



BCBSM Physician Group Incentive Program 2012 Program Year

**Patient-Centered Medical Home
Self-Management Support**

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 Self-Management Support Initiative is to offer support to patients as they learn to assume responsibility for daily management of their chronic condition.

The objective of the Self Management Support 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

An important part of chronic care management is the ability to establish and maintain interdependent provider relationships that engage the clinical decision maker and empower the patient. More than half of all Americans suffer from a chronic disease, and seventy-five percent of all health care expenditures are spent treating these patients. Despite this, health care is still primarily focused on how to best treat acute conditions. 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.² The most common chronic diseases are costing 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 \$10B in direct costs and \$37B in lost productivity.

Self-management is the ability of the patient to deal with the broad scope of challenges associated with a chronic illness, including symptoms, treatment, physical and social consequences, and lifestyle changes.³ With effective self-management, patients can monitor their conditions and choose cognitive, behavioral, and emotional changes they decide are needed to maintain a satisfactory quality of life. *Self-management support* is the transformation of health care providers' systems and approaches to facilitate patient self-management.⁴

As described by Coleman and Newton⁵, “An underlying theory of self-management education is that self-efficacy, or the patient’s belief in his or her own ability to accomplish a specific behavior or achieve a reduction in symptoms, leads to improved clinical outcomes. Self-management support expands the role of health care professionals from delivering information to include helping patients build confidence and make choices that lead to healthier, more satisfying lives.”

An effective self-manager has knowledge of:

- The disease process
 - Understands their condition
 - Follows a care plan that is jointly developed with their health professional
 - Actively shares in decision making

- The emotional consequences
 - Maintains relationships with family and friends
 - Able to communicate effectively about their needs and goals

- Daily Life
 - Adopts healthy lifestyles
 - Plans according to their life context which includes a chronic condition
 - Deals with the financial consequences of their condition

Physician support of patient self-management of chronic conditions is one of the key elements of the chronic care model and the patient-centered medical home.⁶ Increasing evidence shows that self-management reduces hospitalizations, emergency department use, and overall managed care costs.⁷ Numerous studies reveal that training patients in diabetes self-management have resulted in decreased need for medication, and improved diabetes control as reflected by blood glucose levels and knowledge of diabetes.⁸ Self-management training programs that include face-to-face delivery, cognitive reframing teaching methods, and exercise content, have been found to be more likely to improve glycemic control.⁹ Educational interventions that involve patient collaboration are more effective than didactic interventions,¹⁰ and follow-up reinforcement appears to be key to long-term effectiveness.¹¹

The following tables provide further information on the differences between traditional models of health care and the self-management support model, and between traditional patient education and self-management training.

Traditional Model vs. Self-Management Support Model¹²

	Traditional Model	Self-Management Support Model
Relationship between patient and health professionals	Professionals are the experts who tell patients what to do. Patients are passive.	Share expertise with active patients. Professionals are experts about the disease and patients are experts about their lives.

Who is the principal caregiver and problem solver? Who is responsible for outcomes?	The professional.	The patient and professional are the principal caregivers; they share responsibility for solving problems and for outcomes.
What is the goal?	Compliance with instructions. Non-compliance is a personal deficit of the patient.	The patient sets goals and the professional helps the patient make informed choices. Lack of goal achievement is a problem to be solved by modifying strategies.
How is behavior changed?	External motivation.	Internal motivation.
How are problems identified?	By the professional.	By the patient.
How are problems solved?	Professionals solve problems for the patients.	Professionals teach problem-solving skills and help patients in solving problems.

Education vs. Self-Management

	Education	Self-Management
What is taught?	Information and technical skills about the disease.	Skills on how to act on problems.
How are problems formulated?	Problems reflect inadequate control of the disease.	The patient identifies problems he/she experiences that may or may not be related to the disease.
Relation of education to the disease	Education is disease-specific and teaches information and technical skills related to the disease.	Education provides problem-solving skills that are relevant to the consequences of chronic conditions in general.
What is the theory underlying the education?	Disease-specific knowledge creates behaviour change, which in turn produces better clinical outcomes.	Greater patient confidence in his/her capacity to make life-improving changes (self-efficacy) yields better clinical outcomes.
What is the goal?	Compliance with the behaviour changes taught to the patient to improve clinical outcomes.	Increase self-efficacy to improve clinical outcomes.
Who is the educator?	A health profession.	A health professional, peer leader, or other patients, often in group settings.

The implementation of self-management support 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:

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 offer support to patients as they learn to assume responsibility for daily management of their chronic condition. 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. Self-Management Support Initiative Capabilities	
11.1	Member of clinical care team or Physician Organization 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. The intent of this capability is to actively empower the staff within the practice unit to incorporate self-management support efforts into routine clinic process.
11.2	Self-management support is offered to all patients <i>with the chronic condition selected for initial focus</i> (based on need, suitability, and patient interest)
11.3	Systematic follow-up occurs for all patients <i>with the chronic condition selected for initial focus</i> who are engaged in self-management support to discuss action plans and goals, and provide supportive reminders
11.4	Regular patient experience/satisfaction surveys are conducted of patients engaged in self-management support to identify areas for improvement in the self-management

	support efforts
11.5	Self-management support is offered to patients with <i>all chronic conditions</i> prevalent in the practice's patient population (based on need, suitability, and patient interest)
11.6	Systematic follow-up occurs for patients with <i>all chronic conditions</i> prevalent in the practice's patient population who are engaged in self-management support, to discuss action plans and goals, and provide supportive reminders
11.7	Support and guidance in establishing and working towards a self-management goal is offered to every patient, including well patients
11.8	At least one member of Physician Organization 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.

Components of Self-Management Support Included in Other PGIP PCMH Initiatives

Physician support of patients' self-management is typically characterized as including restructuring patient-physician interactions, instituting office system changes, and linking patients to community self-management programs. To facilitate an incremental approach to practice transformation, separate PGIP PCMH Initiatives have been developed for some of these components, as shown in the following table.

Components of Self-Management Support:	PGIP PCMH Initiatives		
	Self-Management Support Initiative	Linkage to Community Services Initiative	Individual Care Management Initiative
Provide self-management education by linking patients to community self-management programs		✓	
Address health literacy issues and medical obstacles to self-management	✓		
Use motivational interviewing techniques to identify problems from the patient's perspective by asking provocative questions and listening to patient responses	✓		
Systematically offer action plan development and goal-setting to all patients with chronic conditions or other complex health care needs			✓
Identify problem-solving strategies to overcome barriers based on patients' immediate concerns	✓		
Follow up with patients systematically about action plans and goals, in person, by phone, or by e-mail.	✓		
Provide group visits that include self-management education.			✓
Schedule planned visits that allow time to address self-management tasks.			✓

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

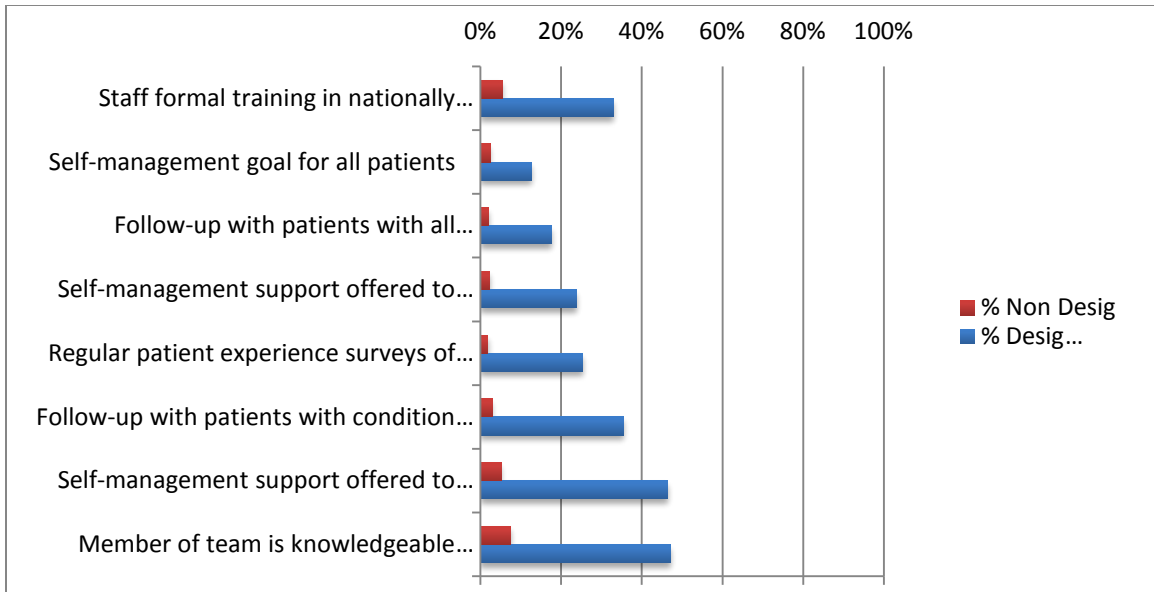
A long-term evaluation of the Patient-Centered Medical Home Program is currently underway. Objectives of the evaluation are as follows:

- 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.

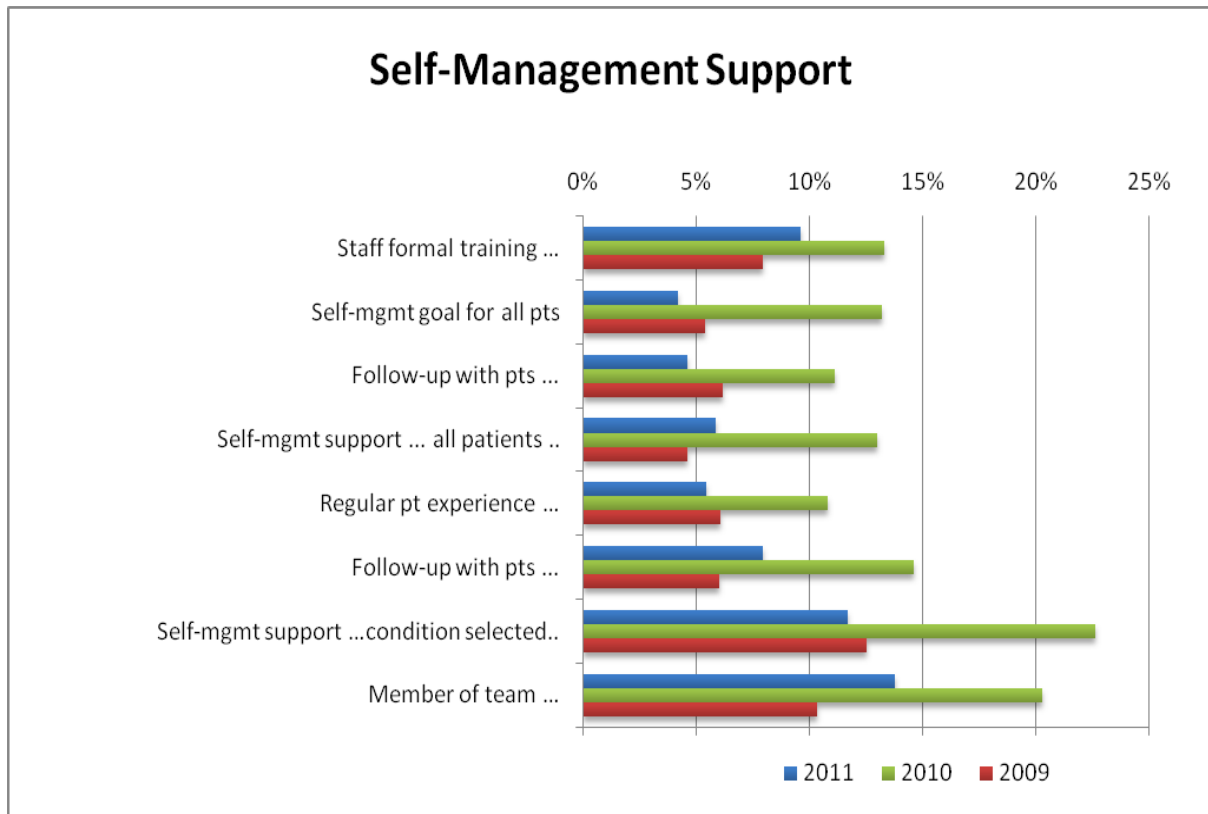
Findings from the long-term evaluation will be available on a rolling basis, beginning in the 2012 program year.

V. Results

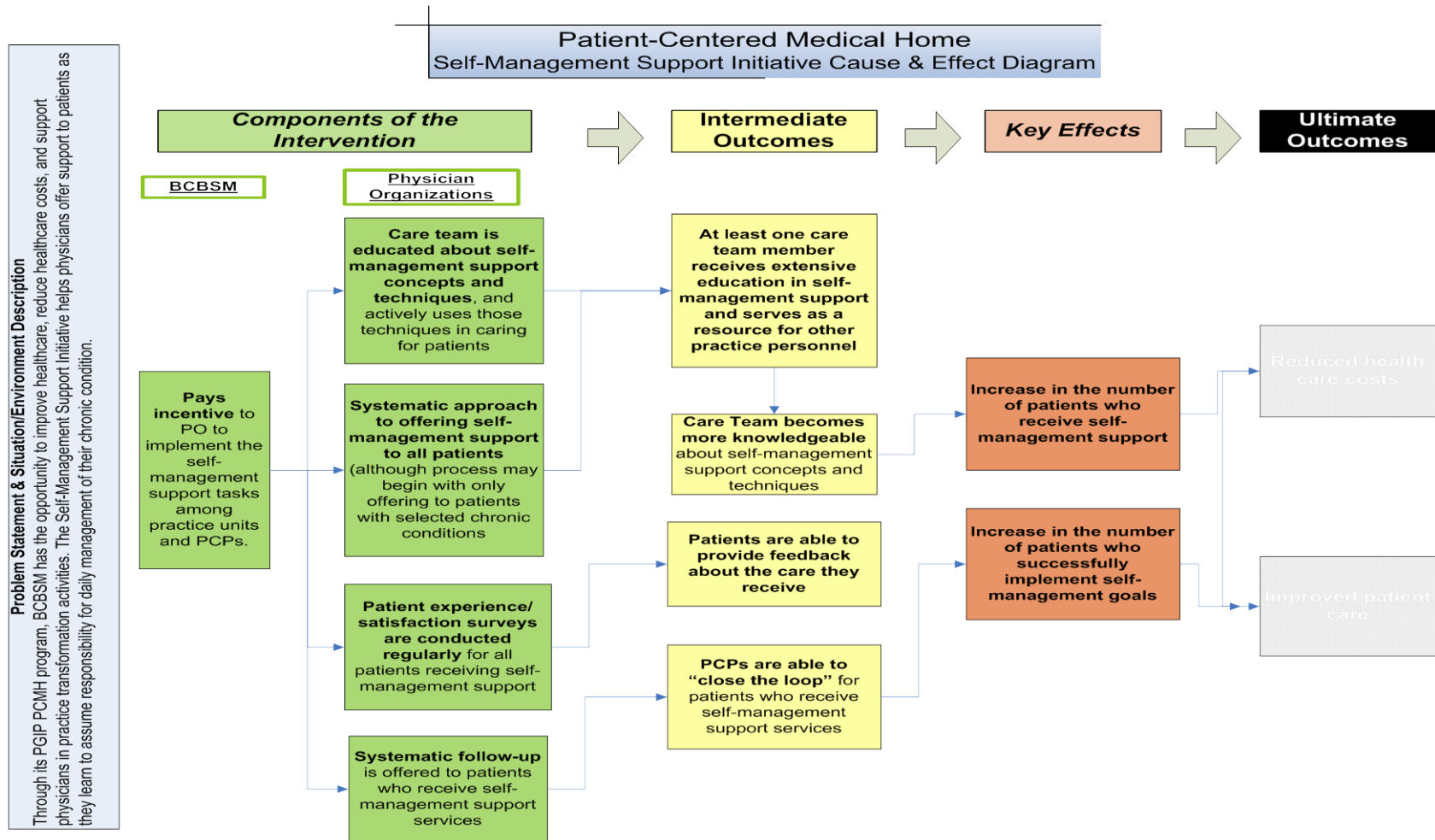
The objective of the Self-Management Support Initiative is to annually increase the percentage of PGIP practice units that have implemented the capabilities associated with this Initiative. As our recent program results show, both designated and non-designated providers are actively implementing capabilities related to self-management support.



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



Appendix II: Additional Resources on Self-Management

*Supporting Self-management in Patients with Chronic Illness, Mary Thoesen Coleman, M.D., Ph.D., and Karen S. Newton, M.P.H., University of Louisville School of Medicine, Louisville, Kentucky. Accessed at: <http://www.aafp.org/afp/20051015/1503.html>

Appendix III: PGIP Initiative Contacts

For more information on the PCMH Self-Management Support Initiative, please contact one of the following individuals:

Lisa Rajt, MSW
Senior Health Care Analyst, Value Partnerships
313-448-3319
lrajt@bcbsm.com

Kat Mackrain, MPH
Health Care Analyst, Value Partnerships
313-448-3345
kmackrain@bcbsm.com

Mike Paustian, MS
Senior Health Care Analyst, Clinical Epidemiology and Biostatistics
313-448-6449
mpaustian@bcbsm.com

Amanda Markovitz, MPH
Health Care Analyst, Clinical Epidemiology and Biostatistics
313-448-4027
amarkovitz@bcbsm.com

Margaret Mason, MHSA
Enhancing Care Value Business Consultant, Physician Group Incentive Program
248-660-6431
mmason@bcbsm.com

David Share, MD, MPH
Vice President, Value Partnerships
dshare@bcbsm.com

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 Health Care Quality Survey, Commonwealth Fund, 2006.

³ Barlow J, Wright C, Sheasby J, Turner A, Hainsworth J. Self-management approaches for people with chronic conditions: a review. *Patient Educ Couns* 2002;48: 177-87.

⁴ Glasgow RE, Davis CL, Funnell MM, Beck A. Implementing practical interventions to support chronic illness self-management. *Jt Comm J Qual Saf* 2003;29:563-74.

⁵ Coleman, Mary T, MD, PhD, Newton, Karen S. Supporting Self-management in Patients with Chronic Illness, University of Louisville School of Medicine, Louisville, Kentucky. Accessed at AAFP website.

⁶ Robert Wood Johnson Foundation. Improving chronic illness care. Accessed online at: <http://www.improvingchroniccare.org>.

⁷ Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. *JAMA* 2002;288:1775-9.

⁸ Deakin T, McShane CE, Cade JE, Williams RD. Group based training for self-management strategies in people with type 2 diabetes mellitus. *Cochrane Database Syst Rev*. 2005 Apr 18;(2):CD003417.

⁹ Ellis SE, Speroff T, Dittus RS, Brown A, Pichert JW, Elasy TA. Diabetes patient education: a meta-analysis and meta-regression. *Patient Educ Couns*. 2004 Jan;52(1):97-105.

¹⁰ Norris SL, Engelgau MM, Narayan KM. Effectiveness of self-management training in type 2 diabetes: a systematic review of randomized controlled trials. *Diabetes Care*. 2001 Mar;24(3):561-87.

¹¹ Norris SL, Lau J, Smith SJ, Schmid CH, Engelgau MM. Self-management education for adults with type 2 diabetes: a meta-analysis of the effect on glycemic control. *Diabetes Care*. 2002 Jul;25(7):1159-71.

¹² Packer, Tanya L. CNAC Workshop, February, 2007, Curtin University of Technology, Center for Research into Disability and Society, School of Occupational Therapy. Perth, Western Australia.