



# **BCBSM Physician Group Incentive Program 2011 Program Year**

**Patient-Centered Medical Home  
Initiative Plan  
Individual Care Management**



## I. Initiative Overview

Blue Cross Blue Shield of Michigan Patient-Centered Medical Home Initiatives are part of the Physician Group Incentive Program (PGIP). Since its inception in 2004, the BCBSM PGIP program 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 August 2010, PGIP includes 37 provider organizations representing over 100 physician groups from across the state of Michigan. The groups represent over 8,600 primary care physicians and selected specialists who are members of BCBSM's TRUST PPO Network. These physicians provide care for over 1.8 million BCBSM members.

### Goals and Objectives

The goal of the Individual Care Management Initiative is to ensure that patients with chronic conditions receive organized, planned care that empowers patients to take greater responsibility for their health, thereby improving the patients' overall health status and decreasing health care costs.

The objective of the Individual Care Management 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 2011, 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

Wagner's Chronic Care Model was developed as an alternative to the processes physicians use to provide care for acute conditions. Under the acute care model, chronic illness care is often a marginally connected string of episodes initiated by patients. The phenomenon, well known to family physicians, has been described as "the tyranny of the urgent."<sup>1</sup>

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.<sup>2</sup> The most common chronic diseases cost 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 \$10.6B in direct costs and \$37.9B in lost productivity.<sup>3</sup>

As envisioned in the Chronic Care Model, individual care management consists of planned, productive interactions between informed, motivated patients and prepared physicians, who use self-management support techniques to empower patients to take greater responsibility for their own health.

The implementation of individual care management capabilities 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 ensure that patients with chronic conditions receive organized, planned care that empowers patients to take greater responsibility for their health. Participants will receive incentive payments for implementing the capabilities listed in Table 1 below, and for 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.

<b>TABLE 1. Individual Care Management Initiative Tasks<sup>IV</sup></b>	
4.1	Practice Unit leaders and staff have been <b>trained/educated</b> and have comprehensive knowledge of the Patient Centered Medical Home model, the Chronic Care model, and practice transformation concepts
4.2	Practice Unit has ability to deliver coordinated care management services with an <b>integrated team of multi-disciplinary providers</b> and a systematic approach is in place to deliver comprehensive care that addresses patients' full range of health care needs
4.3	Systematic approach is in place to ensure that <b>evidence-based care guidelines</b> are established and in use at the point of care by all team members of the Practice Unit
4.4	At least <b>one chronic condition</b> has been identified for initial focus, and practice has assembled and is monitoring all key clinical data, clinical outcomes measures, process measures, and patient satisfaction/office efficiency measures
4.5	Development of written action plan and self-management goal-setting is systematically offered to all patients with the chronic condition selected for initial focus, with patient-friendly documentation provided to the patient
4.6	A systematic approach is in place for <b>appointment tracking, generation of reminders</b> for all patients with the <b>chronic condition selected for initial focus</b>
4.7	A systematic approach is in place to ensure that <b>follow-up for needed services</b> is provided for all patients with <b>the chronic condition selected for initial focus</b>
4.8	<b>Planned visits</b> are offered to all patients with the <b>chronic condition selected for initial focus</b>
4.9	<b>Group visit option</b> is available for all patients in the practice unit with the <b>chronic condition selected for initial focus (as appropriate for the patient)</b>
4.10	<b>Medication review and management</b> is provided at every visit for <b>all patients with chronic conditions</b>
4.11	<b>Action plan development and self-management goal-setting</b> is systematically offered to <b>all patients with chronic conditions</b> or other complex health care needs, prevalent in the practice's patient population.
4.12	A systematic approach is in place for <b>appointment tracking and generation of reminders for all patients</b>
4.13	A systematic approach is in place to ensure <b>follow-up for needed services for all patients</b>
4.14	<b>Planned visits</b> are offered to <b>all patients with chronic conditions</b> prevalent in the practice population
4.15	<b>Group visit option</b> is available to <b>all patients with chronic conditions</b> prevalent in the practice population

## Criteria for Participation

To participate in this initiative, POs must currently participate in the Physician Group Incentive Program.

## BCBSM Deliverables

BCBSM will provide Interpretive Guidelines to participating POs, updated at least once annually. The Interpretive Guidelines provide comprehensive detail on each capability associated with each PCMH Initiative, to deepen PO and practice unit understanding of the tasks required for optimal performance.

BCBSM will also conduct annual site visits, intended to enrich PO and practice unit understanding of the Patient-Centered Medical Home Initiatives.

BCBSM will provide bi-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. At the end of each six-month incentive payment period, POs will be expected to complete the following reporting requirements in a timely manner:

- Submit a progress report for each PCMH Initiative for which capabilities were implemented during the previous six months, identifying best practice accomplishments, challenges encountered, and outlining plans to overcome barriers to success
- Update their PCMH self-reported data, identifying all tasks implemented by each participating Practice Unit
- 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 POs total physicians that complete 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.*

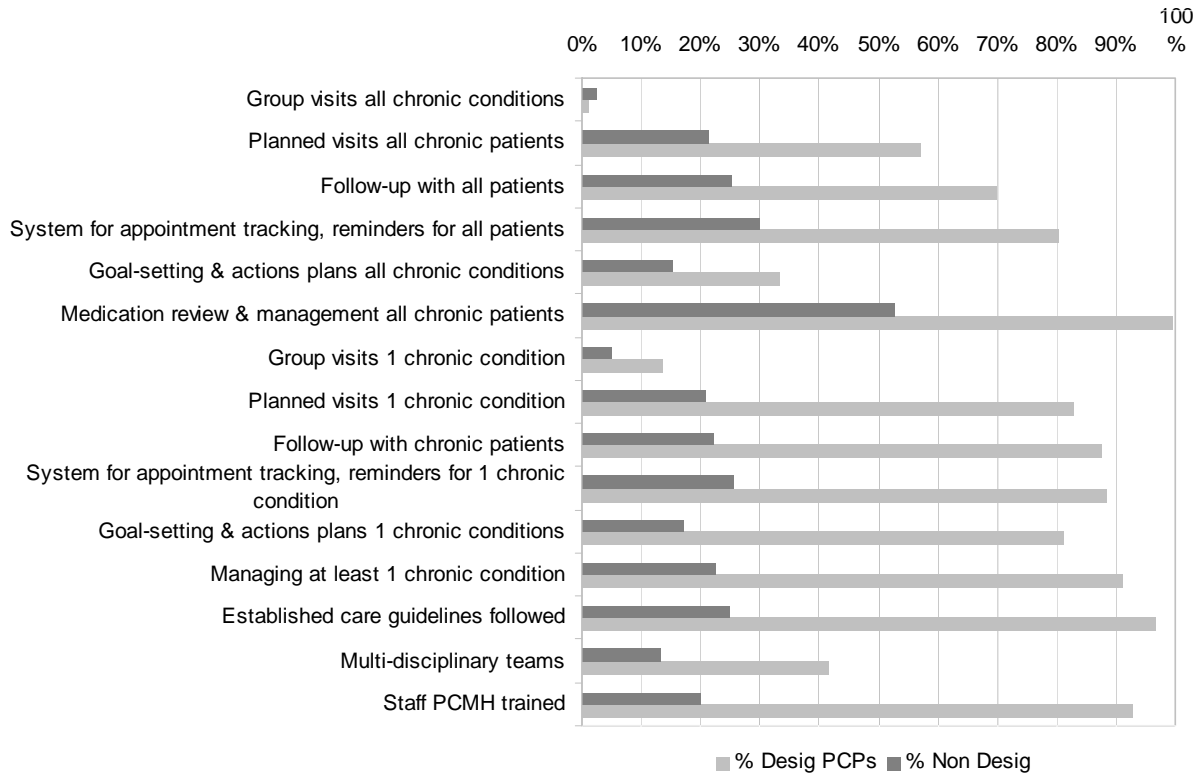
## **IV. Evaluation**

An in-depth evaluation of the PCMH Initiatives will be completed in 2011. The evaluation will focus on the correlation between PCMH capabilities and cost/use performance, as well as quality, use, efficiency and cost trends.

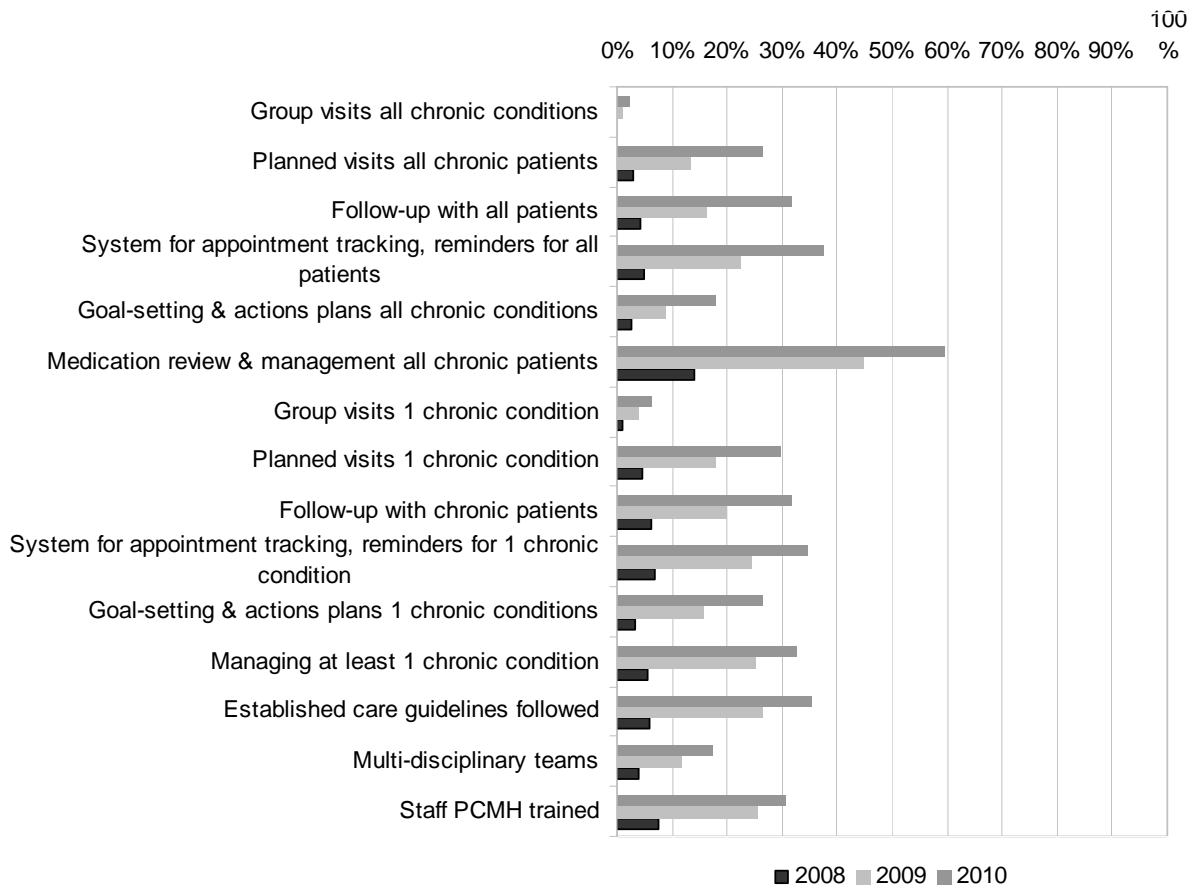
For more information on the process outcomes related to all aspects of PCMH general participation and the PCMH designation program, please refer to Appendix III.

## V. Results

The objective of the Individual Care Management 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 individual care management.

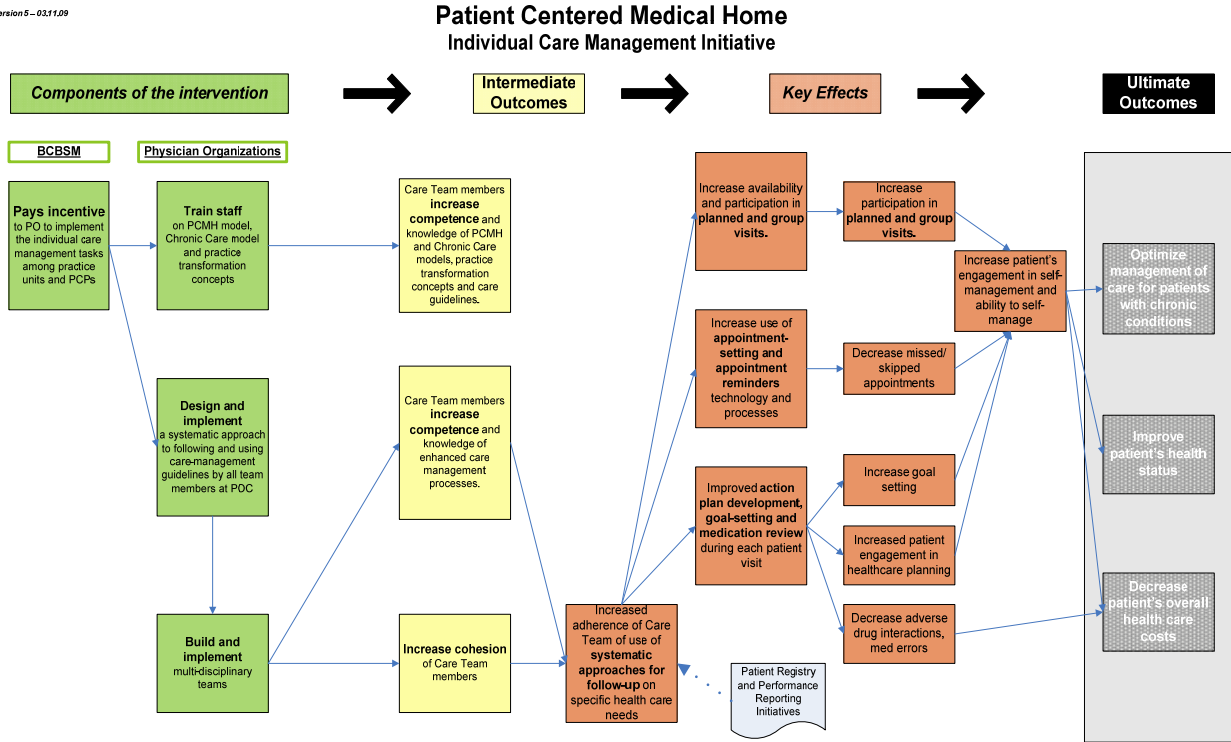


In addition, the percentage of practice units that have implemented each capability associated with this initiative has steadily increased over time, which shows that overall, PCMH-participating providers across the state are transforming their practices to become more patient-centered.



# Appendix I: Cause and Effect Diagram

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## **Appendix II: Additional Resources on Individual Care Management**

ICIC: tools, resources, articles on the Chronic Care Model, clinical practice change, actions plans. Available at:

[http://www.improvingchroniccare.org/index.php?p=Clinical\\_Practice\\_Change&s=3](http://www.improvingchroniccare.org/index.php?p=Clinical_Practice_Change&s=3)

AAFP website: tools, resources, articles on group visits, individual care management, patient-centered care. Available at:

<http://www.aafp.org/online/en/home/publications/journals/fpm/collections/transformation.html>

## Appendix III: Patient Centered Medical Home Evaluation Plan for 2011

Category	Process Metric	Data Source	Measurement	Metric
<b>PO PCMH program team</b>	Identification of the Clinical Lead	Progress Report	A) Please identify the name of the Clinical Lead for the PCMH program.	% of participating PGIP POs who identified a Clinical Lead
			B) What percentage of time does the Clinical Lead dedicate to the PCMH program (FTE)?	% of participating PGIP POs with a Clinical Lead who spends at least 25% or .25 FTE toward the initiative
	Identification of the Analytic Lead	Progress Report	A) Please identify the name of the Analytic Lead for the PCMH program.	% of participating PGIP POs who identified an Analytic Lead
			B) What percentage of time does the Analytic Lead dedicate to the PCMH program (FTE)?	% of participating the PGIP POs with an Analytic Lead who spends 25% of time or .25 toward the initiative
	PGIP Data Users Workgroup (DUWG) Representative	A) Progress Report	A) Please identify the name of the DUWG representative for the PCMH program.	% of participating PGIP POs who identified a representative to attend the DUWG
		B) Data Users Workgroup Meeting Minutes	B) What percentage of the DUWG meetings does the representative attend?	% of DUWG meetings attended by each PO
<b>Participation in the PCMH program</b>	PO participation  PU participation PCP participation Member participation			
<b>Participation in PCMH program-related initiatives</b>	Clinical Team	Progress Report	Participating PGIP POs who identify a Clinical Lead, an Analytic Lead, and a Data Users Workgroup Representative	% of participating PGIP POs who met the minimum necessary requirements for the program
	PO participation	Self Assessment Database	Total POs who participate in the following PCMH initiatives:	Number and percent of non-Oncology POs participating in each PCMH-related initiative

		<ul style="list-style-type: none"> <li>1) Patient-provider partnership</li> <li>2) Patient registry</li> <li>3) Performance reporting</li> <li>4) Individual care management</li> <li>5) Extended access</li> <li>6) Test results tracking and follow-up</li> <li>7) Preventive services</li> <li>8) Linkage to community services</li> <li>9) Self-management support</li> <li>10) Patient web portal</li> <li>11) Coordination of care</li> <li>12) Specialist referral process</li> </ul>	
Practice unit participation	Self Assessment Database	<p>Total PUs who participate in the following PCMH initiatives:</p> <ul style="list-style-type: none"> <li>1) Patient-provider partnership</li> <li>2) Patient registry</li> <li>3) Performance reporting</li> <li>4) Individual care management</li> <li>5) Extended access</li> <li>6) Test results tracking and follow-up</li> <li>7) Preventive services</li> <li>8) Linkage to community services</li> <li>9) Self-management support</li> <li>10) Patient web portal</li> <li>11) Coordination of care</li> <li>12) Specialist referral process</li> </ul>	Number and percent of practice units participating in the initiative
Physician participation	Self Assessment Database	<p>Total PCPs who may be impacted by each of the following initiatives:</p> <ul style="list-style-type: none"> <li>1) Patient-provider partnership</li> <li>2) Patient registry</li> <li>3) Performance reporting</li> <li>4) Individual care management</li> </ul>	Number and percent of physicians who participate in the PCMH program

			<ul style="list-style-type: none"> <li>5) Extended access</li> <li>6) Test results tracking and follow-up</li> <li>7) Preventive services</li> <li>8) Linkage to community services</li> <li>9) Self-management support</li> <li>10) Patient web portal</li> <li>11) Coordination of care</li> <li>12) Specialist referral process</li> </ul>	
	Member participation	Self Assessment Database	<p>Total members who may be impacted by each PCMH initiative:</p> <ul style="list-style-type: none"> <li>1) Patient-provider partnership</li> <li>2) Patient registry</li> <li>3) Performance reporting</li> <li>4) Individual care management</li> <li>5) Extended access</li> <li>6) Test results tracking and follow-up</li> <li>7) Preventive services</li> <li>8) Linkage to community services</li> <li>9) Self-management support</li> <li>10) Patient web portal</li> <li>11) Coordination of care</li> <li>12) Specialist referral process</li> </ul>	Number and percent of total members and PGIP members assigned a PCP relationship to a PCP participating in each of the PCMH initiatives
<b>Participation in PCMH initiative capabilities</b>	Participation by PO, PU, physician, and member for each PCMH capability	Self Assessment Database	<p>Total POs, practice units, physicians, and members by absence or presence of capabilities under each initiative (see interpretive guidelines document for listing of PCMH capabilities)</p> <ul style="list-style-type: none"> <li>1) Patient-provider partnership capabilities 1.1 to 1.8</li> <li>2) Patient registry capabilities 2.1 to 2.18</li> <li>3) Performance reporting capabilities 3.1 to 3.13</li> </ul>	Number and percent of POs, practice units, physicians, and members by absence or presence of capabilities under each initiative

			<p>4) Individual care management capabilities 4.1 to 4.15</p> <p>5) Extended access capabilities 5.1 to 5.9</p> <p>6) Test results tracking and follow-up capabilities 6.1 to 6.9</p> <p>7) Preventive services capabilities 9.1 to 9.8</p> <p>8) Linkage to community services capabilities 10.1 to 10.8</p> <p>9) Self-management support capabilities 11.1 to 11.8</p> <p>10) Patient web portal capabilities 12.1 to 12.12</p> <p>11) Coordination of care capabilities 13.1 to 13.9</p> <p>12) Specialist referral process capabilities 14.1 to 14.9</p>	
<b>PCMH Designation</b>	Practice unit recognition for progress toward achieving PCMH	PCMH Designation Database	Practice units nominated for PCMH designation	Number and percent of practice units who were nominated by POs for PCMH designation
		PCMH Designation Database	Practice units designated as PCMH	Number and percent of practice units who were designated as a PCMH
		PGIP Physician list	PCPs located in practice units nominated for PCMH designation	Number and percent of PCPs who were nominated by POs for PCMH designation
		PGIP Physician list	PCPs located in practice units designated as PCMH	Number and percent of PCPs who were designated as a PCMH
		PCP Care relationship assignment	Members assigned a care relationship with PCPs located in practice units nominated for PCMH designation	Number and percent of members assigned a care relationship with PCPs who were nominated by POs for PCMH designation
		PCP Care relationship assignment	Members assigned a care relationship with PCPs located in practice units designated as PCMH	Number and percent of members assigned a care relationship with PCPs who were designated as a PCMH

## Endnotes

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<sup>1</sup> Philip J. Mohler, MD, and Nancy B. Mohler, RD, MS, CDE, Improving Chronic Illness Care: Lessons Learned in a Private Practice, Family Practice Management, Nov-Dec 2005.

<sup>2</sup>Health Care Quality Survey, Commonwealth Fund, 2006.

<sup>3</sup> DeVol R, Bedroussian A. An Unhealthy America: The Economic Burden of Chronic Disease, Milken Institute, October 2007.