



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

## **Patient-Centered Medical Home Initiative Plan Patient Registry**



## 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 Patient Registry Initiative is to encourage PGIP participants to establish a comprehensive patient registry that can be used to optimally manage a population of patients, improve patient health status, and ultimately lower health care costs.

The objective of the Patient Registry 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

Effective management of patients with chronic diseases has become increasingly important as the prevalence of chronic conditions continues to grow. More than half of all Americans suffer from one or more chronic disease and seventy-five percent of health care spending is for chronic disease.<sup>1</sup> Yet researchers report that only 56% of patients with chronic diseases receive clinically appropriate care, and only 27% of adults report having full access to a well organized source of health care.

Patient registries are a central component of Wagner's Chronic Care Model and the Patient-Centered Medical Home. Research suggests that patient registries are associated with improved outcomes for patients with a range of chronic diseases.<sup>2</sup> Patient registries enable physician practices to efficiently and effectively manage their entire population of patients,

ensuring that patients with chronic diseases are well-managed and that all patients receive appropriate preventive services.

### 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 establish a comprehensive registry that can be used to efficiently and effectively manage a population of patients. 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 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. Patient Registry Initiative Tasks	
2.1	A paper or electronic all-payer registry is being used to manage all patients in the Practice Unit with: <b>Diabetes</b>
2.2	Registry incorporates patient clinical information, for all established patients in the registry, for a substantial majority of <b>health care services received at other sites that are necessary to manage chronic care and preventive services for the population</b>
2.3	Registry incorporates <b>evidence-based care guidelines</b>
2.4	Registry information is available and in use by the PU team <b>at the point of care</b>
2.5	Registry contains information on the individual <b>attributed practitioner</b> for every patient currently in the registry who has a medical home in the PU

TABLE 1. Patient Registry Initiative Tasks	
2.6	Registry is being used to generate <b>routine, systematic communication to patients</b> regarding gaps in care
2.7	Registry is being used to flag <b>gaps in care</b> for every patient currently in the registry
2.8	Registry incorporates information on <b>patient demographics and key clinical parameters</b> for all patients currently in the registry
2.9	Registry is <b>fully electronic, comprehensive and integrated</b> , with analytic capabilities
2.10	Registry is being used to manage all patients with: <b>Asthma</b>
2.11	Registry is being used to manage all patients with: <b>Coronary Artery Disease (CAD)</b> <i>[not applicable to pediatric practices]</i>
2.12	Registry is being used to manage all patients with: <b>Congestive Heart Failure (CHF)</b> <i>[not applicable to pediatric practices]</i>
2.13	Registry is being used to manage patients with <b>at least two other chronic conditions for which there are evidence-based guidelines and the need for ongoing population and patient management</b> , and which are sufficiently prevalent in the practice to warrant inclusion in the registry based on the judgment of the practice leaders
2.14	Registry incorporates <b>preventive services guidelines</b> and is being used to generate routine, systematic communication to all patients in the practice
2.15	Registry incorporates patients who are assigned by managed care plans and are not established patients in the practice
2.16	Registry is being used to manage all patients with: Chronic Kidney Disease
2.17	Registry is being used to manage all patients with: Pediatric Obesity
2.18	Registry is being used to manage all patients with: Pediatric ADHD

## 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 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**

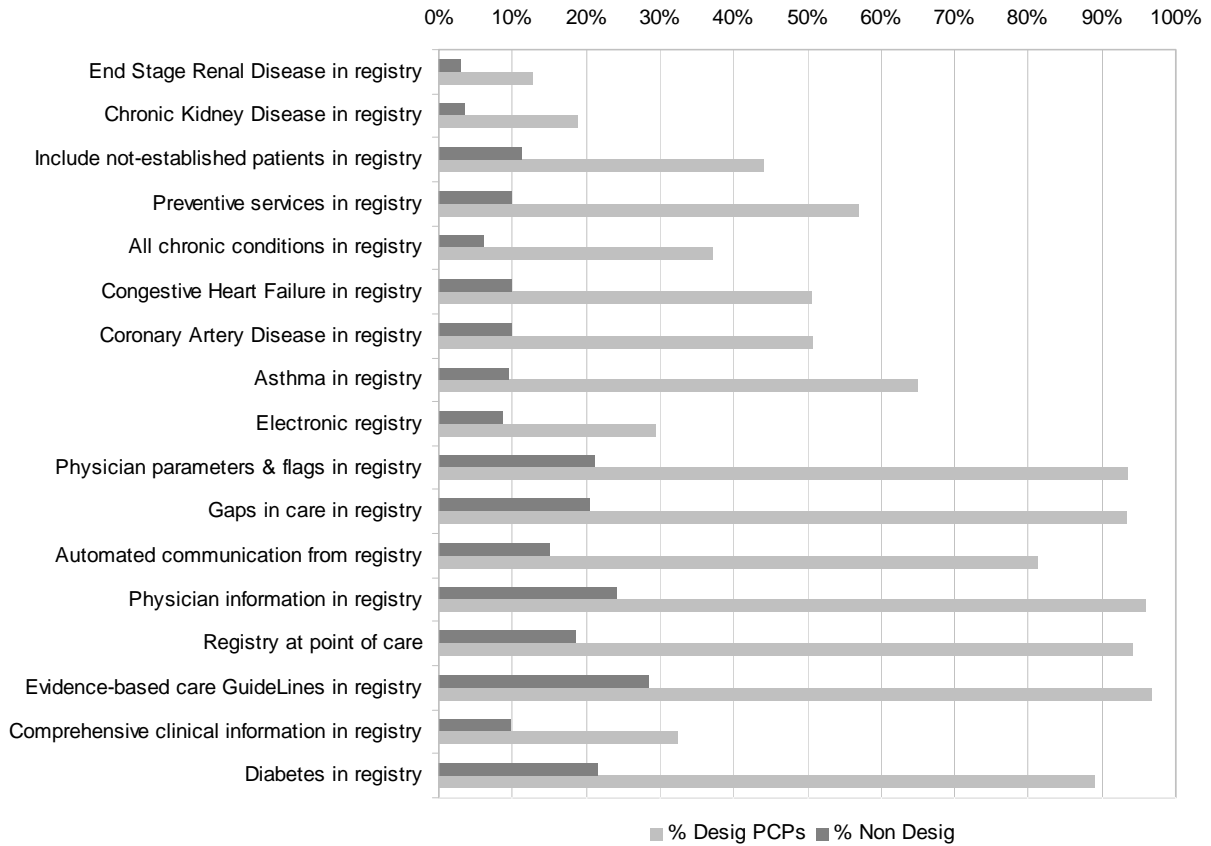
An in-depth evaluation of the PCMH Initiatives will be completed in 2011. The evaluation will focus on the correlation between PCMH capabilities and cost/use performance, as well as quality, use, efficiency and cost trends.

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

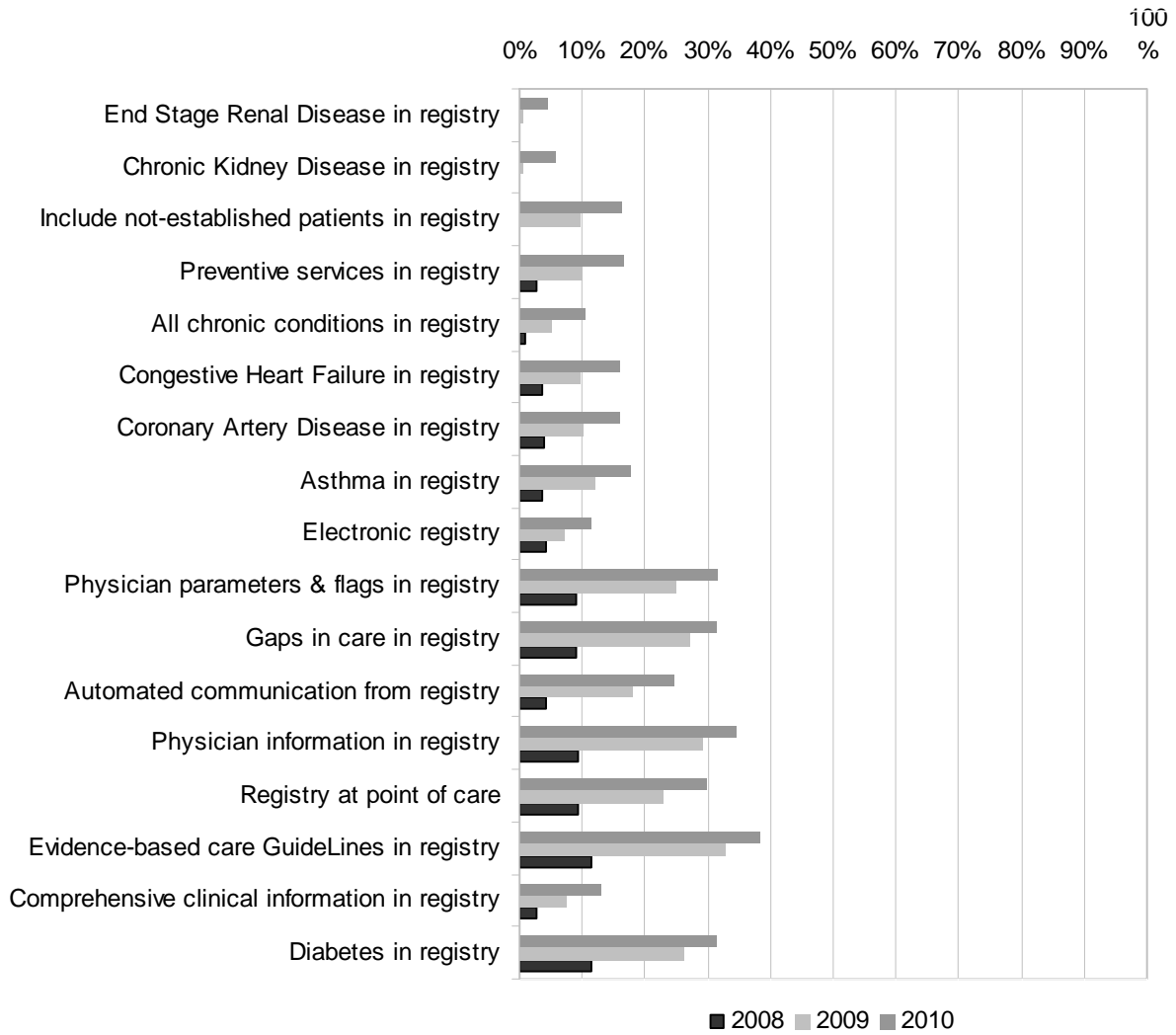
## **V. Results**

The objective of the Patient Registry 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 the patient registry.

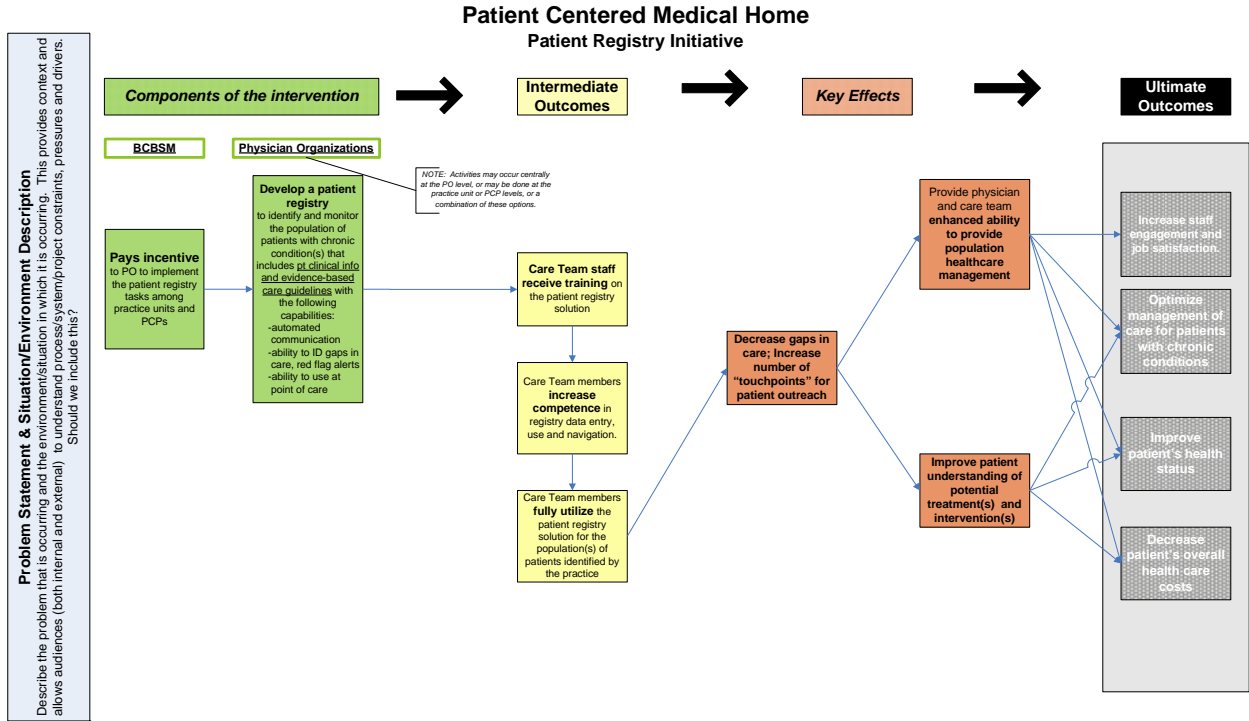


In addition, the percentage of practice units that have implemented each capability associated with this initiative has steadily increased over time, which shows that overall, PCMH-participating providers across the state are transforming their practices to become more patient-centered.



# Appendix I: Cause and Effect Diagram

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

Table 1: Process Outcomes				
Category	Process Metric	Data Source	Measurement	Metric
PO PCMH program team	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	% of DUWG meetings attended by each PO
Participation in the PCMH program	PO participation PU participation PCP participation Member participation			
Participation in PCMH program-related initiatives	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> DeVol R, Bedroussian A. An Unhealthy America: The Economic Burden of Chronic Disease, Milken Institute, October 2007.

<sup>2</sup> Phil McEvoy, Sylvain Laxade, British Journal of Community Nursing, Vol. 13, Iss. 3, 07 Mar 2008, pp 127 - 133