



FACT SHEET: 2009 Physician Group Incentive Program Coordination of Care PCMH Initiative New for 2009

Initiative Overview

The purpose of the initiative is to improve patient care by implementing processes that will help providers coordinate treatment, communicate with one another, manage health care setting transitions, communicate care options to the patient, and track patient activity.

Objectives

Physician Organizations and Practice Units will provide patients with fully coordinated care that is:

- *Comprehensive:* Health care will be tracked, monitored and organized in a timely manner
- *Clear:* Results and outcomes of the patient care will be communicated to all involved parties
- *Cost-effective:* Reduced incidence of duplicate tests, medical errors, and polypharmacy will result in lower health care costs
- *Prioritized:* Available resources will be matched to patient needs by prioritizing appropriately

Initiative Criteria

- It is expected that all initiative tasks be completed within **four years**
- Implement full coordination of care using a gradual approach
- Practice Units must have a fully functioning disease registry in place

Incentive Design

All PCMH (Patient Centered Medical Home) Initiatives will have three phases that correspond to incentive payment periods:

Year I

- **PO Planning Phase:**
First incentive payment:
PO to provide self-assessment and an implementation plan
- **Initial Performance Phase:**
Second incentive payment:
Each Practice Unit will implement one task

Year II and thereafter

- **Ongoing Performance Phase:**
 - Two incentive payments per year for subsequent years of PO participation
 - Practice Units will implement 3 tasks per year, minimum one task per payment period

Initiative Tasks

- 13.1 For every patient with chronic condition selected for initial focus, mechanism is established for being notified of each patient admittance and discharge; or other type of encounter at facilities with which the PCMH physician has admitting privileges or other ongoing relationship
- 13.2 Process is in place for sending necessary medical records and discussing continued care arrangements with other facilities
- 13.3 Systematic approach is in place to use patient registry to systematically track care coordination activities
- 13.4 Systematic approach is in place to flag for immediate attention any patient registry data that indicates a potentially time-sensitive health issue
- 13.5 For patients leaving the practice (i.e., because they are moving, going into a nursing home, or choosing to leave the practice), capability is in place to develop written transition plan in collaboration with patient and their caregivers
- 13.6 Capability is in place to coordinate care with health plan case manager(s) regarding extra-contractual benefits and services
- 13.7 All members of care team are adequately trained on care coordination processes as determined by each Practice Unit, 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

Metrics

TBD

Results

TBD

Initiative Launched: 2009 Ref# CCP-09-08 Version 1.0