BCBSM
Physician Group Incentive Program
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Patient-Centered Medical Home Initiative Plan for Individual Care Management

BCBSM PGIP Patient-Centered Medical Home
Individual Care Management Initiative Plan

I. Background

Problem Statement

The U.S. model of care continues to be based on treatment of acute conditions, although more than half of all Americans suffer from one or more chronic disease and seventy-five percent of health care spending is for chronic disease. Researchers report that only 56% of those with chronic disease receive clinically appropriate care, and only 27% of adults (and 12% of low-income Americans) report having full access to a well-organized source of health care.[i] The most common chronic diseases are costing the economy more than $1 trillion annually, and costs are projected to rise as high as $6 trillion by 2050. In 2003, chronic disease treatment cost Michigan, which ranked 28th out of the 50 states in incidence of chronic diseases, $10.6B in direct costs and $37.9B in lost productivity.[ii]

Constraints/Considerations

Implementation of individual care management capabilities will require substantial transformation of care processes, staff responsibility, information access/flow, and patient expectations. Practices report that the key to practice transformation is a strong, highly functioning team.

II. Initiative Description

Goals

Ensure that all patients with chronic conditions or other ongoing health needs receive care that involves goal setting, planned visits (with generation of reminders), group visits, medication management and reminders, and follow-up support to receive needed services, based on evidence-based guidelines.

Objectives

Redesign existing practice systems to create processes and infrastructure necessary to meet Advanced PC-MH criteria for Individual Care Management Domain of Function (see PC-MH Overall Plan and PC-MH Designation Program Fact Sheet).

Expectations

Recognizing that POs will need adequate time to communicate with Practice Units and plan effectively, in the first year POs will be expected to conduct a self-assessment, complete an

implementation plan for the Initiative Tasks (see Table 1, below), and submit progress reports each reward period.

In subsequent years, Practice Units will be expected to implement Initiative Tasks, and the PO will be expected to submit a progress report each reward period, listing completed Initiative Tasks by Practice Unit and identifying best practice accomplishments, barriers/challenges encountered and plans to overcome. Practice Units will be expected to implement one new Initiative Task per reward period (or three per year). Practice Units may implement the Initiative Tasks in any sequence they choose.

TABLE 1. Individual Care Management Initiative Tasks[iii]
1. Train/educate Practice Unit leaders and staff to ensure comprehensive knowledge of the Patient Centered-Medical Home model, the Chronic Care model, and practice transformation concepts
2. Assemble a team of multi-disciplinary providers and implement systematic approach for providing comprehensive care that addresses patients' full range of health care needs • Team may include physician, R.N., N.P., P.A., nutritionist, C.D.E., respiratory therapist, case manager, front office staff, health educator, medical assistant, pharmacist, and information system staff • Provider Organization may elect to assemble "travel teams" to support multiple Practice Units • Establish regular team meetings (e.g., morning "huddles")
3. Select and implement care guidelines to be systematically followed by all members of Practice Unit (e.g., MQIC Guidelines) • Guidelines are available and used at the point of care by all physicians in the Practice Unit • Guidelines are used by PO to evaluate performance of physicians, Practice Units, and PO
4. Identify one chronic condition for initial focus and assemble key clinical data for all patients with those conditions • Select clinical outcomes measures, process measures, and patient satisfaction/office efficiency measures to track and assess current performance relative to the measures selected
5. Implement capability to systematically offer development of action plans and goal-setting to all patients with the chronic condition selected for initial focus
6. Implement systematic approach to appointment tracking, generation of reminders (based on evidence-based guidelines) for all patients with the chronic condition selected for initial focus
7. Implement systematic approach to ensuring follow-up for needed services (based on evidence-based guidelines) for all patients with the chronic condition selected for initial focus
8. Implement planned visits for all patients with the chronic condition selected for initial focus

TABLE 1. Individual Care Management Initiative Tasks[iii]
9. Implement systematic approach to ensuring group visit option is offered to all patients with the chronic condition selected for initial focus (as appropriate for the patient) • May be done in collaboration with other Practice Units
10. Implement medication review and management at every visit for all patients with chronic conditions
11. Expand availability of development of actions plans and goal-setting to all patients with chronic conditions or other complex health care needs • Assemble key clinical data • Update clinical outcomes measures, process measures, and patient satisfaction/office efficiency measures to track and assess current performance for all patients relative to the measures selected
12. Expand system for appointment tracking and generation of reminders to all patients
13. Expand system for follow-up for needed services to all patients
14. Expand availability of planned visits to all patients with chronic conditions
15. Expand group visit option to all patients with chronic conditions

Timeframe

Each Practice Unit should complete all Individual Care Management Initiative Tasks within **6 years** of the start of participation. Thus, it is advisable to register for participation only those Practice Units that are ready to actively engage in the Initiative. If ongoing progress has been demonstrated and significant barriers have been encountered, however, Practice Units exceeding the specified time frame may apply for an extension of time to continue to participate in the Initiative.

Note that the defined timeframes apply to Practice Units, and not necessarily to the overall PO. Different Practice Units within a single PO may begin participating in an Initiative at different points in time, so a PO may end up participating in an Initiative for a number of years longer than the defined timeframe for that Initiative.

Practice Units that achieve "Advanced PC-MH" competency in all the Individual Care Management domains of function will generally no longer be eligible to participate in the Individual Care Management Initiative. Likewise, Practice Units that have already completed some of the Initiative Tasks at the start of participation will be eligible to participate only for the time it takes to implement the remaining Tasks at the rate specified in the Initiative Plan.

Incentive Design

In the first year, the incentive payment will be based 100% on the PO's **participation.** In subsequent years, the incentive payment will continue to have a PO **participation** component, but will be primarily based on Practice Unit **performance**.

PC-MH Individual Care Management Incentive Design

Year 1	First payment (April 2008)	Second payment (September 2008)	Third payment (January 2009)

Participation is defined as:	○ Completed progress report ○ Conducted a self-assessment	○ Completed progress report ○ Developed implementation plan	○ Completed progress report ○ Completed implementation plan

Subsequent years	First payment (April)	Second payment (September)	Third payment (January)
Participation is defined as:	○ Completed progress report	○ Completed progress report	○ Completed progress report ○ Updated implementation plan
Performance improvement is evaluated using the following metrics:	○ % of physicians completing one or more "Initiative Tasks"	○ % of physicians completing one or more "Initiative Tasks"	○ % of physicians completing one or more "Initiative Tasks"

Performance payments will be based on the percent of the PO's total physicians that complete an Initiative Task, so there is no advantage to registering all physicians as participants in an Initiative if the expectation is that only a subset will be actively engaged.

Please note that POs employing a phased approach to Practice Unit involvement in an Initiative will not be financially penalized: the lower reward amount in the short-term (for fewer physicians completing Initiative Tasks) will be offset by longer-term eligibility to participate in that initiative.

Additional Resources on Individual Care Management

ICIC: tools, resources, articles on the Chronic Care Model, clinical practice change, actions plans. Available at:
http://www.improvingchroniccare.org/index.php?p=Clinical_Practice_Change&s=3

AAFP website: tools, resources, articles on group visits, individual care management, patient-centered care. Available at:
http://www.aafp.org/online/en/home/publications/journals/fpm/collections/transformation.html

Endnotes

[i]Health Care Quality Survey, Commonwealth Fund, 2006.
[ii] DeVol R, Bedroussian A. An Unhealthy America: The Economic Burden of Chronic Disease, Milken Institute, October 2007.
[iii] Drawn from *Improving Your Practice Manual*. ICIC (Improving Chronic Illness Care). Available at: http://www.improvingchroniccare.org/index.php?p=Steps_for_Improvement&s=37