



# 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.*

## Individual Care Management Initiative

### Overview

The purpose of the Individual Care Management initiative is to ensure that patients with chronic conditions receive organized, planned care from a team of multi-disciplinary providers, and that patients are empowered to take greater responsibility for their health, leading to improved health status and decreased health care costs.

### 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

- 4.1 Practice Unit leaders and staff have been trained/educated and have comprehensive knowledge of the Patient Centered Medical Home model, the Chronic Care Model, and practice transformation concepts
- 4.2 PU has ability to deliver coordinated care management services with an integrated team of multi-disciplinary providers 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 evidence –based care guidelines are established and in use at the point of care by all team members of the PU
- 4.4 At least one chronic condition 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 Action plan development and self-management goal-setting is systematically offered to all patients with the chronic condition selected for initial focus
- 4.6 A systematic approach is in place for appointment tracking and generation of reminders for all patients with the chronic condition selected for initial focus
- 4.7 A systematic approach is in place to ensure that follow-up for needed services is provided for all patients with the chronic condition selected for initial focus
- 4.8 Planned visits are offered to all patients with the chronic condition selected for initial focus
- 4.9 Group visit option is available for all patients with the chronic condition selected for initial focus
- 4.10 Medication review and management is provided at every visit for all patients with chronic conditions
- 4.11 Action plan development and self-management goal-setting is systematically offered to all patient with chronic conditions or other complex health care needs
- 4.12 A systematic approach is in place for appointment tracking and generation of reminders for all patients
- 4.13 A systematic approach is in place to ensure follow-up for needed services for all patients
- 4.14 Planned visits are offered to all patients with chronic conditions
- 4.15 Group visit option is available to all patients with chronic conditions

### *Genesys HealthWorks in Action: A Patient Story*

*"A 39 year- old, low-income and uninsured male with a 6-year history of hypertension was assessed by a Health Navigator following a hospital admission. Unable to work due to his high blood pressure, the patient had stopped following his treatment plan due to the high cost of his prescription medication. In addition, the patient smoked, did not exercise and ate an unhealthy diet. After receiving self-management support through the HealthWorks model, the patient experienced improved care for his hypertension, and adopted healthy behaviors including increasing his physical activity, improved diet, and smoking cessation. These changes are leading to a decreased need for high-cost acute care via hospital admissions and ED visits."*

Questions about the Individual Care Management 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:  
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