BCBSM Physician Group Incentive Program November 2007

Patient-Centered Medical Home Initiative Plan for Patient-Provider Partnership

BCBSM PGIP Patient-Centered Medical Home
Patient-Provider Partnership Initiative Plan

I. Background

Problem Statement

The current United States health care system is increasingly regarded as having reached a state of crisis. The U.S. spends more money on health care than any of the 30 other countries in the Organization for Economic Cooperation and Development (OECD) (most of which are considered the most economically advanced countries in the world), yet consistently ranks low in international comparisons. U.S. health care spending -- $6,102 per capita in 2004 – is more than double the OECD average and 19.9% higher than Luxembourg, the second-highest spending country.[i] A 2004 review of adults' health care experience in five countries, however, found the U.S. primary care system ranked either last or significantly lower on almost all dimensions of patient-centered care: access, coordination, and physician-patient experiences (the U.S. was highly ranked only in preventive measures).[ii]

Multiple studies have found that having a regular source of care, and continuous care with the same physician over time, leads to better health on both the individual and population levels, and lower overall costs of care,[iii] as well as reductions in disparities in health for socially disadvantaged subpopulations,[iv] and higher rates of preventive screening.[v]

Correlation between Screening Tests and Insurance vs. Medical Home

Percent of Adult Patients Having Cholesterol Level Checked	Medical Home	No Medical Home
Insured	59%	30%
Not Insured	45%	16%

Source: Journal of Family Practice, 1996

Constraints/considerations

The major barriers to execution of a care partnership agreement between a patient and a provider are lack of patient and provider awareness of the PC-MH concept, physician time constraints in discussing the PC-MH concept with the patient, and difficulty in reaching patients who do not visit the office regularly. Key concepts that may help overcome barriers include:

- Emphasize with the patient that the agreement is not legally binding and has no punitive implications
    - Patients may have concerns regarding enforcement of agreement. The requirement instituted under the West Virginia Medicaid program in 2006 for patients to sign and conform to an agreement in order to receive

"enhanced" benefit packages has been widely criticized for disparately affecting children, placing physician in the role of enforcer and potentially having to deny health care services to their highest need patients, leading to future increase in inpatient admissions.[vi]

- Build broad-based physician and team understanding and support of the PC-MH concept before presenting the concept to patients
- Make agreement or PC-MH information available to patients for review in a variety of venues:
    - Post in waiting room
    - Post on website
    - Mail to patients who are not seen regularly; place phone calls to those with chronic conditions
    - Provide information to patients when they sign in for appointment

II. Initiative Description

Goals

Expand physician, health care team, and patient understanding of and commitment to PC-MH concept, and strengthen bond between patients and their care-giving team:

- Expand patient knowledge of PC-MH concept and patient and provider/health team roles and responsibilities associated with PC-MH
- Clearly define and strengthen care partnership between patient and physician/health care team

Support ability of providers to identify, track and engage with patients with ongoing health care needs

- Engage patients who do not visit regularly

Objective

Develop and execute patient-provider agreement or document other type of clear communication with at least 90% of patients to meet Advanced PC-MH criteria for Patient-Provider Partnership Domain of Function (see PC-MH Overall Plan and PC-MH Designation Program Fact Sheet).

Expectations

In the first reward period, POs will be expected to conduct a self-assessment, complete an implementation plan for the Initiative Tasks (see Table 1, below), and submit a progress report.

In subsequent reward periods, Practice Units will be expected to complete implementation of 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.

<table>
<tr><th>TABLE 1. Patient-Provider Partnership Initiative Tasks</th></tr>
<tr><td>
1. Establish process for implementing patient-provider agreement or other documented patient communication process

Create data field in patient registry to track which patients have accepted PC-MH invitation
Draft patient-provider agreement or other patient information documents, submit to BCBSM and finalize

Document may indicate that PC-MH capabilities will be phased in over time
Essential elements: patient will contact provider first for health care needs, and provider promises to listen and be responsive and helpful
Incorporate concepts of PC-MH (see Appendix A for suggested concepts to include)
Incorporate statement of patient rights and responsibilities and provider responsibilities (see Appendices B and C for suggested concepts to include)

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2. Conduct patient education and outreach

Provide patients with PC-MH information/copies of agreement
Conduct focused outreach to patients who do not visit regularly to educate them about PC-MH concept

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3. Implement patient-provider agreement or other documented patient communication process with 10% of patients

Disseminate PC-MH information and/or copies of agreement to patients
At end of scheduled appointments:

Physician engages patient in discussion about establishment of partnership
Document discussion in medical record
Options for patient role

Invite patient to sign agreement indicating acceptance of physician offer to function as patient’s PC-MH; place copy of signed agreement in medical record and provide patient with copy
Provide patient with copy of PC-MH information sheet and document patient’s response in medical record

Update patient registry to identify patients accepting PC-MH invitation
Follow-up questions may be answered by clinical team members

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<tr><td>4. Implement patient-provider agreement or other documented patient communication process with 30% of patients</td></tr>
<tr><td>5. Implement patient-provider agreement or other documented patient communication process with 50% of patients</td></tr>
<tr><td>6. Implement patient-provider agreement or other documented patient communication process with 60% of patients</td></tr>
<tr><td>7. Implement patient-provider agreement or other documented patient communication process with 80% of patients</td></tr>
<tr><td>8. Implement patient-provider agreement or other documented patient communication process with 90% of patients</td></tr>
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Timeframe

Each Practice Unit should complete all Patient-Provider Partnership Initiative Tasks within **3 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 Patient-Provider Agreement domains of function will generally no longer be eligible to participate in the Patient-Provider Agreement 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 Patient-Provider Partnership Incentive Design

	First payment (April 2008)	Second payment (September 2008)	Third payment (January 2009)
Participation is defined as:	o Conducted a self-assessment o Developed implementation plan o Completed progress report	o Completed progress report	o Completed progress report o Updated implementation plan
Performance improvement is evaluated using the following metrics:		o % of physicians completing one or more "Initiative Tasks"	o % of physicians completing one or more "Initiative Tasks"

Subsequent years	First payment (April)	Second payment (September)	Third payment (January)
Participation is defined as:	o Completed progress report	o Completed progress report	o Completed progress report o 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.

Appendix A - Principles of Patient-Centered Medical Home

1. Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
2. The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients, using a planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
3. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
4. The goal of the physician and the team is to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
5. The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals, for all stages of life: acute care; chronic care; preventive services; and end of life care. Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services).
6. Evidence-based medicine and clinical decision-support tools guide decision making.
7. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
8. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
9. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Appendix B – Patient Rights and Responsibilities

Patient rights

1. High quality, medical care, without discrimination, that is compassionate and respects personal dignity, values and beliefs.
2. Participate in and make decisions about their care and pain management, including refusing care to the extent permitted by law. Care providers (doctor, nurse, etc.) will explain the medical consequences of refusing recommended treatment.
3. Have illness, treatment, pain, alternatives and outcomes be explained in an understandable manner, with interpretation services as needed.
4. Treatments, communications and medical records kept private to the extent permitted by law.
5. Access to medical records in a reasonable timeframe, to the extent permitted by law.
6. Full information regarding charges; counseling on the availability of known financial resources for health care.
7. Access to an advocacy or protective service agencies and a right to be free from abuse.
8. Forum for having concerns and complaints addressed; and guarantee that sharing concerns and complaints will not compromise access to care, treatment and services.

Patient responsibilities

1. Partner with the provider/medical home staff in establishing collaborative relationship to address patient's personal health and health behavior issues.
2. Keep scheduled appointments or cancel in advance if at all possible
3. Contact provider first for all medical issues, other than emergencies perceived to be life-threatening or with potential to permanently impair health status
4. Reports changes in condition or symptoms, and keep medical record up to date, including information on all over-the-counter medications and dietary supplements (such as vitamins, herbal supplements)
5. Share concerns and questions, needs and priorities
6. Identify personal life goals and establish care management plans, including clearly identified self-management goals and responsibilities
7. Take the medicine prescribed
8. Read information from provider, and ask questions if help or clarification is needed
9. Meet financial obligations

Appendix C – Provider Responsibilities

Provider Responsibilities

1. Create trusting, collaborative relationship with the patient and their family to ensure that patient's health care needs are met
2. Use evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors
3. Provide patients with 24 hour access via phone or email to a clinical decision-maker linked to PC-MH
4. Provide same day access for appointments
5. Maintain knowledge of the patient's health history
6. Listen to the patient's concerns and needs
7. Develop a patient care plan based on evidence-based guidelines when needed
8. Provide clear direction regarding prescriptions, and recommendations regarding over-the-counter medications and herbal supplements
9. Facilitate communication between the patient and other health care providers when referrals are necessary
10. Treat the patient with compassion and understanding

References

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