



# Fact Sheet

## Physician Group Incentive Program

### 2012

#### **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**

The Physician Group Incentive Program (PGIP) began in 2005 to encourage and incentivize physicians to more effectively manage populations of patients and build an infrastructure to more robustly measure and monitor care quality. As of September 2011, 40 physician organizations (POs) across the state of Michigan representing nearly 15,000 primary care physicians and specialists are working together to improve health care for nearly 2 million Michigan Blues members. Additionally, PGIP is cultivating a healthier future for all Michigan residents by catalyzing all payer system development. Patients throughout the state, regardless of payer, benefit from the improved care processes developed through the PGIP provider community.

#### **Michigan Transitions of Care Collaborative (M-TC<sup>2</sup>)**

##### **Overview**

The Michigan Transitions of Care Collaborative targets variations in care transitions that could lead to preventable readmission by supporting interventions aimed at improving planning and communication between the inpatient and outpatient sectors. Physician organizations (POs) and hospitals partner through this professional collaborative quality improvement initiative (CQI) to improve care transitions from the hospital to home or ongoing care settings. The University of Michigan Health System and St. Joseph Mercy Health System have worked in partnership to serve as the Coordinating Center for M-TC<sup>2</sup> and are utilizing the Society of Hospital Medicine's (SHM's) Better Outcomes for Older Adults through Safe Transitions (BOOST) Care Transitions methodology.

##### **Objectives**

- Encourage POs to increase collaboration and develop interconnected processes with their partnering hospitals to address opportunities for improvement in the care transition process
- Encourage hospitalists to implement positive system-based changes to promote collaboration between the care providers serving patients during their discharge to home
- Test new approaches to systematizing care transitions
- Reduce 30-day readmissions rates
- Reduce preventable 14-days post-discharge ED utilization rates

##### **Incentive Design**

The 2012 incentive model will be based on participation. The M-TC<sup>2</sup> Coordinating Center will evaluate each site/team bi-annually on participation metrics that have been developed to ensure program compliance and enhance site performance. POs will be paid proportional to performance on participation metrics.



## Participation Criteria

All PGIP POs with primary care providers are eligible to participate in this initiative. Since this initiative requires communication between inpatient and outpatient, it is a **critical requirement** that each PO engage a hospitalist champion to enlist and oversee the collaboration of the hospital.

Primary care physicians (PCPs), including general practice, internal medicine, pediatrics, geriatric medicine, and family medicine, as well as hospitalists are a part of the targeted physician population.

## Evaluation

Evaluation of the M-TC<sup>2</sup> initiative will primarily focus on participants' performance on processes necessary to achieve long-term goals.

## Results

Results are to be determined and will be reported in future updates.

Questions about the M-TC<sup>2</sup> Initiative?

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For more information on PGIP, or for a copy of the full initiative plan, please contact:

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