



FACT SHEET: 2009 Physician Group Incentive Program Linkage to Community Services PCMH Initiative New in 2009

Initiative Overview

The goal of the initiative is to help patients connect with community resources by implementing processes that coordinate care between the health system, community service agencies, family, caregivers, and the patient.

Objectives

- Establish a comprehensive community resource database; form partnerships with key agencies whose services reflect the needs of various patient populations
- Patients and their families will be provided with up-to-date information about resources in their community (e.g. behavioral health services, and support groups)
- A system will be put in place to refer patients to appropriate resources and ensure they receive needed services
- Practice unit care teams will receive training to ensure adequate knowledge of community resources
- Patient care will include an evaluation of the need for referrals to community resources

Initiative Criteria

- It is expected that all initiative tasks be completed within **four years**
- Practice Units may implement tasks in any sequence they choose

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

- 10.1 PO has conducted comprehensive review of community resources for the geographic population that they serve, in conjunction with Practice Units
- 10.2 POs maintain a community resource database based on input from Practice Units that serves as a central repository of information for all Practice Units. The database may include resources such as the United Way's 2-1-1 hotline, or links to online resources such as the Michigan Primary Care Initiative
- 10.3 Partnerships for collaboration with appropriate agencies and organizations are established at the Practice Unit level in conjunction with the PO
- 10.4 All members of care team involved in establishing treatment plans have received training on community resources so that they identify and refer patients appropriately
- 10.5 Systematic approach is in place for evaluating all patients who may need a referral to community resources
- 10.6 Systematic approach is in place for referring patients to community resources
- 10.7 Systematic approach is in place for tracking referrals made by the resource provision team, and ensuring that patients complete the referral activity
- 10.8 Systematic approach is in place for conducting follow-up with patients regarding any indicated next steps

Metrics

TBD

Results

TBD