Multiple studies have found that having a regular source of care, and continuous care with the same physician over time, leads to better health on both individual and population levels. Access to primary care also is associated with lower overall costs of care,³ reductions in disparities in health for socially disadvantaged subpopulations,⁴ and higher rates of preventive screening.⁵ The establishment of a patient-provider partnership is a foundational step in creating a patient-centered medical home, providing physicians with the opportunity to discuss the commitment of the practice to care for the person, rather than simply treat the disease.

The major barriers to execution of a care partnership between a patient and a provider are lack of patient and provider awareness of the PCMH concept, physician time constraints in discussing the PCMH concept with the patient, and difficulty in reaching patients who do not visit the office regularly. Key concepts that may help overcome barriers include:

- Emphasizing with the patient that the agreement is not legally binding and has no punitive implications
- Building broad-based physician and team understanding and support of the PCMH concept before presenting the concept to patients

- Making the written partnership or other PCMH information available to patients for review in a variety of venues:
 - Waiting room
 - Website
 - Mailers to patients who are not seen regularly; place phone calls to those with chronic conditions
 - Provide information to patients when they sign in for appointment

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 expand overall awareness of and commitment to the Patient-Centered Medical Home model, and strengthen the bond between patients and their care-giving team. 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. Patient-Provider Partnership Initiative Tasks	
1.1	Practice Unit has developed PCMH-related patient communication tools, has trained staff, and is prepared to implement patient-provider partnership with each established patient, which may consist of a signed agreement or other documented patient communication process to establish patient-provider partnership

TABLE 1. Patient-Provider Partnership Initiative Tasks	
1.2	Process of reaching out to established patients is underway, and Practice Unit is using a systematic approach to inform patients about PCMH, including patients who do not visit the practice regularly
1.3	Patient-provider partnership or other documented patient communication process is implemented and documented for at least 10% of current patients
1.4	Patient-provider partnership implemented for at least 30% of patients
1.5	Patient-provider partnership implemented for at least 50% of patients
1.6	Patient-provider partnership implemented for at least 60% of patients
1.7	Patient-provider partnership implemented for at least 80% of patients
1.8	Patient-provider partnership implemented for at least 90% of 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

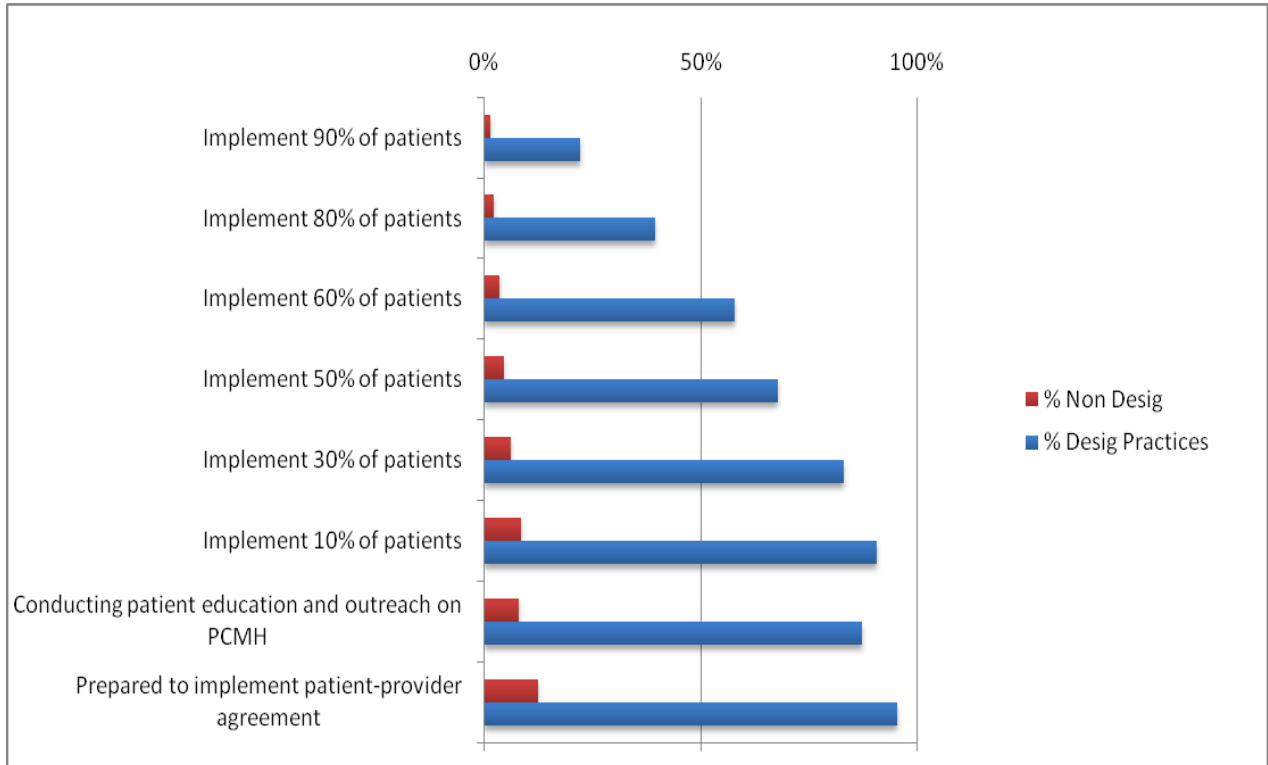
A long-term evaluation of the Patient-Centered Medical Home Program is currently underway. Objectives of the evaluation are as follows:

- 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.

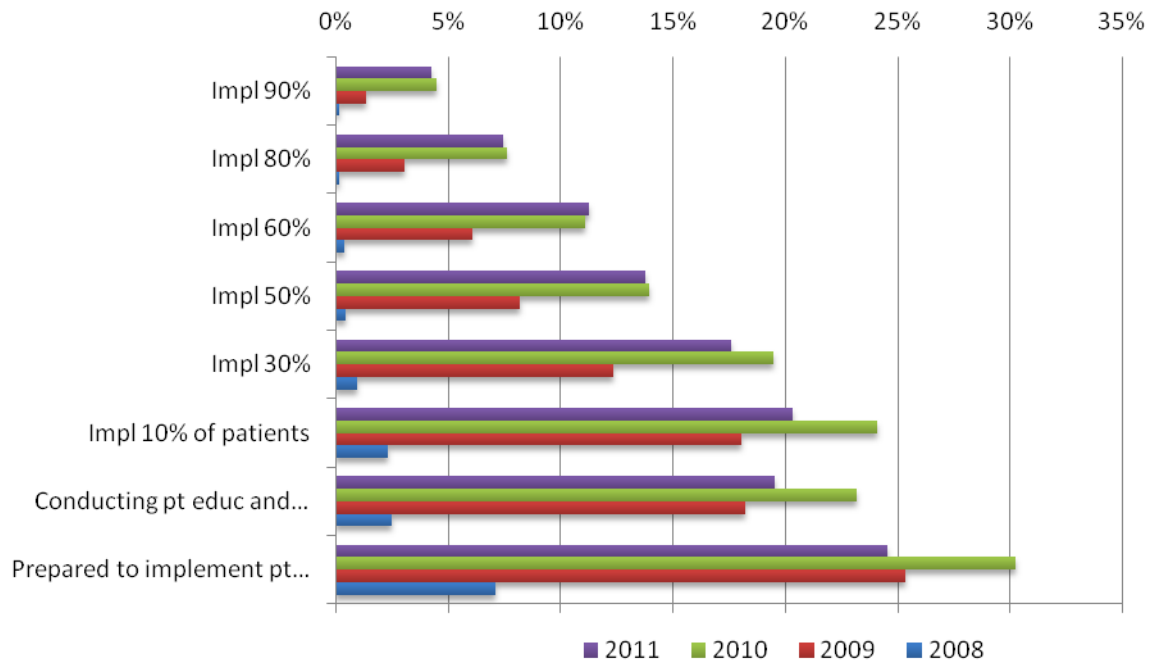
V. Results

The objective of the Patient-Provider Partnership 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 primary care providers are actively implementing capabilities related to the patient-provider partnership.



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.

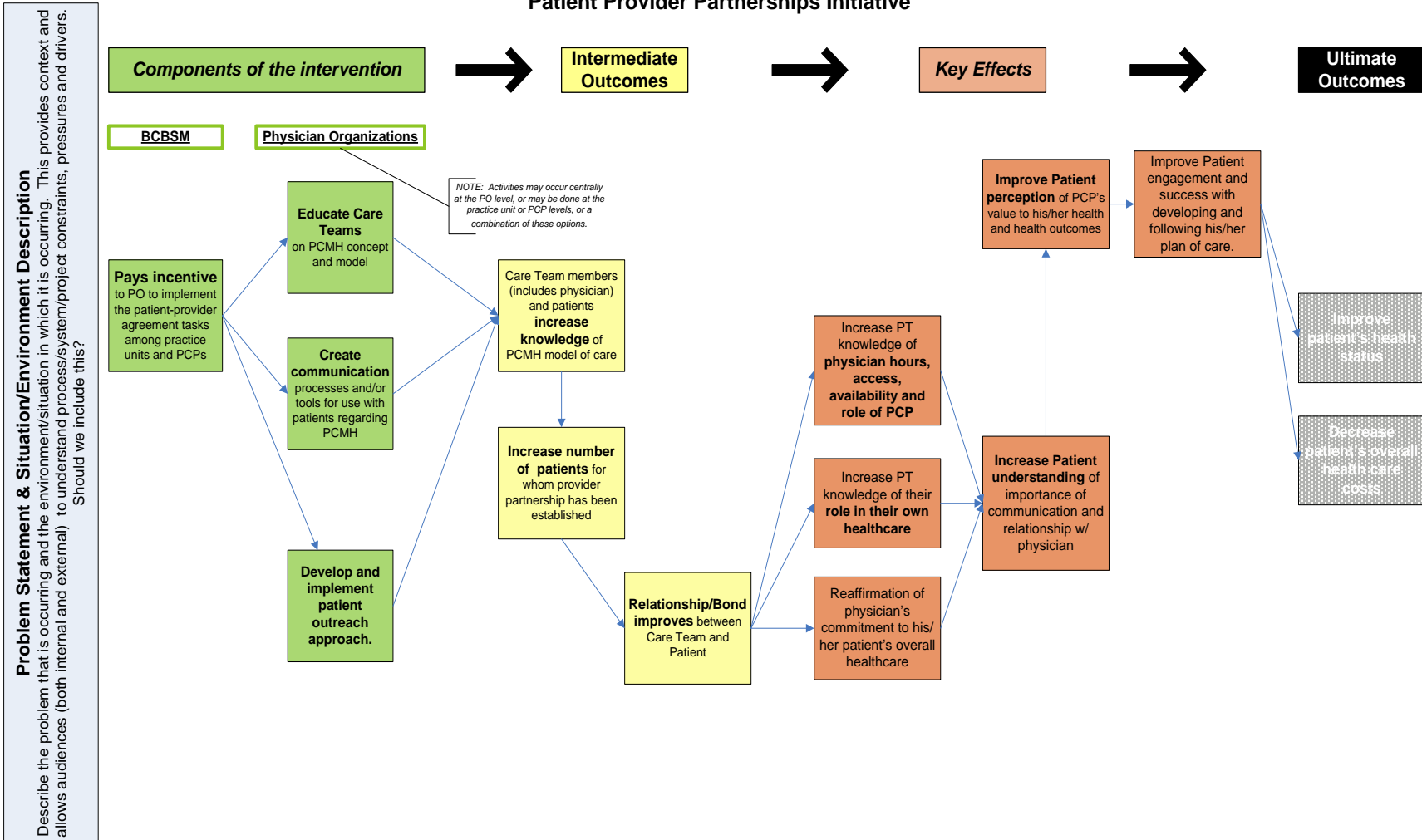
Patient Provider Partnership



Appendix I: Cause-Effect Diagram

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Patient Centered Medical Home Patient Provider Partnerships Initiative



Appendix II: Principles of Patient-Centered Medical Home

1. Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
2. The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients, using a planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
3. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
4. The goal of the physician and the team is to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
5. The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals, for all stages of life: acute care; chronic care; preventive services; and end of life care. Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).
6. Evidence-based medicine and clinical decision-support tools guide decision making.
7. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
8. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
9. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Appendix III: Patient Rights and Responsibilities

Patient Rights

1. High quality, medical care, without discrimination, that is compassionate and respects personal dignity, values and beliefs.
2. Participate in and make decisions about their care and pain management, including refusing care to the extent permitted by law. Care providers (doctor, nurse, etc.) will explain the medical consequences of refusing recommended treatment.
3. Have illness, treatment, pain, alternatives and outcomes be explained in an understandable manner, with interpretation services as needed.
4. Treatments, communications and medical records kept private to the extent permitted by law.
5. Access to medical records in a reasonable timeframe, to the extent permitted by law.
6. Full information regarding charges; counseling on the availability of known financial resources for health care.
7. Access to an advocacy or protective service agencies and a right to be free from abuse.
8. Forum for having concerns and complaints addressed; and guarantee that sharing concerns and complaints will not compromise access to care, treatment and services.

Patient Responsibilities

1. Partner with the provider/medical home staff in establishing collaborative relationship to address patient's personal health and health behavior issues.
2. Keep scheduled appointments or cancel in advance if at all possible
3. Contact provider first for all medical issues, other than emergencies perceived to be life-threatening or with potential to permanently impair health status
4. Reports changes in condition or symptoms, and keep medical record up to date, including information on all over-the-counter medications and dietary supplements (such as vitamins, herbal supplements)
5. Share concerns and questions, needs and priorities
6. Identify personal life goals and establish care management plans, including clearly identified self-management goals and responsibilities
7. Take the medicine prescribed
8. Read information from provider, and ask questions if help or clarification is needed
9. Meet financial obligations

Appendix IV: Provider Responsibilities

Provider Responsibilities

1. Create trusting, collaborative relationship with the patient and their family to ensure that patient's health care needs are met
2. Use evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors
3. Provide patients with 24 hour access via phone or email to a clinical decision-maker linked to PCMH
4. Provide same day access for appointments
5. Maintain knowledge of the patient's health history
6. Listen to the patient's concerns and needs
7. Develop a patient care plan based on evidence-based guidelines when needed
8. Provide clear direction regarding prescriptions, and recommendations regarding over-the-counter medications and herbal supplements
9. Facilitate communication between the patient and other health care providers when referrals are necessary
10. Treat the patient with compassion and understanding

Appendix V: PGIP Initiative Contacts

For more information on the PCMH Patient-Provider Partnership 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 Schoen C, Osborn R, Trang Huynh P, Doty M, Davis K, Zapert K, Peugh J. Primary Care And Health System Performance: Adults' Experiences In Five Countries. *Health System Primary Care, Commonwealth Fund*, 28 October 2004. Available at: <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.487/DC1>.

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.

⁵ 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.