



# 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.*



## Patient Registry Initiative

### Overview

The purpose of the Patient Registry initiative is to establish a comprehensive patient registry that can be used to optimally manage a population of patients, improve health status, and ultimately lower 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.

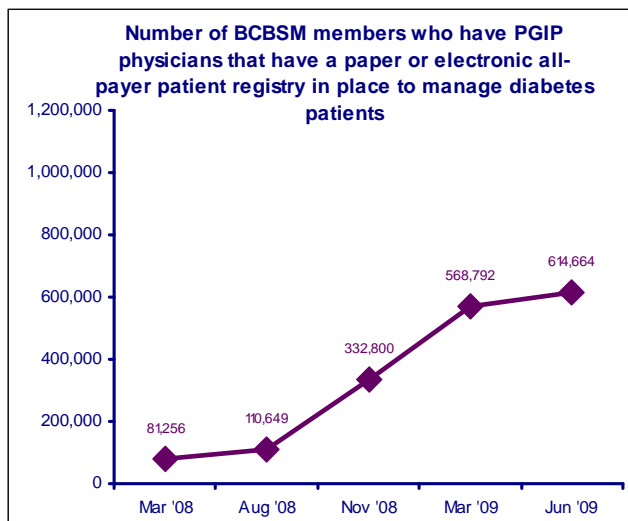
### Evaluation

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

- 2.1 Practice Unit is using an all-payer (including Medicare) paper or electronic registry to manage all established patients with diabetes
- 2.2 Registry incorporates patient clinical information for all established patients in the registry, for a substantial majority of health care services received at other sites that are necessary to manage chronic care and preventive services for the population
- 2.3 Registry incorporates evidence-based care guidelines
- 2.4 Registry information is available and in use by the PU team at the point of care
- 2.5 Registry contains information on the individual attributed practitioner for every patient currently in the registry who has a medical home in the PU
- 2.6 Registry is being used to generate routine, systematic communication to patients regarding gaps in care
- 2.7 Registry is being used to flag gaps in care for every patient currently in the registry
- 2.8 Registry incorporates information on patient demographics and key clinical parameters for all patients currently in the registry
- 2.9 Registry is fully electronic
- 2.10 Registry is being used to manage all patients with asthma
- 2.11 Registry is being used to manage all patient with coronary artery disease (CAD) *{not applicable to pediatric practices}*
- 2.12 Registry is being used to manage all patient with congestive heart failure (CHF) *{not applicable to pediatric practices}*
- 2.13 Registry is being used to manage patients with any additional chronic condition for which there are evidence-based guidelines and the need for ongoing population and patient management.
- 2.14 Registry incorporate preventive services guidelines 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 end stage renal disease

## Evaluation and Results



Compared to baseline data taken 2/29/2008, the number of members that see PGIP physicians that use a patient registry to manage diabetes patients have increased more than six times.



Questions about the Patient Registry 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](mailto:providerpartnerships@bcbsm.com)