2017 PGIP Executive Summary

Patient-Centered Medical Home

Summary of Changes for 2017

New capabilities have been added to the Patient Centered Medical Home (PCMH) program for 2017. There are two new capabilities in the Individual Care Management initiative:

1. 4.22: Provider initiating advance care plan in 4.16 ensures that all care partners are aware of and have copies of advance care plan
2. 4.23: Practice has engaged in root cause analysis of any areas where there are significant opportunities for improvement in patient experience of care using tested methods such as Journey Mapping or LEAN techniques

We also developed new PCMH capabilities as part of our Electronic Prescribing and Management of Controlled Substances Initiative. This initiative augments our existing e-Prescribing capability (8.7, “full e-prescribing system is in place and actively in use by all physicians”) by adding four more capabilities that specifically address controlled substances.

1. 8.8: Electronic prescribing system is routinely used to prescribe controlled substances
2. 8.9: Michigan Automated Prescription System (MAPS) reports are routinely run prior to prescribing controlled substances
3. 8.10: Controlled Substance Agreements are in place for all patients with long-term controlled substance prescriptions
4. 8.11: Controlled Substance Agreements are shared with all patient’s care providers

Overview

Building on the foundation laid by PGIP, our Patient-Centered Medical Home Initiative launched in 2008, and our designation program launched a year later in 2009. Currently, Blue Cross’s Patient-Centered Medical Home program is the largest of its kind in the country. Over 16,000 providers in Michigan, including primary and specialty care physicians, are actively working to implement PCMH capabilities.

In 2016, 4,534 primary care physicians from 1,638 medical practices across the state were designated as a Blue Cross Patient-Centered Medical Home. The number of designated practice units has increased each year since the program began in 2009. Designated practices are those that have made the most progress in implementing PCMH capabilities, and that have achieved strong performance on quality, use and efficiency measures.

Background

Our award-winning Patient-Centered Medical Home model was influenced by Wagner's Chronic Care Model, which was also the basis for the PGIP initiatives that predated the PCMH program. Our 12 PCMH initiatives were a direct result of the Joint Principles of the Patient-Centered Medical Home, released by the four major medical societies in 2007. Each PCMH initiative was developed in collaboration with the provider community in the state of Michigan.

Results

Program results for 2017 are based on those practices participating in the PCMH designation program. Results compare the 2016 pool of 1,638 PCMH designated practices to their non-designated peers; (adult patients aged 18-64 only; using 2015 claims data.) Results suggest PCMH practices have lower utilization and stronger performance on quality metrics than their non-designated counterparts.

- Emergency department visits for adults were **15.0 percent** lower for designated practices compared to non-designated, and emergency department visits for children were **17.2 percent** lower.
- Primary Care Sensitive ED visits for adults were **18.1 percent** lower for designated practices compared to non-designated, and **22.7** percent lower for children.
- Ambulatory Care Sensitive inpatient discharges were **21.4 percent** lower for designated practices compared to non-designated.
- High-tech radiology services were **8.7 percent** lower for designated practices compared to non-designated.
- High-tech radiology standard cost PMPM was **7.7 percent** lower for designated practices compared to non-designated.
- Low tech radiology services for adults were **10.6 percent** lower for designated practices compared to non-designated, and were **9.5 percent** lower for children.
- Low tech radiology standard cost PMPM was **9.6 percent** lower for designated practices compared to non-designated.

Goals and Objectives

Each PCMH initiative has its own unique goals and objectives. For more information, please refer to the *PCMH Master Initiative* plan located on the PGIP Collaboration site.

Measures Tied to Payment

There are two forms of reimbursement associated with the PCMH program. The first is PGIP

reward pool dollars paid to physician organizations (POs) twice annually for the implementation of PCMH capabilities among their primary care and specialist practices. The second is value-based reimbursement paid on an ongoing basis to primary care physicians, for becoming PGIP Patient-Centered Medical Home designated.

Data Delivery Timeline

These data elements are not specific to participation in the PCMH initiatives; rather, they are provided to all POs that participate in PGIP.

Data Provided/Period Covered	Frequency*
Claims feed - all claims processed by Blue Cross in the previous month including facility, professional, and pharmacy, which includes a variety of data elements, including member (or patient) information and PGIP physician information standard costs.	Commercial claims data is sent on the 25th of each month, and Medicare Advantage data is sent on the 1st business day of each month (or next business day if those dates fall on a weekend or holiday)

**Data frequency dates subject to change.*

PO Deliverables

Physician organizations that work with their practices to implement PCMH capabilities must report the capabilities each practice has put into place twice a year through the Self-Assessment Database (SAD) tool. In addition, POs are expected to nominate primary care practices that are worthy of PCMH designation once per year.

For additional information about this Initiative contact:

Lisa Rajt, Health Care Manager, Value Partnerships, Blue Cross at lrajt@bcbsm.com.

About Value Partnerships

Over a decade of innovation, Value Partnerships is a collection of clinically-oriented initiatives among Michigan physicians, hospitals, and Blue Cross that are improving clinical quality, reducing health complications, controlling cost trends, eliminating errors, and improving healthcare outcomes throughout Michigan.

About PGIP

PGIP, part of Blue Cross's **Value Partnerships** program, encourages, and rewards practitioners to more effectively manage patient populations and build an infrastructure to more robustly measure and monitor care quality. Over **40** physician organizations across the state of Michigan - representing nearly **20,000 primary care physicians and specialists** - are working together

in PGIP to improve the delivery of healthcare for Michigan Blues members. PGIP is cultivating a healthier future for all Michigan residents by catalyzing an all-payer system. Patients throughout the state, regardless of payer, benefit from improved care processes developed in the PGIP provider community.

For additional information about PGIP:
Send an email to valuepartnerships@bcbsm.com.