Renovating the Medical Home: Lessons from Blue Cross Blue Shield Michigan

Presentation to:

RWJF/Academy Health Conference on Payment Reform – Honing the Models and Pushing the Boundaries

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Overview of BCBSM

- Serving **4.4 million** Michigan members and over **1.2 million** out of state members
- More than **7,000** employees state-wide
- Michigan Blues have largest network in the state
    - More than **156 hospitals** *(100% of all MI hospitals)*
    - Nearly **30,000 physicians** *(95% of all MI physicians)*
- In 2012, BCBSM paid **$18.6 million** in claims to doctors, hospitals and health care providers

Root Causes of Low System Performance

Lack of population focus

Weak primary care foundation

Fragmented healthcare delivery

Poorly aligned payments

Lack of focus on process excellence

Evolution of Value Based Programs

- BCBSM's strategy addresses both traditional and emerging Value Based Care levers, including:

Traditional Total Cost of Care Levers

Product Design

Network and Provider Management

UM, CM, DM, Wellness

Member Engagement

Emerging Total Cost of Care Levers

Influence Provider Behavior
(e.g. PGIP, OSCs, PCMH, PDCM)

Influence Consumer Behavior
BCBSM: cost sharing, tiered benefits, wellness incentives, transparency tools, etc.
PGIP Providers: Empowering consumers, *Choosing Wisely*

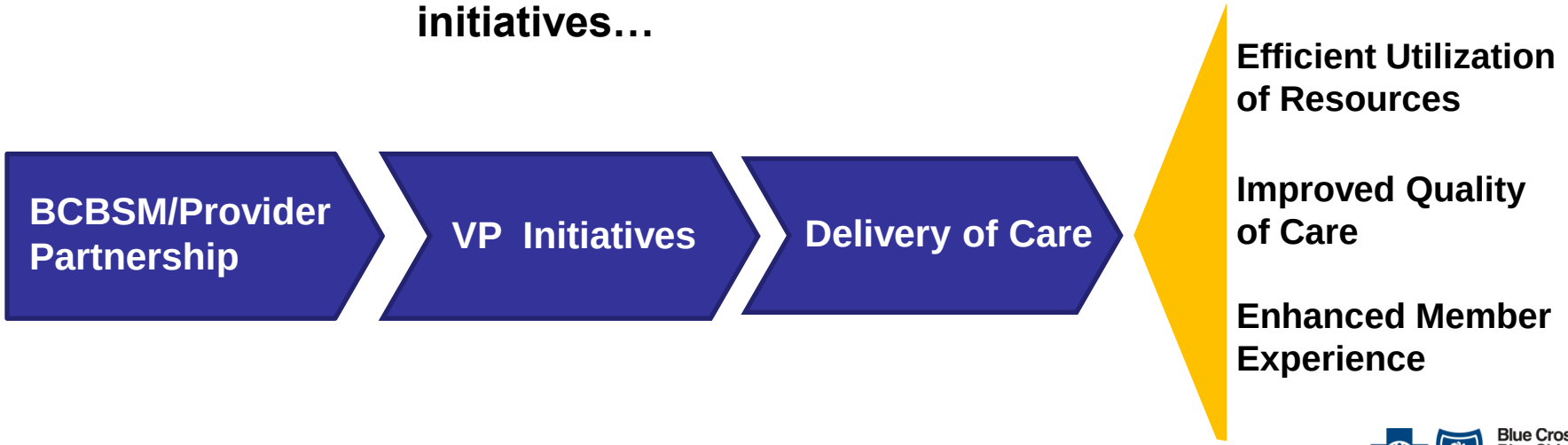
Value Partnerships programs incentivizes providers to alter the delivery of care by encouraging responsible and proactive physician behavior, ultimately driving better health outcomes and financial impact.

BCBSM provides the financing, tools and support…

…so physicians can engage in specific initiatives…

…that change the way healthcare is delivered...

…and drive meaningful impacts for our members



BCBSM Partnering for Value Philosophy

1. Design and execute programs in a ***customized and collaborative*** manner rather than using a one-size-fits-all approach
2. Recognize and reward performance of ***physician organizations (POs)***, not only individual physicians
3. Reward ***improvement,*** not just highest performance, to create meaningful incentives for all physician organizations
4. Focus on investments in ***long-term changes in care processes***
5. Encourage ***collaboration*** among participants
6. Focus on ***population-based*** cost measures, rather than per-episode cost, to avoid stimulating overuse

Phase I: PGIP

(2005- present)

Building the PCP Foundation

BCBSM infrastructure support: "pay for participation"

Initial focus

- ✓ Connect physicians with POs
- ✓ Engage POs in PGIP
- ✓ Address chronic care challenges
- ✓ Increase generic Rx use
- ✓ Implement e-Prescribing
- ✓ Improve performance on HEDIS measures
- ✓ Address excessive radiology use

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PGIP 101:
Key Statistics

- Physician Organizations = 45
- Physicians in PGIP = 19,272
  - Primary Care Physicians = 5,866
    - 70+% of BCBSM's network, but account for ~85% of claims
  - Specialists = 13,406
    - 51% of network specialists
- Practice Units = 6,544
  - PCP Practices = 2,407
- PGIP-participating physicians provide care to nearly 2M commercial members
- 87% of our commercial PPO population is cared for by PGIP physicians

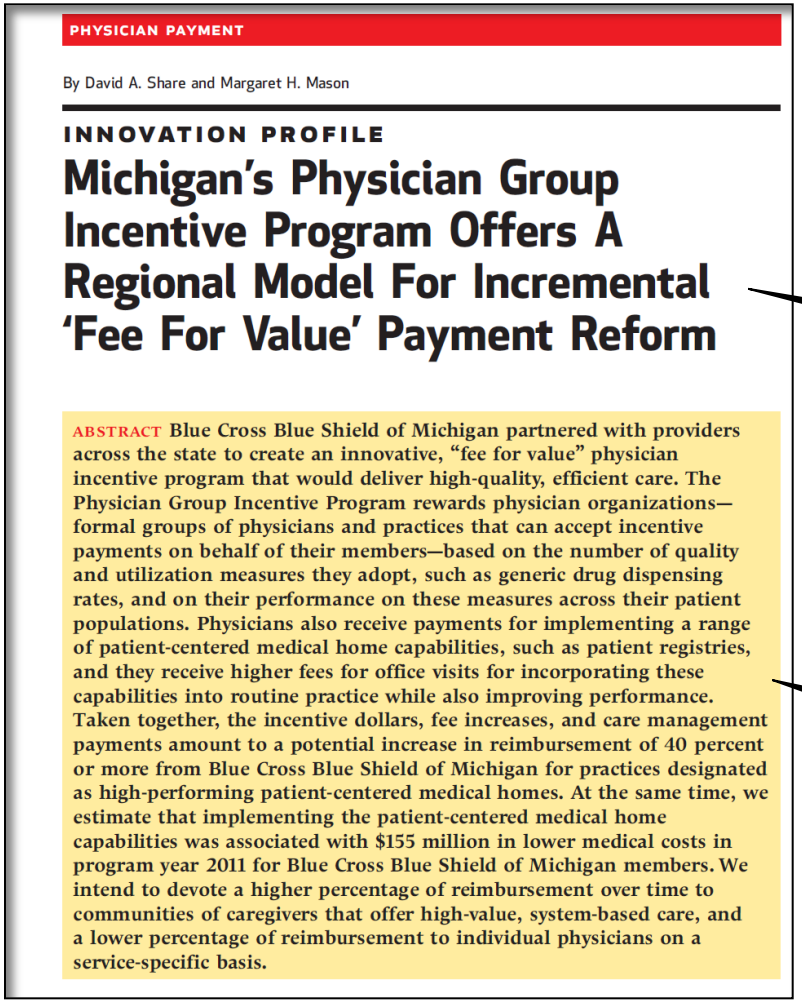
Physician Group Incentive Program:
Health Plan Role

- Convene and catalyze; not engineer and control
- Provide resources to reward infrastructure development and process transformation
- Reward quality and cost results (improvement and optimal performance) at the population level
- Structure reimbursement to support system transformation
- Reward performance at population level
- Share data at organization, office and physician level
- Leave management of individual patient care to practices and of physician practices to PO

Physician Group Incentive Program:
Physician Organization Role

- Collaborate on crafting future vision
- Collaborate on implementation
  - PGIP quarterly meetings
  - Common interest groups
- Provide physicians and other practice leadership to serve as Subject Matter Experts. SMEs work collaboratively with PGIP staff on initiative development
- Animate physician members
- Develop and deploy new systems of care
- Work with PO members to examine and optimize performance

Improving Quality of Care in Michigan through the Physician Group Incentive Program (PGIP)



PHYSICIAN PAYMENT

By David A. Share and Margaret H. Mason

INNOVATION PROFILE

Michigan's Physician Group Incentive Program Offers A Regional Model For Incremental 'Fee For Value' Payment Reform

ABSTRACT Blue Cross Blue Shield of Michigan partnered with providers across the state to create an innovative, "fee for value" physician incentive program that would deliver high-quality, efficient care. The Physician Group Incentive Program rewards physician organizations—formal groups of physicians and practices that can accept incentive payments on behalf of their members—based on the number of quality and utilization measures they adopt, such as generic drug dispensing rates, and on their performance on these measures across their patient populations. Physicians also receive payments for implementing a range of patient-centered medical home capabilities, such as patient registries, and they receive higher fees for office visits for incorporating these capabilities into routine practice while also improving performance. Taken together, the incentive dollars, fee increases, and care management payments amount to a potential increase in reimbursement of 40 percent or more from Blue Cross Blue Shield of Michigan for practices designated as high-performing patient-centered medical homes. At the same time, we estimate that implementing the patient-centered medical home capabilities was associated with $155 million in lower medical costs in program year 2011 for Blue Cross Blue Shield of Michigan members. We intend to devote a higher percentage of reimbursement over time to communities of caregivers that offer high-value, system-based care, and a lower percentage of reimbursement to individual physicians on a service-specific basis.

Health Affairs, Sept 2012
Vol 31(9). p.1993-2001
By David A. Share MD, MPH, Margaret M. Mason, MHSA

"Telling people what to do inspires doing the least necessary. Empowering people to transform health care inspires doing the most possible."
-David Share, MD, MPH, SVP, Value Partnerships, BCBSM

Incentive programs must reward incremental progress and improvement in how practices are organized and function, not just expect and reward absolute

Through PGIP, and the move from volume-focused fee-for-service payment to fee-for-value payment, Blue Cross Blue Shield of Michigan is transforming the payer into a catalyst for change, the provider into an empowered change agent, and the patient into an active partner in his or her health care.

Phase II: PCMH
(2008 - present)

Transforming Primary Care to Focus on Population Health

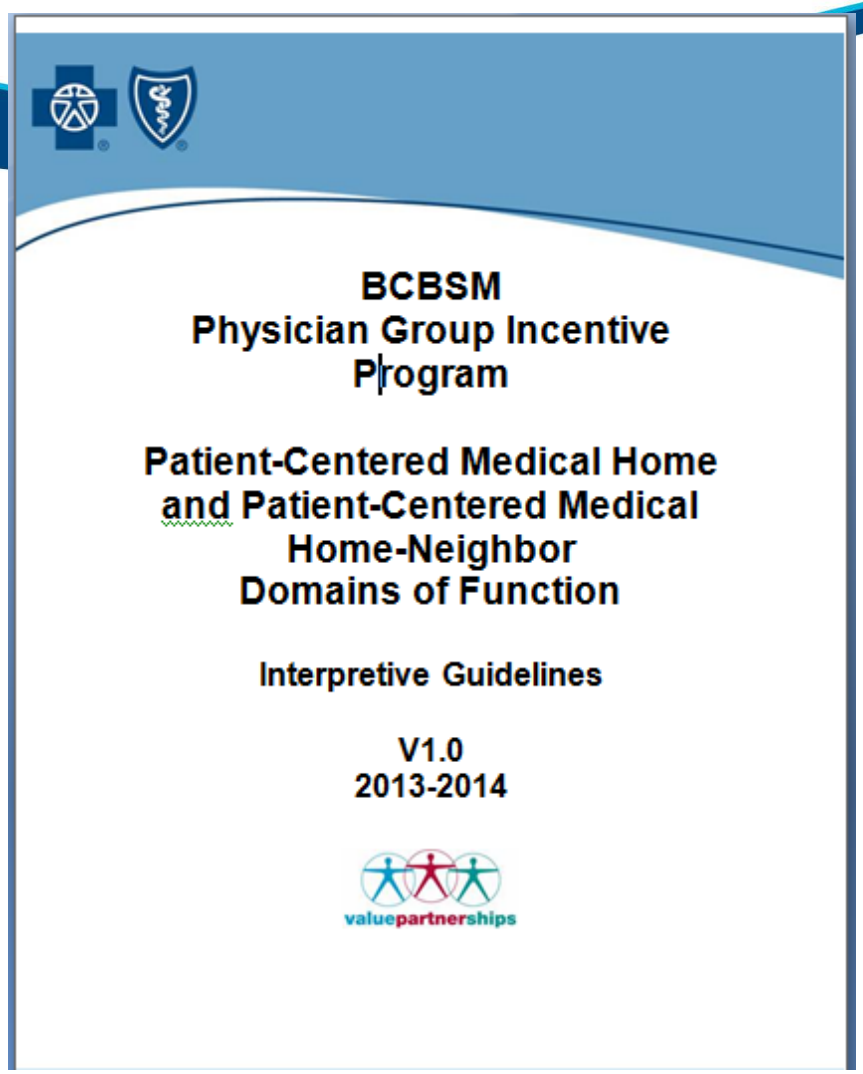
PCPs across Michigan rewarded for developing practice-level infrastructure to support PCMH model via

12 PCMH Domains of Function (140 capabilities) which leads to:

- Improved Quality
- Reduced Inefficiency
- Improved PMPM

As of July 2014, there are 4,022 BCBSM designated PCPs in 1,422 PCP practice units across Michigan (Over 2 of every 3 PGIP PCPs are PCMH designated)

50+ Pages of PCMH Interpretive Guidelines



BCBSM
Physician Group Incentive Program

Patient-Centered Medical Home and Patient-Centered Medical Home-Neighbor Domains of Function

Interpretive Guidelines

V1.0
2013-2014

valuepartnerships

5.0 Extended Access

5.1
Patients have 24-hour access to a clinical decision-maker by phone, and clinical decision-maker has a feedback loop within 24 hours or next business day to the patient's PCMH

Guidelines:

- Clinical decision-maker must be an M.D., D.O., P.A., or N.P. If not M.D. or D.O., clinical-decision maker must have ability to contact supervising M.D. or D.O. on an immediate basis if needed
  - Clinical decision-maker may be, but is not required to be, the patient's primary care provider
- Clinical decision-maker has the ability to direct the patient regarding self-care or to an appropriate level of care.
- Clinical decision-maker communicates all clinically relevant information via phone conversation directly to patient's primary physician, by email, by automated notification in an EMR system, or by faxing directly to primary physician regarding the interaction within 24 hours (or next business day) of the interaction
- Clinical decision-maker responds to patient inquiry in a timely manner (generally 15-30 minutes, and no later than 60 minutes after initial patient inquiry)

5.2
24-hour patient access to clinical decision-maker (as defined in 5.1) is enhanced by enabling clinical decision-maker to access and update patient's EMR or registry info during the phone call

Guidelines:

- Clinical decision-maker should routinely have access to patient's EMR or registry information for all calls
  - Occasional technical problems, such as failure of internet service in rural areas, may occur and would not constitute failure to meet the requirements of 5.2 as long as access to the EMR or registry is typically and routinely available

5.3
Provider has made arrangements for patients to have access to non-ED after-hours provider for urgent care needs during at least 8 after-hours per week and, if different from the PCP office, after-hours provider has a feedback loop within 24 hours or next business day to the patient's PCMH

Guidelines:

PCMH Program Consists of Two Components

1) PGIP PCMH Initiatives

- Opportunity for PGIP POs to participate in 12 PCMH-focused PGIP Initiatives that support implementation of 140 specific PCMH capabilities (started 2008)
- All PCPs and Specialists in PGIP may participate
- Financial incentives, **paid to the POs**, based on the number of PCMH capabilities implemented during each six-month payment period

POs work on Initiatives to achieve practice transformation.

2) PGIP PCMH Designation Program

- Opportunity for PGIP Practice Units to be PCMH- designated by BCBSM and rewarded for additional time and resources required (started in July 2009)
- Only PCPs are eligible to participate
- Increased E&M fees, **paid to primary care physicians**:

  Office visits → 99211 – 99215

  Preventive → 99381 – 99397

  - Increase office visit fees to PCMH-designated practices (+10%),
  - Additional increase (+10%) in office visit fees for those PCMH-designated practices in POs with optimal population level cost performance

BCBSM's PCMH Designation Program Goals

#1 Reward implementation of PCMH capabilities

PCMH Domains of Function
Patient-provider partnership
Patient registry
Performance reporting
Individual care management
Extended access
Test tracking and follow-up
Electronic prescribing
Preventive services
Linkage to community services
Self-management support
Patient web portal
Coordination of care
Specialist referral process

#2 Reward performance that comes from successful implementation

Quality

- Evidence Based Care and Preventive Services – reflects use of patient registries and proactive practice teams.

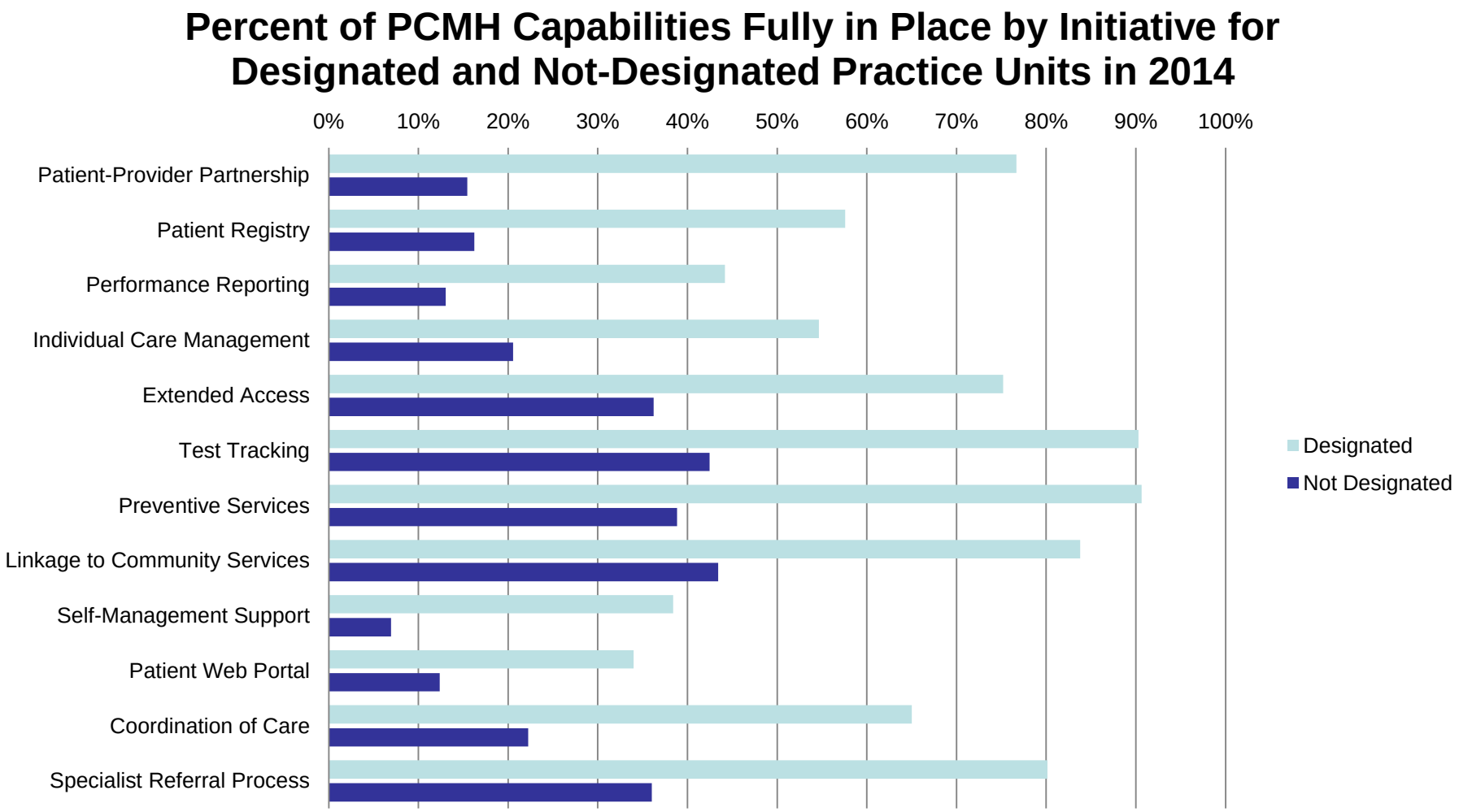
Use

- Emergency Department (ED) Visits for Primary Care Sensitive Conditions – reflects improved patient access to care.
- Imaging Use – reflects judicious use of ancillary services.

Efficiency

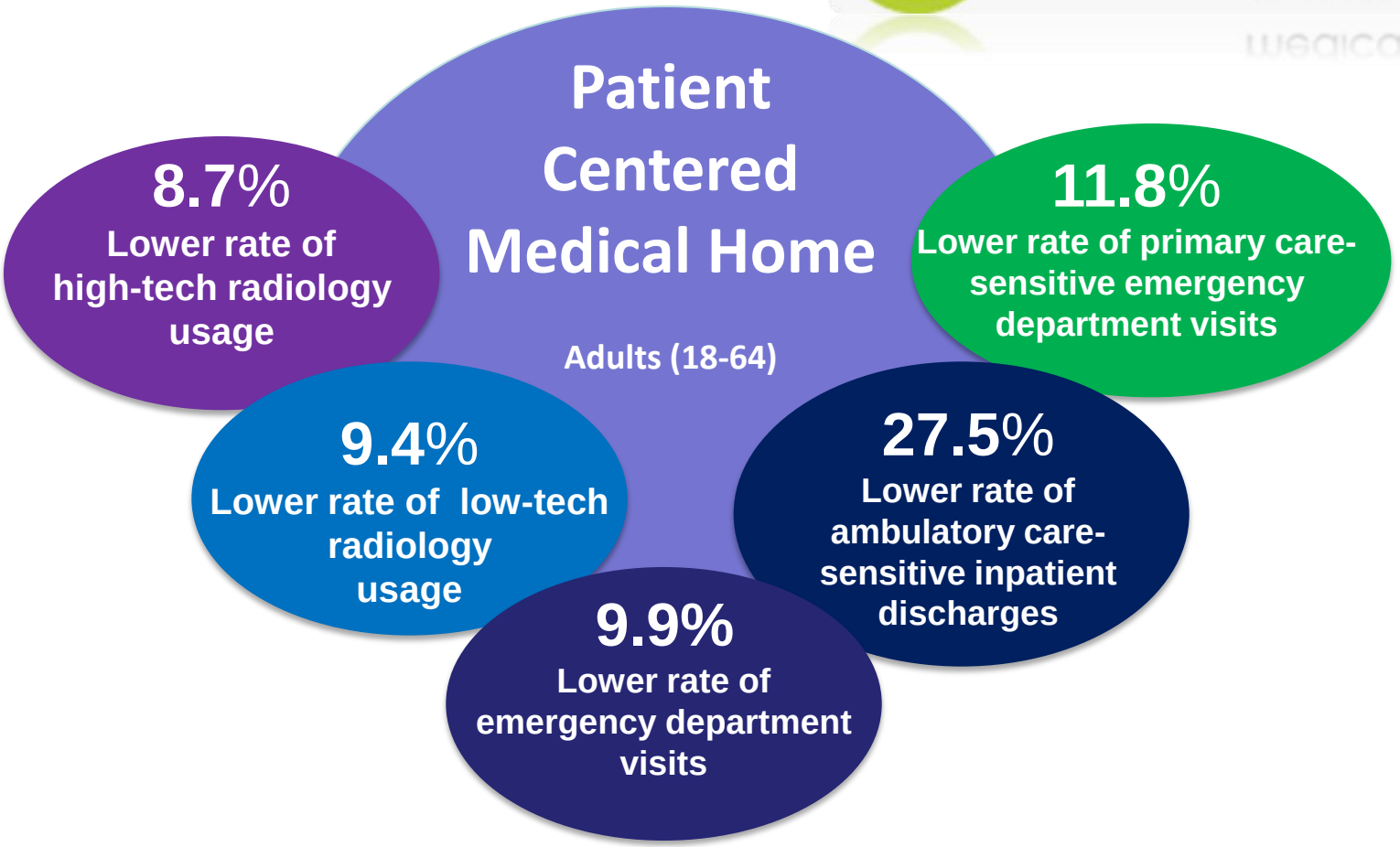
- Generic Drug Use – reflects efforts to better manage healthcare resources.

Development of PCMH Capabilities Continues



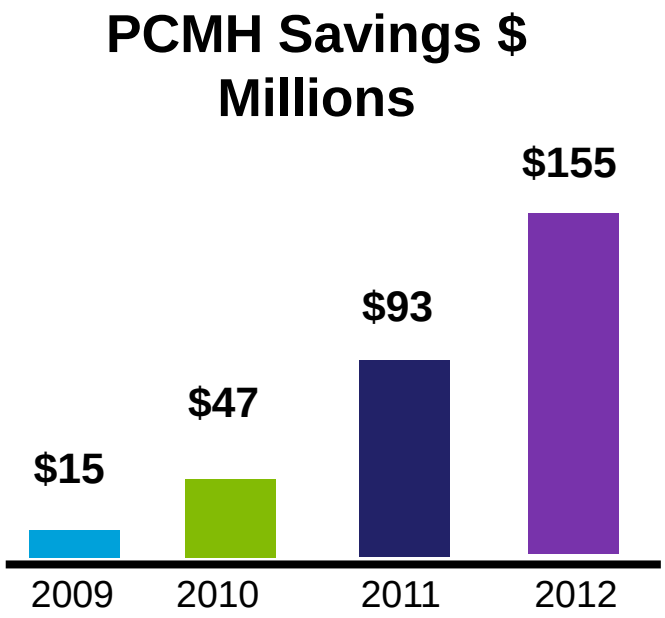
*For the "not designated" cohort, only PCMH Designation eligible practice units were included in the analysis; practices not functioning as primary care providers are excluded. *SOURCE: Winter 2012 SRD

2014 Performance comparisons, for PCMH-designated practices as compared to non-PCMH designated



HCV Data Analytics, BCBSM, PCMH 2014 Designation: Final Results, 7/2/14, CY 2013

Michigan PCMH practices drive increased savings



For a practice that has fully implemented PCMH, expected cost savings of $26.37 lower PMPM adult medical costs per *Health Services Research* article (July 2013)

Caveat: No practice has yet accomplished full capability implementation

Designated Practices: Impact on Patient Experience

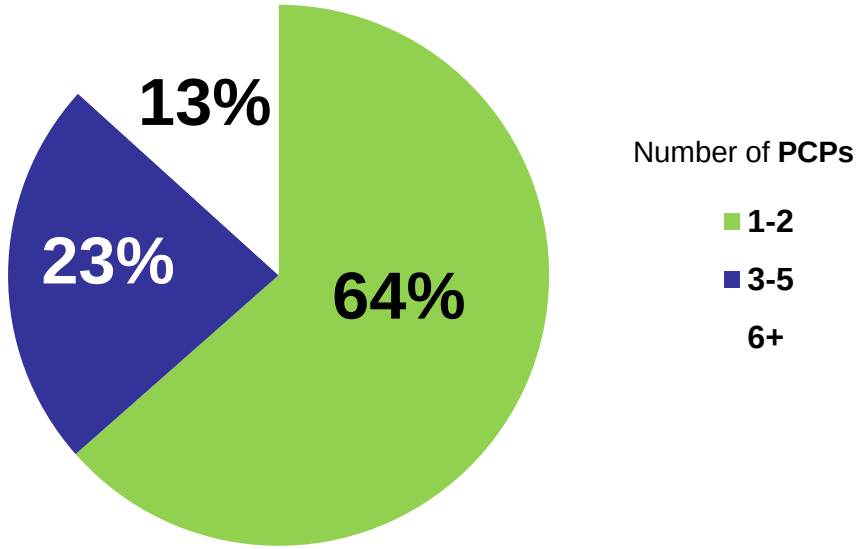
PCMH Designated practices have made great progress in implementing capabilities that support patients. Designated practices have:

- Over 99% of PCMH designated practice units have:
  - Patients informed about abnormal test results
    - Medication review and management for all patients with chronic conditions
    - Directories of specialists and community resources are kept up-to-date for patient referral purposes
    - 24-hour access to a clinical decision-maker
    - And many more
  - In 2014, the average number of capabilities in place among designated practices is 85.5, and the median is 88.0 (out of 140)

PCMH Practices Come in All Shapes and Sizes: Designation Status and Practice Size

- 64% of 2014 PCMH Designated PUs have only 1 or 2 physicians in their practices
- 75% of 2014 PCMH Designated PUs have 1 - 3 physicians in their practices
- Finally, 87% of 2014 PCMH Designated PUs have between 1 and 5 physicians in their practices

Percent of 2014 Designated PUs by Number of PCPs



PCMH Penetration, by County

- 78 of Michigan's 83 counties now have PCMH designated provider(s)
- Since only 81 counties in Michigan have PCPs, that means there are designated providers in 96% of Michigan's counties
- Percent of PCMH designated physicians among PGIP participating PCPs in highly populated counties:

County	# of PGIP PCPs	# of Designated PCPs	% PCMH Designated
Kent	415	351	84.58%
Washtenaw	362	283	78.18%
Ingham	260	193	74.23%
Macomb	578	421	72.84%
Genesee	276	198	71.74%
Oakland	987	586	59.37%
Wayne	962	536	55.72%

PCMH Designation Program - Challenges, Responses and Lessons Learned

Challenges	Responses and Lessons Learned
First Year of Program:	
PO/physician concern about higher co-pays for patients due to 10% higher reimbursement	• Incremental increase in member liability is modest • Patients receive better, more responsive patient care • Overall lower patient cost due to fewer labs, images, procedures, ED visits and hospitalizations
Providers in rural areas felt disadvantaged and excluded from program (initial concentration was primarily in SE MI and Grand Rapids)	• Modified PCMH Interpretive Guidelines to accommodate special circumstances of rural practices • Increased PCMH designations in rural areas in second year
The PCMH name caused some confusion; some associated with nursing homes	• Promoted program with PR exposure, press kits, and videos/articles/testimonials from PCMH designated providers. • Patient Provider Partnership Initiative catalyzes practices to educate members about PCMH model and value of team-based care, and actively engage members as partners in the care process

PCMH Designation Program - Challenges, Responses and Lessons Learned continued

Challenges	Responses and Lessons Learned
Significant variation among POs in criteria for nominating practices	• Provided POs with reports showing quality, use, and efficiency scores for each practice, as well as PCMH capability scores; flagged practices that would have been designated if nominated • Encouraged POs to nominate all engaged, motivated practices
Widely varying interpretation of initial PCMH capabilities	• Developed PCMH Interpretive Guidelines in collaboration with the provider community • Update Guidelines annually in partnership with provider leaders with extensive experience in implementing capabilities
Some providers expected to be paid for capabilities in place at baseline	• Explained that we'd been financially supporting implementation of registries and other elements of the chronic care model through other PGIP initiatives for 4 years
Employer groups and employees had little knowledge of PCMH model	• Created materials for employers and members with input from Sales and Marketing staff
Concern that annual re-scoring process would result in frequent churn among PCMH designated providers	• Expanded designation program each year • Fewer than 5% of our designated practices lose designation each year

PCMH Designation Program - Challenges, Responses and Lessons Learned continued

Challenges	Responses and Lessons Learned
In More Recent Years:	
***Health Affairs* article indicating that PCMH only viable for physicians who are part of large system and have many resources**	• Chief Medical Officer wrote response discussing our success in Michigan with engaging smaller practices http://content.healthaffairs.org/content/30/11/2217.1.full
Tendency for PCMH studies with negative results to be extrapolated to all PCMH programs	• Clinical/analytics team wrote response explaining why results are not generalizable across all PDCM program: http://www.pcpcc.org/sites/default/files/news_files/PCMH%20research%20commentary%20from%20BCBSM.PDF
Internal resistance to developing high performing network with PCMH providers as the foundation	• Extensive internal discussion, research by Product area • Currently developing network of high-performing providers aligned with our Organized Systems of Care model (similar to an ACO; uses PCMH as the foundation)

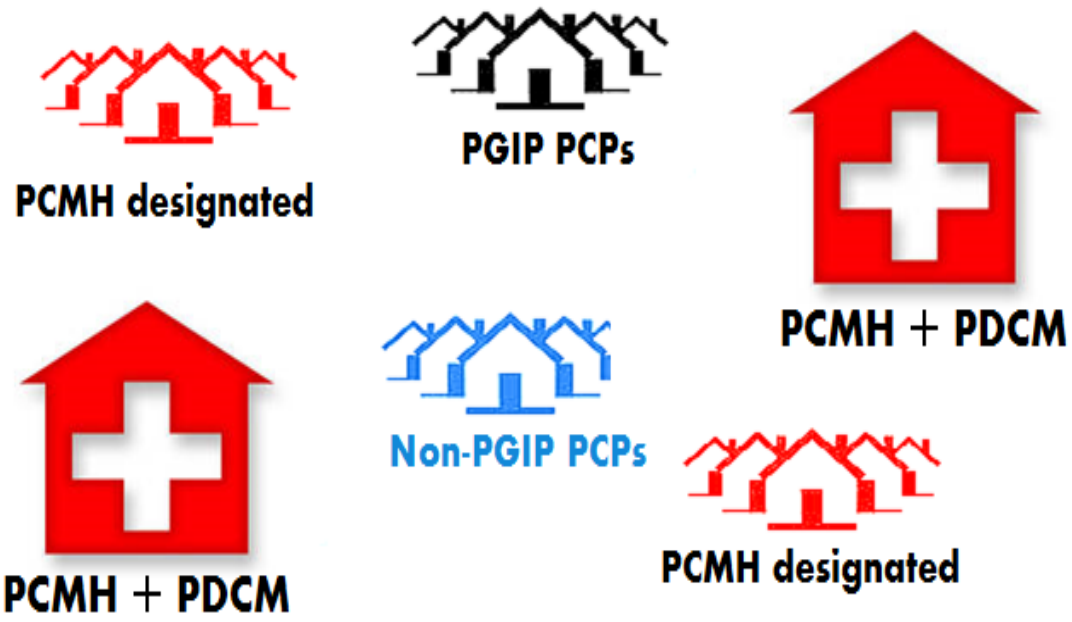
PCMH Designation Program - Challenges, Responses and Lessons Learned continued

Challenges	Responses and Lessons Learned
Ensuring access to PCMH providers statewide (five counties don't have PCMH designated providers; two of those counties have no PGIP physicians at all)	• Ongoing efforts to engage physicians who are not currently in PGIP, and to support and encourage practice transformation efforts of practices in those counties
Member ability to find PCMH provider using the Provider Search on bcbsm.com	• Temporarily relying on non-searchable PDF directory on our website • Search capabilities are expected to resume in 2015
Ensuring that practices with large numbers of BCBSM patients are engaged and achieving PCMH designation	• Working with individual POs and providers on a case-by-case basis
Ensuring that POs and practices are continuing to progress on their practice transformation journey	• Ongoing collaboration with physician leaders across the state • Field team that meets regularly with POs and conducts annual site visits with practices to assist providers in optimizing performance • Ongoing webinars, PGIP quarterly meetings, and annual enhancement of the PCMH and PCMH-N Interpretive Guidelines

Phase III: Provider Delivered Care Management

(2010 - present)

Enhancing PCP Care by Expanding Services



PDCM is care management delivered in the PCPs office by highly qualified care managers in conjunction with the PCP and clinical care team

Provider Delivered Care Management

- Phase I (5 POs) pilot ran from 2010-2012; Phase II (statewide project) Michigan Primary Care Transformation (MiPCT) to run from 2012-2014
  - CMS-supported Multi-Payer Advanced Primary Care Practice demonstration project
  - Michigan one of eight states participating; our cohort comprises 50% of participants nationally

- Phase II includes approx. 1,560 physicians in 380 practices across MI
  - All practices have been “PCMH Designated” for past five years
  - Providers working with care managers tend to be more sophisticated with more PCMH capabilities in place, strong performance on Q/U/E
  - PDCM practices have 6% lower cost for adult population compared to non-PDCM practices

- Phase III (continuation of MiPCT through12/31/16) – six states continue

PDCM - Challenges, Responses and Lessons Learned, continued

Challenges	Responses and Lessons Learned
State of Michigan submitted an all-payer application to participate in the CMS Michigan Primary Care Transformation Project, but most of the other payers ended up not participating	• Financial challenge for providers to maintain care management teams with partial payer support • BCBSM fulfilled its pledge to provide significant financial support ($3pmpm)
Due to sales team concerns about legal challenges, self-funded groups, which comprise over 50% of BCBSM customers, currently must elect to participate in PDCM; has resulted in high volume of denied claims, provider confusion	• Continued internal discussion and education • Pursuing change in strategy so that self-funded groups will automatically be enrolled; likely to occur in 2015 • The market is trending towards PDCM/PCMH being perceived as an integral part of health plan offerings, not an optional add-on
Care managers focus on highest-need patients first, which typically are Medicare and Medicaid patients	• BCBSM established a target for providers that they should deliver care management services to at least 10% of our members, and titrated payments based on proximity to target • Conducted numerous webinars and in-person billing education sessions statewide

PDCM - Challenges, Responses and Lessons Learned continued

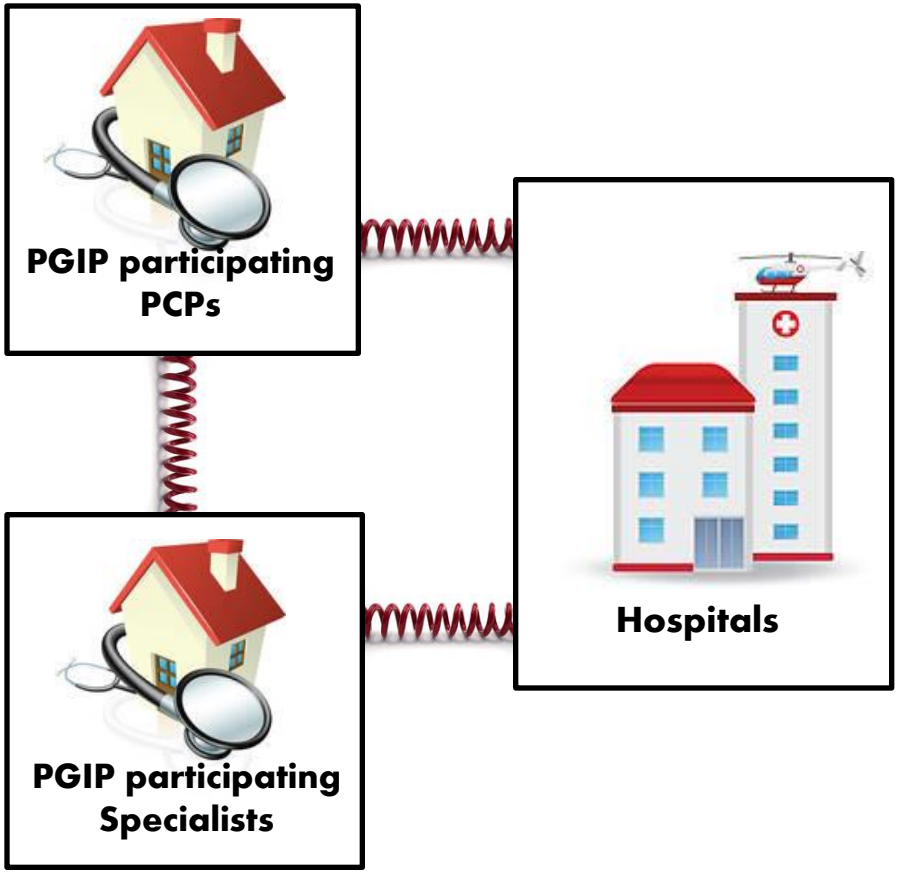
Challenges	Responses and Lessons Learned
Care managers sometimes offer care management to all patients, not just those who are eligible to receive services; this potentially contaminates the program evaluation results	• Educated providers on importance of having true control group for evaluation • Analytic team modified evaluation approach
Initially, T-codes (part of the office visit benefit) were used for non-physician care management (originally part of PCMH efforts – preceded PDCM program), but were not widely adopted due to patient liability, inability for POs to bill, and administrative complexity since only BCBSM (and BCN) reimburse	• For PDCM, used new codes (combination of G-codes and CPT codes) that were part of Wellness and Care Management benefit, alleviating the patient liability issue and reducing administrative complexity
Inappropriate claims denials due to benefit and claims issues	• Ongoing monitoring to ensure claims pay appropriately • Investigation and correction of data and benefit issues (such as claims denying because customer has rider to deny claims with obesity diagnoses)

PDCM - Challenges, Responses and Lessons Learned continued

Challenges	Responses and Lessons Learned
Customer groups' expectation for reports with detailed process metrics about targeting and engagement, similar to what they receive from our in-house care management program	• Educate customers about value of PDCM by focusing on clinical impact and outcomes • Generate annual customer reports • Working to integrate PDCM into existing Wellness and Care Management processes and reports
Initial skepticism that provider delivered care management would add value	• Ongoing education and communication to Sales and Marketing areas and customer groups about PDCM as an integral component of the PCMH model • Establishment of four-hour training session for account managers about entire Value Partnerships program

Phase IV: PCMH-N + Organized Systems of Care
(2012 - present)

Building Connectivity to Improve Population Health



PCMH – Neighborhood
(the Specialists)
- 140 PCMH Capabilities

Organized Systems of Care Initiatives (3)
- Integrated Patient Registry
- Integrated Performance Measurement
- Integrated Processes of Care

Hospital/PO Data Transfer
- Admission, Discharge & Transfer (ADT) Initiative (2013 - present)

BCBSM's PCMH Neighbor Efforts

1. Incorporates American College of Physicians et al concept of "PCMH Neighbor". PCMH-N:
   - Ensures **effective communication**, **coordination**, and **integration** with PCMH practices
   - Provides **appropriate** and **timely consultations** and **referrals** that complement and advance the aims of PCMH practices
   - Defines **roles** and **responsibilities** of PCPs and specialists in caring for patient

2. Expanded PCMH Interpretive Guidelines to incorporate specialist-specific expectations
   - PCMH Initiatives have always been open to participation by specialists, new Guidelines explicitly address specialist role in each domain

3. Developed sample Primary Care-Specialty Care Agreement

What is an Organized System of Care?

Organized System of Care

- BCBSM term used to describe a **community of caregivers** with a shared commitment to quality and cost-effective health care delivery for the primary care-attributed population of patients

Organized Systems of Care

- Goal: Decrease fragmentation of care and encourage communities of caregivers to provide integrated, coordinated, efficient care to a PCP-attributed patient population
- 39 OSCs in Michigan comprised of 4,300 PCPs and 9,500 specialists caring for 1.3 million BCBSM members
- Similar to PCMH, there is significant need for infrastructure development; 42 possible OSC capabilities to implement
- Since data collection began in 2012, all of the OSCs have begun implementing OSC capabilities
- Percent of OSCs Implementing at least one capability:

Integrated Patient Registry (23 capabilities)	Integrated Performance Measurement (7 capabilities)	Integrated Processes of Care (12 capabilities)
100%	70%	16%

Statewide Notification Service for Admission, Discharge, Transfer and ER Visits

- Uses existing health information exchange capabilities to
  - Receive all-patient, real-time ADT notifications from each hospital
  - Match each notification against a patient-provider relationship file
  - Send the notification to the patient's caregivers
- Blue Cross incentive payments used to promote provider participation
  - Support to hospitals sending all-patient notifications
  - Support to physician organizations sending updated patient-provider lists ("active care relationships")
- Practitioners are able to receive a comprehensive daily census report for their patients, regardless of payer or hospital the patient uses
- Expected outcomes include improved care transitions and reduced readmissions
  - Expected reduction in potentially avoidable readmission rates is 10% (based on data from statewide ADT implementation in other states)
  - BCBSM estimated annual savings: $6.1 million

Engagement in BCBSM ADT Initiatives

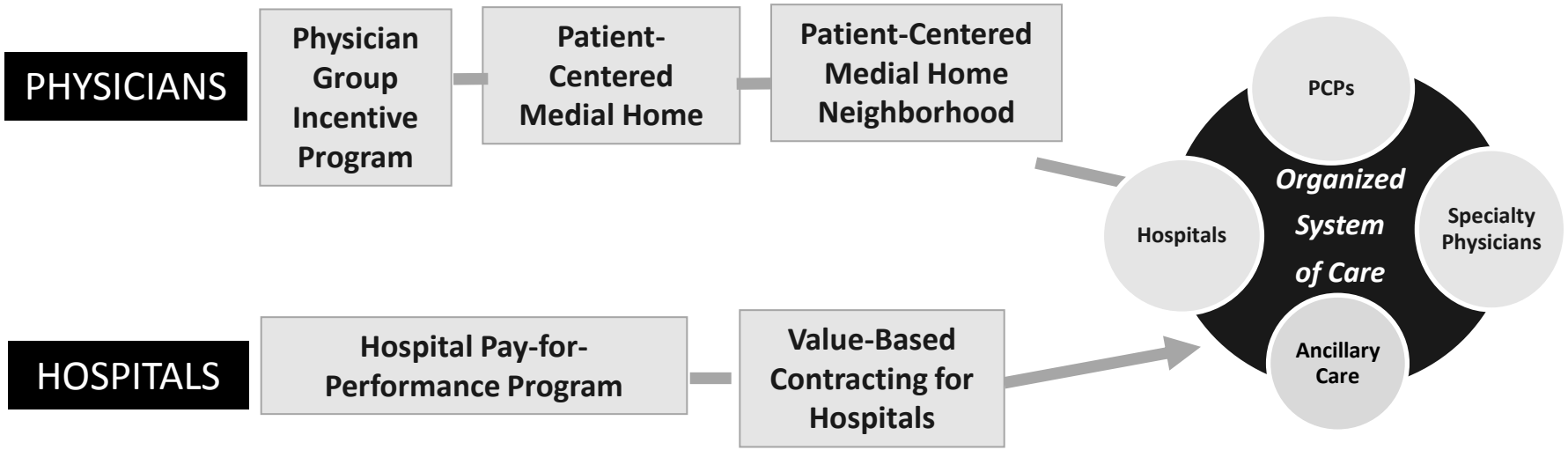
	Current* and Projected Hospital Participants		
	Current	**4Q2014**	**1Q2015**
Number of Hospitals	52	65	86+
Percent of BCBSM Admits	79%	92%	95%+

- Currently, five POs participate as well as most Michigan Primary Care Transformation practices, representing over 2.1 million patients statewide

Current* and Projected Participating POs		
Current	**3Q2014**	**4Q2014**
5	8-12	12-15

*As of Sept. 5, 2014

Aligning Incentives and Focus: All Eyes on Population Management



Lessons Learned as we move to Fee for Value

- All payment methods have inherent risks: e.g., fee for service-over use; global payment-under use; episode payment-episode volume
- An incentive system must be driven by explicit purpose. BCBSM's is:
  - Improving the population wellbeing at lower cost
  - Moving from volume to value (From procedure-based care to relationship-based care for both PCPs *and* specialists)
- Making a substantial portion of FFV reimbursement dependent on system development and performance can move the needle on cost and quality
- Collaboration among providers is essential: align incentives for PCPs, specialists and facilities so they create clinically integrated systems which best serve the community
- Savings will come from moderating procedure, ED and inpatient use; right-sizing facility capacity is necessary and requires a glide path for facilities

Success In Michigan

- Michigan is now has the lowest per capita healthcare costs in the Midwest
- Actively addressing the root causes of poor performance creates significant savings
- Focusing on Total Care enables accountability; focusing on individual service categories “squeezes the balloon,” reducing accountability and shifting costs to other categories, often with *higher* total costs
- Improving care achieves progressive savings as providers get better at proactive, coordinated, effective care

Our Formula:

Value =

$$\frac{\text{Patient Experience + Quality}}{\text{Cost}}$$

Value Partnerships

Nationally Recognized
Award Winning
Statewide Programs

Gregg J. Stefanek, DO
Gratiot Family Practice, PC


GOLF


E N D S
NOTRE DAME.
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NOTRE DAME.
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SAINT MARY'S COLLEGE


4TH & GOAL
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Root Cause of Low System Performance

- Non-activated, non-empowered patient
  - Lack of education
  - Lack of finances
  - Poor access
  - Paternalistic practice style
  - Disease care system not a health care system
  - Lack of intrinsic motivation to take good care of themselves
  - Poor relationships with their health care team

Patient-Centered Medical Home: What is It?

- **Superb Access to Care:**
  - Patients can easily make appointments and select the day and time. Waiting times are short. E-mail and telephone consultations are offered. Off-hours service is available.

- **Patient Engagement In Care:**
  - Patients have the option of being informed and engaged partners in their care. Practices provide information on treatment plans, preventative and follow-up care reminders, access to medical records, assistance with self-care, and counseling.

- **Clinical Information Systems:**
  - These systems support high-quality care, practice-based learning, and quality improvement. Practices maintain patient registries; monitor adherence to treatment; have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments.

SOURCE: Karen Davis, Stephen Schoenbaum, MD, Anne-Marie Audet, MD, "A 2020 Vision of Patient-Centered Primary Care", 2006 Commonwealth Fund Annual Report; PCPCC Joint Guiding Principles Approved by AAFP, AOA, AAP, ACP www.pcpcc.net

Patient Centered Communication
Relationship-based Care

"...evidence over the last 30 years has shown that the adoption of patient-centered care - which really translates into patient-centered communications – is what leads to improved engagement, better quality outcomes, lower lab test costs, fewer ER visits and hospital readmits and better patient experiences."

Stephen Wilkins

New Patient Orientation Session

- History of the practice
- Inform on operational aspects of our practice
- Delineate services offered at our practice
- Discuss the PCMH model of care, team approach
- Set the table on what we expect out of our patients
- Discourage unnecessary testing and medications
- Discourage use of ER’s and urgent care
- Discuss how we are responsive to our patients needs

What Do We Expect From Our Patients?

- It’s not our job to take care of them! We expect them to strive for healthy habits
- They are experts in how they feel
- Expected to participate in programs
- Expected to learn, know their medications, know their numbers, and to come prepared and to ask questions!
- Good health is not an accident and better health happens intentionally
- Are more aware of the potential harm that can occur from interactions with the health care system. *Choosing Wisely®.*

Choosing Wisely®

- The initiative's aim is to promote conversations between physicians and patients by helping choose care that is:
  - Supported by evidence
  - Not duplicative of other tests or procedures already received
  - Free from harm
  - Truly necessary


You have chosen wisely

How Are We More Responsive?

- Enhanced access - attitude is the key
  - Portal, email, text, cell phone
  - Same-day appointments
- Prompt test results, todays work today!
- Follow up regarding treatment
- Connected directly with specialists and hospital systems
- Patient surveys
- Voice of the Patient

How are Insurers and Employers More Responsive?

- BCBSM has lead the way
  - Is your provider in a PCMH practice?
  - Plan design
  - Encouraging goal setting
  - Moving from pay for performance to pay for behavior change, for both consumers and providers
- Employers are engaging in wellness programs
  - Carrot versus stick approach may encourage only participation, not real change
  - Moving from “wellness” to “well-being”

Care Management

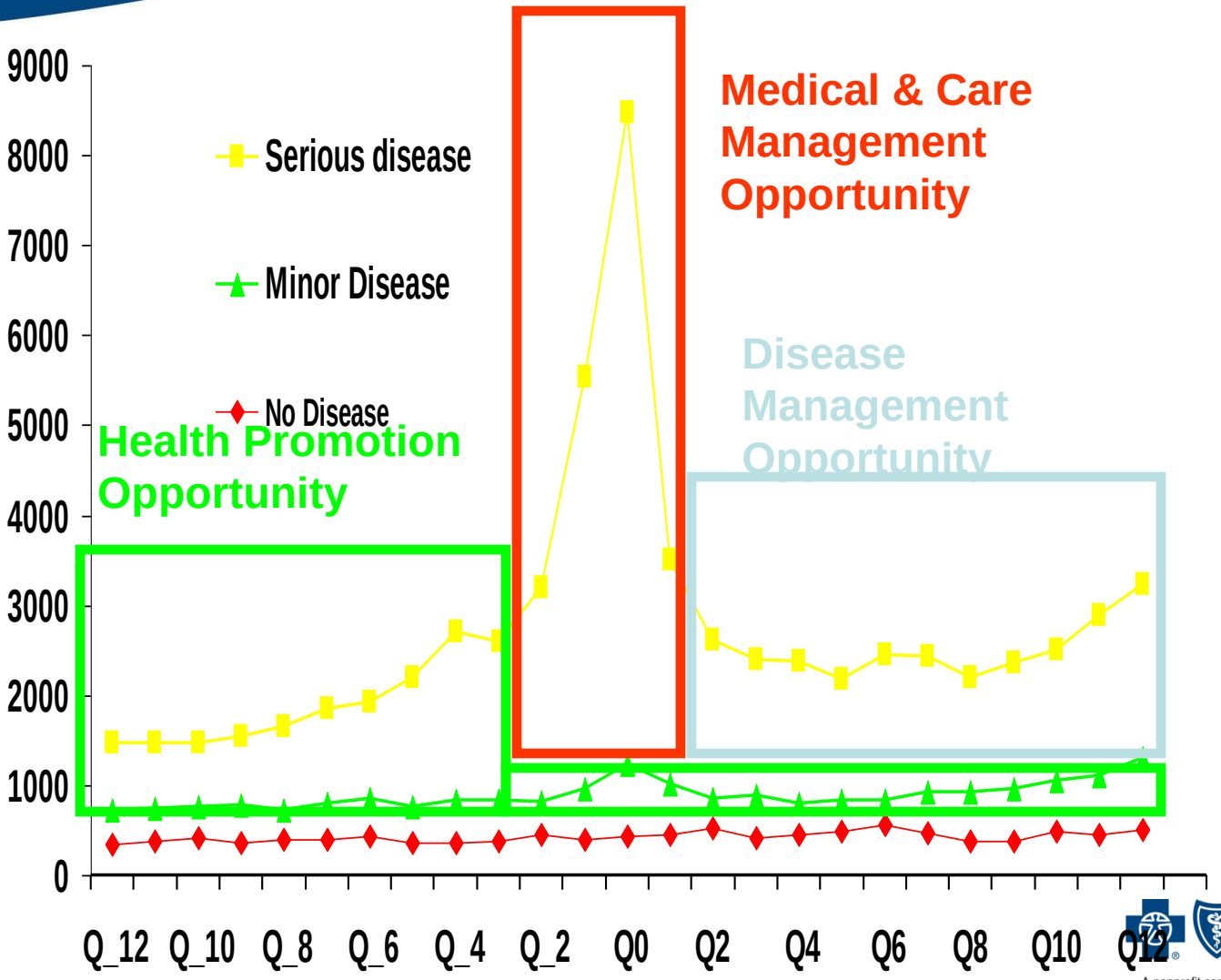
- Focus has been on the high complexity patient and their many needs
- Transitions of care focus is working
- Exciting to have help and support for my patients medical and social needs
- Teaching patients to be self-managers is the key
- Energizing patients!

No individual will achieve his or her fullest potential without believing that staying healthy is just as important as treating sickness

Dee Edington

Where are the Opportunities for Population Health Management?

Medical and Drug Costs only



“You can dream, create, design, and build the most wonderful place in the world, but it requires people to make the dream a reality”

Walt Disney


PHYSICIANS' DESK REFERENCE


347
AIN'T
NOBODY
GOT
TIME
FOR
DAT.
meijer

What is the Role of Physicians?

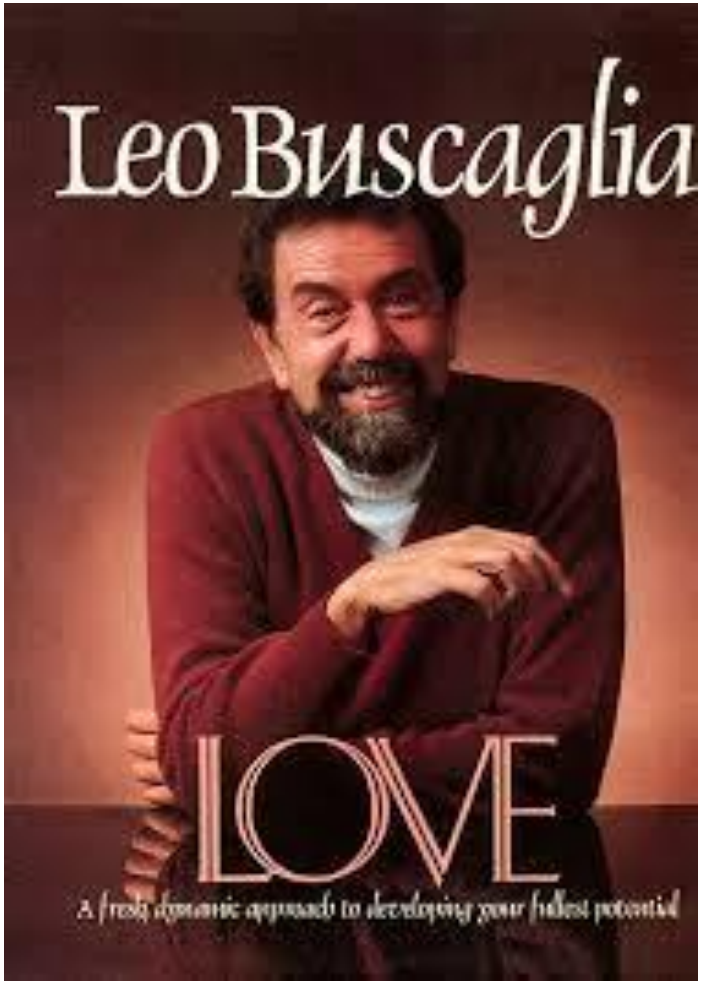
Before

- Disease care system
- Manage individuals
- Paid for volume
- Derive satisfaction for helping people through sickness and death
- Being passive
- Dictate by being paternalistic

What Lies Ahead

- Health care system
- Manage populations
- Paid for Value
- Derive satisfaction from helping people self-manage and staying healthy
- Being responsible
- Motivate by being in relationship


Raghib Ismail
Flanker, 1988-90

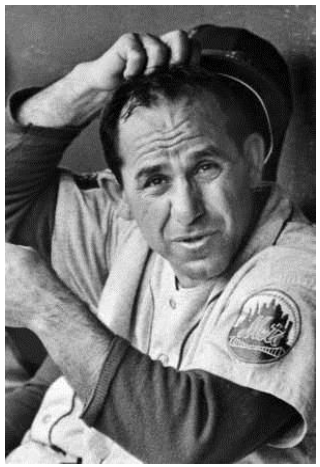


"Too often we underestimate the power of a touch, a smile, a kind word, a listening ear, an honest compliment, or the smallest act of caring, all of which have the potential to turn a life around"

Leo Buscaglia


COVENANT
Sue
Clerical Medical Assistant
Practice Management
COVENANT
Cynthia
Radiographer
Practice Management

"Always go to other people's funerals, otherwise they won't come to yours"



Thank You

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Value Partnerships: a diverse set of clinically oriented Blue Cross Blue Shield Michigan programs developed in collaboration with Michigan physicians and hospitals. Value Partnerships is transforming health care, improving quality and reducing adverse events. All Michigan residents, regardless of whether they carry a Blue card, are reaping the results of BCBSMs commitment to making health care better. Michigan's provider community has implemented a national model for health care delivery of the future.

VALUE Partnerships