



# FACT SHEET

## Physician Group Incentive Program Patient-Centered Medical Home

### About Value Partnerships

*Value Partnerships is a collection of clinically oriented initiatives among Michigan physicians, hospitals and Blue Cross Blue Shield of Michigan that are improving clinical quality, reducing complications, controlling cost trends, eliminating errors, and improving health outcomes throughout Michigan.*

### About The Physician Group Incentive Program

*This program began in 2005 to encourage and incentivize physicians to more effectively manage populations of patients with chronic diseases and build an infrastructure to more robustly measure and monitor care quality. As of January 2010, 38 physician organizations and 8,148 physicians are working together to improve health care for roughly 1.8 million Michigan Blues members.*

### The Patient Centered Medical Home Model

*In July 2009, BCBSM established the PCMH Designation program to provide additional financial support to those PGIP primary care physicians who have made significant progress in incorporating PCMH infrastructure and care processes into routine practice and have achieved outstanding results on quality and efficiency measures.*



## Linkage to Community Resources Initiative

### Overview

The purpose of the Linkage to Community Services initiative is to enable the practice unit to have knowledge of, and collaborative relationships with key community resources, and to assist patients in receiving needed community services through a systematic process for referrals and follow-up.

### Objectives

- Increase patient access to care and decrease fragmentation of care
- Reduce cost and use
- Improve health care processes and outcomes
- Increase patient and provider satisfaction

### Incentive Design

Physician Organizations will receive incentive payments commensurate with their performance on implementing PCMH capabilities during the six-month incentive payment period. The first time a PO reports implementation activity for a particular PCMH Initiative, the PO should also submit an Initial Implementation Plan for that Initiative; for that six-month incentive period only, incentives will be paid for participation as well as performance.

### Evaluation

Performance improvement is evaluated based on Practice Unit progress toward implementing PCMH capabilities. Results from the Progress Reports and Self-Assessment Database will be used to gauge performance improvement twice a year.

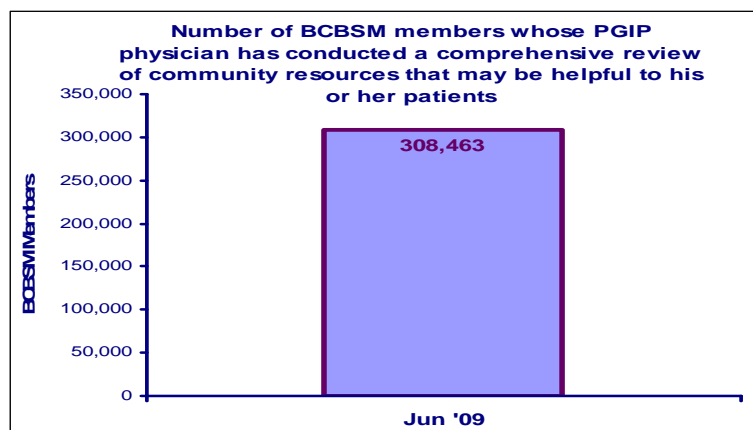
## Initiative Capabilities

- 10.1 Physician Organization (PO) has conducted a comprehensive review of community resources for the geographic population that they serve, in conjunction with Practice Units
- 10.2 PO maintains a community resource database based on input from PU's that serves as a central repository of information for all Practice Units
- 10.3 PO, in conjunction with Practice Units, 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 educating all patients about community resources and assessing/discussing 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

### *Integrated Health Partners In Action:*

*Integrated Health Partners' Pathways to Health Consumer Advisory Council has conducted an exhaustive search of local and national medical related resources available to the residents of Calhoun County. Resources include, but not limited to, transportation, financial aid, prescription medications, chronic illness care, depression, diet and exercise, and support groups. This information has been incorporated into the local 211 resource database and has been used to develop a Community Resource Guide that is available to provider offices and their patients at no cost. An ongoing process is in place to identify new resources and provide updated information to our provider offices.*

## Evaluation and Results



Questions about the Linkage to Community Services Initiative? Please contact Margaret Mason, MHSA  
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For more information on PGIP, or for a copy of the full initiative description, please contact:  
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