



BCBSM Physician Group Incentive Program 2011 Program Year

Patient-Centered Medical Home Initiative Plan Preventive Services



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 Preventive Services Initiative is to coordinate patient care through Primary Care Physicians (PCPs) in a patient centered medical home (PCMH) that involves a process of actively counseling, screening, and educating patients on preventive care.

The objective of the Preventive Services 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

Preventive health care within a primary care setting has the potential to reduce illness burden for many commonly-occurring conditions. The goals of preventive services are

to protect, promote, and maintain health and well being, and prevent disease, disability and premature death.ⁱ Poor health takes an enormous toll on the economy, and sick workers cost employers millions of dollars in lost productivity.

It is well documented that premature mortality can be reduced through modification of health risk factors and timely receipt of clinical preventive services. For instance, routine breast cancer screenings can reduce mortality and improve quality of life through prompt treatment. Likewise, there is strong scientific consensus that tobacco use, excessive alcohol use, physical inactivity, obesity, and failure to use safety belts increase mortality risk.ⁱⁱ Health providers can positively impact patients' behaviors in regard to these risk factors and increase wellness across their patient populations.

In addition to promoting wellness, preventive services save lives and potentially millions of dollars. In a July 2008 report, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*, stated that an investment of \$10 per person per year in proven community-based programs could save the country more than \$16 billion annually within five years. This is a return of \$5.60 for every \$1 investment,ⁱⁱⁱ making preventive services a cost-effective way to improve care.

According to the Centers for Disease Control and Prevention (CDC), more than 75 percent of the \$2 trillion in U.S. health care costs are attributed to people with a chronic disease. The instance of costly chronic conditions such as heart disease, cancer and diabetes may be decreased by employing preventive services, and their onset may be delayed or severity diminished when regular screenings, monitoring, and treatment are employed. Without a focus on prevention, early symptoms most likely will worsen and result in expensive and preventable hospital care.

Pneumonia is one illness that exemplifies the importance of preventive services. According to the Agency for Healthcare Research and Quality (AHRQ), 1.2 million Americans were hospitalized for pneumonia in 2006, making this lung infection the most common reason for hospital admission other than childbirth. Treating pneumonia – which is partially preventable through vaccination – cost hospitals \$10 billion in 2006.^{iv} Appropriate and timely vaccination – a critical component of preventive services - can substantially reduce the impact of vaccine-preventable infectious disease.

With good reason, the U.S. medical community and health insurers have long promoted prevention as an important way to reduce rising health care costs.

Preventive Services: Primary, Secondary and Tertiary Issues

Many of the PCMH initiatives address preventive care and encourage the development of systems to uniformly provide preventive care. Preventive care can address primary, secondary, or tertiary health care issues.

- Primary Prevention – Primary prevention focuses on precluding the development of a disease. Most population-based health promotion activities are primary preventive measures
- Secondary Prevention – Secondary prevention activities are aimed at early disease detection, thereby increasing opportunities for interventions to prevent progression of the disease and emergence of symptoms.
- Tertiary Prevention – Tertiary prevention reduces the negative impact of an already established disease by restoring function and reducing disease-related complications.

Components of Preventive Services Included in Other PGIP PCMH Initiatives

The concept of preventive services includes care processes that are addressed in other PGIP PCMH Initiatives, as shown in the table below:

Components of Preventive Services Initiative:	PGIP PCMH Initiatives			
	Preventive Services Initiative	Coordination of Care Initiative	Individual Care Management Initiative	Patient Registry Initiative
Primary Care Prevention	✓	✓		
Secondary Care Prevention	✓	✓		
Tertiary Care Prevention	✓		✓	✓
Implement systematic approach for appointment tracking and generation of reminders for all patients	✓	✓	✓	

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

Providers will work to expand the delivery of preventive services, develop policies and processes to encourage individuals to make healthy lifestyle choices, and proactively identify individuals who could benefit from treatment for a condition using a variety of prevention techniques. Participants will receive financial incentives for implementing the capabilities listed 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 the capabilities to successfully accomplish 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 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 and future practice audits are possible.

Table 1. Preventive Services Initiative Capabilities	
9.1	Primary prevention program is in place that focuses on identifying and educating patients about personal health behaviors to reduce their risk of disease and injury
9.2	A systematic approach is in place to providing preventive services
9.3	Strategies are in place to promote and conduct outreach regarding ongoing well care visits and screenings for all populations, consistent with guidelines for such age and gender-appropriate services promulgated by credible national organizations
9.4	Practice has process in place to inquire about a patient’s outside health encounters and has capability to incorporate information in patient tracking system or medical record
9.5	Practice has a systematic approach in place to ensure the provision/documentation of tobacco use assessment tools and advice regarding smoking cessation.
9.6	Written standing order protocols are in place to authorize PU care team members to authorize and deliver preventive services according to physician- approved protocol without examination by a clinician
9.7	Secondary prevention program is in place to identify and treat asymptomatic persons who have already developed risk factors or pre-clinical disease, but in whom the disease itself has not become clinically apparent
9.8	Staff receives regular training and/or communications in health promotion and disease

prevention, and incorporate preventive-focused practices into ongoing administrative operations

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.

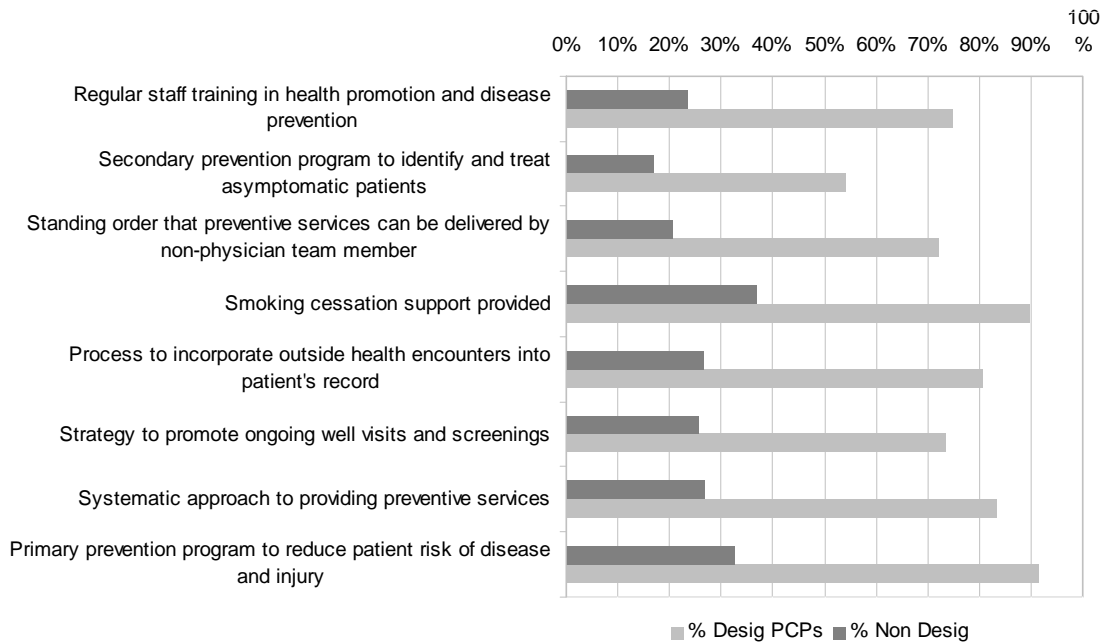
IV. Evaluation

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.

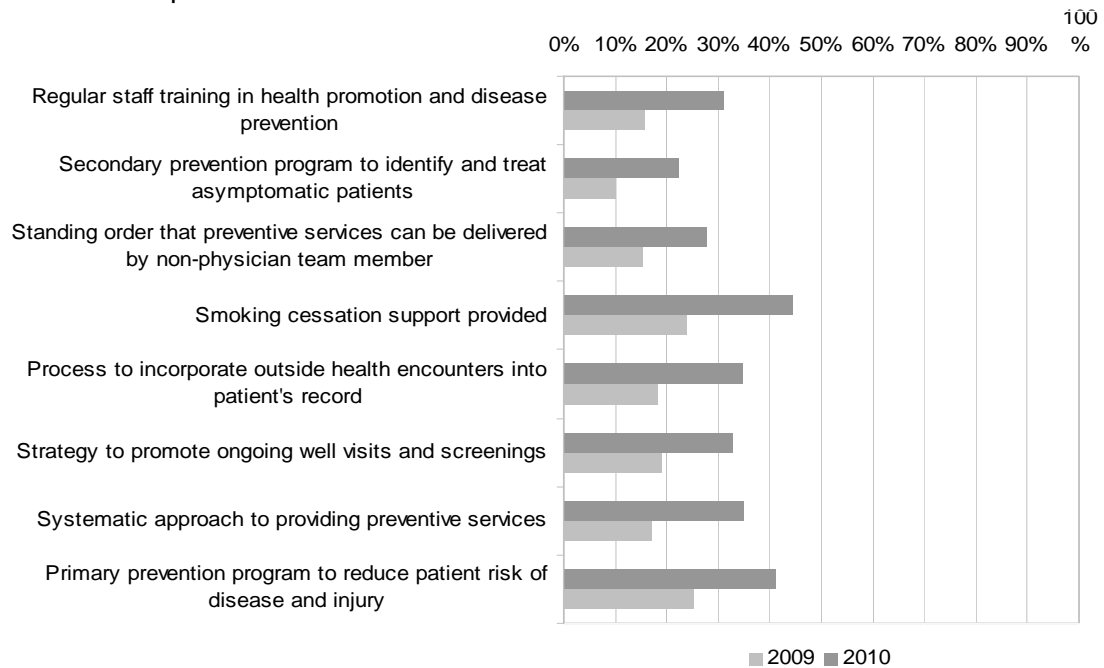
For more information on the process outcomes related to all aspects of PCMH general participation and the PCMH designation program, please refer to Appendix A.

V. Results

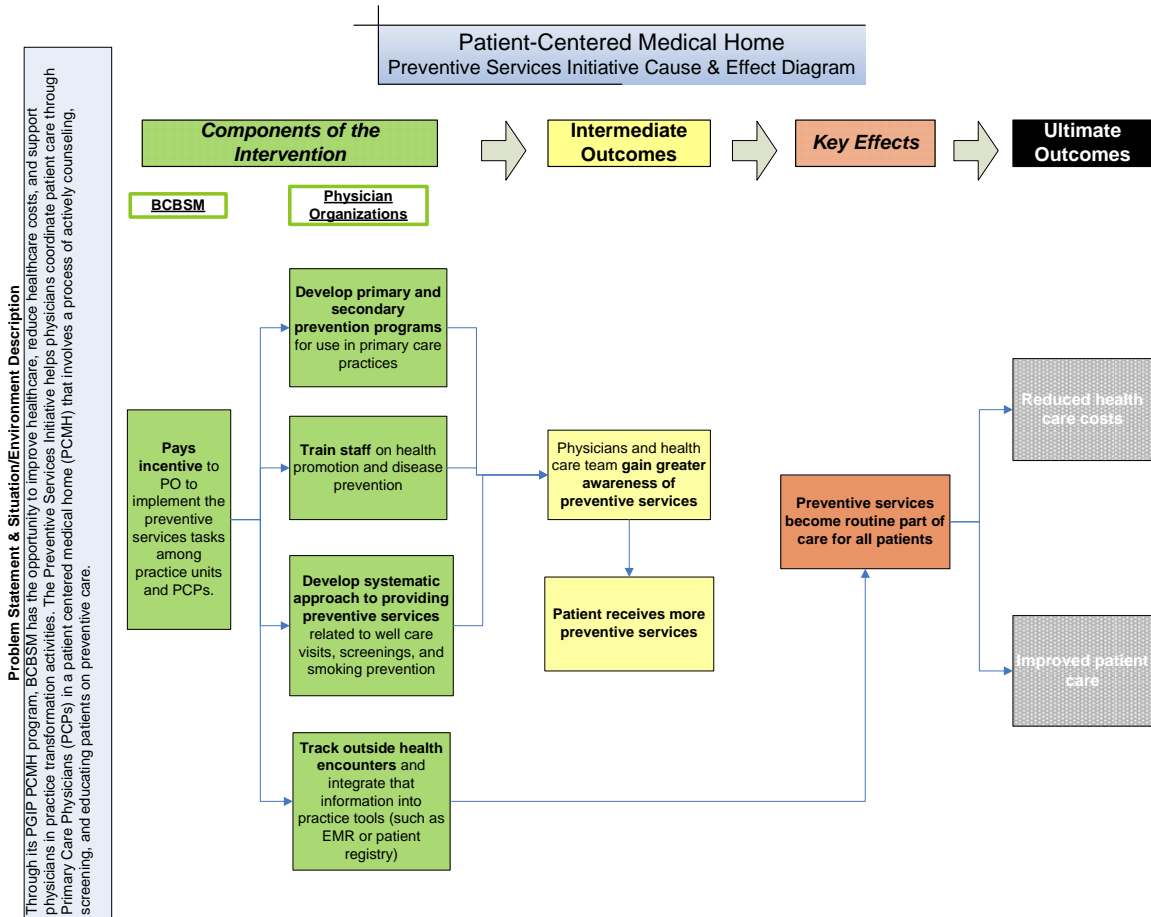
The objective of the Preventive Services Initiative is to annually increase the percentage of PGIP practice units that have implemented the capabilities associated with this initiative. As our recent program results show, both designated and non-designated providers are actively implementing capabilities related to preventive services.



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



Appendix II: Patient Centered Medical Home Evaluation Plan for 2011

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	B) What percentage of the DUWG meetings does the representative attend?	% 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: 1) Patient-provider partnership 2) Patient registry 3) Performance reporting 4) Individual care management 5) Extended access 6) Test results tracking and follow-up 7) Preventive services 8) Linkage to community services 9) Self-management support 10) Patient web portal 11) Coordination of care 12) Specialist referral process	Number and percent of non-Oncology POs participating in each PCMH-related initiative
	Practice unit participation	Self Assessment Database	Total PUs who participate in the following PCMH initiatives: 1) Patient-provider partnership 2) Patient registry 3) Performance reporting 4) Individual care management 5) Extended access 6) Test results tracking and follow-up	Number and percent of practice units participating in the initiative

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

			<ul style="list-style-type: none"> 4) Individual care management 5) Extended access 6) Test results tracking and follow-up 7) Preventive services 8) Linkage to community services 9) Self-management support 10) Patient web portal 11) Coordination of care 12) Specialist referral process 	
Participation in PCMH initiative capabilities	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"> 1) Patient-provider partnership capabilities 1.1 to 1.8 2) Patient registry capabilities 2.1 to 2.18 3) Performance reporting capabilities 3.1 to 3.13 4) Individual care management capabilities 4.1 to 4.15 5) Extended access capabilities 5.1 to 5.9 6) Test results tracking and follow-up capabilities 6.1 to 6.9 7) Preventive services capabilities 9.1 to 9.8 8) Linkage to community services capabilities 10.1 to 10.8 	Number and percent of POs, practice units, physicians, and members by absence or presence of capabilities under each initiative

		<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>		
PCMH Designation	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

ⁱ Eggert RW, Parkinson MD. *Preventive medicine and health system reform. Improving physician education, training, and practice.* JAMA 1994(9); 272:688-693

ⁱⁱ David E Nelson, MD, MPH; Shayne Bland, MS; Eve Powell-Griner, PhD; Richard Klein, MPH; Henry E Well, MS; Gary Hogelin, MPH,MPA; James S. Mark, MD, MPH_ *State Trends in Health Risk Factors and Receipt of Clinical Preventive Services Among US Adults During the 1990s* JAMA. 2002; 287:2659-2667.

ⁱⁱⁱ Levi J, Segal LM and Juliano C. RWJF Advances newsletter; July 2008
www.rwjf.org/pr/product.jsp?id=32711&c=EMC-ADV. Accessed August 1, 2008

^{iv} *News and Numbers* from the Agency for Healthcare Research and Quality (AHRQ). Agency for Healthcare Research and Quality, news release, July 2, 2008