



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.

Coordination of Care Initiative

Overview

The purpose of the Coordination of Care initiative is to improve coordination of patient care across the health system through a process of active collaboration and communication between the patient, providers and care-givers.

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

- 13.1 For every patient with chronic condition selected for initial focus, mechanism is established for being notified of each patient admit and discharge, or other type of encounter, at facilities with which the PCMH physician has admitting privileges, or other ongoing relationships.
- 13.2 Process is in place for exchanging necessary medical records and discussing continued care arrangements with other providers, including facilities, for all patients with chronic condition selected for initial focus
- 13.3 Approach is in place to systematically track care coordination activities for each patient with chronic condition selected for initial focus
- 13.4 Process is in place to systematically flag for immediate attention any patient issue that indicates a potentially time-sensitive health issue for all patients with chronic condition selected for initial focus
- 13.5 Process is in place to ensure that written transition plans are developed, in collaboration with patient and caregivers, where appropriate, for patients with chronic condition selected for initial focus who are leaving the practice (i.e., they are moving, going into long term care facility, or choosing to leave the practice)
- 13.6 Process is in place to coordinate care with payer case manager for patients with complex or catastrophic conditions
- 13.7 Practice has written procedures and/or guidelines on care coordination processes, and appropriate members of care team are trained on care coordination processes and have clearly defined roles within that process
- 13.8 Care coordination capabilities are extended to all patients with chronic conditions that need care coordination assistance
- 13.9 Care coordination capabilities are extended to all patients that need care coordination assistance

Promed/Borgess Ambulatory Care in Action: A Patient Story

“Two months ago the care coordination team at Borgess Ambulatory Care began following up on patients how visited the emergency room for non-emergent needs. The team calls the patient within 24 hours of their visit. During this call they evaluate how the patient is currently doing and offer to make a follow-up appointment with their PCP. Additionally, they reinforce the desire to treat non-emergent needs in the physician office and ask the patient if there were any barriers to seeking services in the physician office. The response from patients has been overwhelmingly positive. They love that their physician knew they were in the ER. As an organization, we have learned so much about our practices, and barriers we need to eliminate for our patients.”

Questions about the Coordination of Care 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: providerpartnerships@bcbsm.com