Pay-for-Performance
Improving Quality and Revenue through Patient-Centered Medicine

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Objectives
• Historical overview of Pay-for-Performance (P4P)
• Blue Cross Blue Shield of Michigan Physician Group Incentive Program (PGIP)
• Priority Health Partners in Performance (PIP)
• Blue Care Network Performance Recognition Program (PRP)
• The Pine Medical Group’s P4P journey

Physician Group Incentive Program (PGIP) History
• Initially the Physician Organization Gain Sharing (POGS), this program rewarded physicians for prescribing generic drugs when appropriate
• Evolved into PGIP with additional measures: Evidence-Based Care, Radiology Testing, Emergency Room Utilization, Hospital Admissions, etc.
• Measures became basis for Patient-Centered Medical Home Designation
Partners in Performance (PIP) History

- Created by Priority Health in 1996, PIP rewards physicians for managing chronic disease, screening for prevention of disease and achieving standards for the health of patient populations
- About 2008, Priority began to award grants to practices to achieve NCQA Patient-Centered Medical Home certification

Performance Recognition (PRP) History

- Blue Care Network’s Performance Recognition Program
- Tiered payments to physicians for systematic preventive measures, e.g., diabetes, child and adolescent immunizations, etc.
- $0.75 to $2.25 per-member-per-month
- Bonus for other performance, e.g. systematic follow-up after hospitalizations, etc.

Further Evolution

- P4P begins to embrace the Patient-Centered Medical Home
- Multiple payers demand value over volume
- Primary care focus
Patient-Centered Medical Home (PCMH)  
*A brief history of a public policy initiative whose time has come*

Patient-Centered Medical Home  
- 1967 - the American Academy of Pediatrics introduces the terminology "medical home"  
- 2002 through 2007 - U.S. national family medicine organizations recommend that:  
  - "Every American should have a personal medical home through which to receive his or her acute, chronic and preventive services"  
- 2005 - American College of Physicians develops an "advanced medical home" model

Patient-Centered Medical Home  
*Joint Principles*  
- Personal Physician  
- Physician Directed Medical Practice  
- Whole Person Orientation  
- Care is Coordinated and/or Integrated Across the Health Care Delivery System  
- Quality and Safety are Hallmarks  
- Enhanced Access  
- Payment is Appropriate
Patient-Centered Medical Home

**Gaining Momentum**
- In 2006, IBM and other organizations created the *Patient-Centered Primary Care Collaborative* to promote PCMH
  - Membership includes more than 500 large employers, insurers, consumer groups and physicians
- In 2008 through 2010, physician groups, employers, payers and government agencies begin to embrace the PCMH concept


Patient-Centered Medical Home

**Designation and Recognition Programs**
- PCMH designation programs are offered by NCQA, URAC, BCBSM and others
- Key health information technology domains are identified as necessary for the success of the PCMH model:
  - Tele-health, measurement of quality and efficiency, care transitions, personal health records, registries, team care, and clinical decision support for chronic diseases


Patient-Centered Medical Home

*Michigan is at the Forefront of PCMH*
- BCBSM is a recognized leader in developing, promoting, designating and rewarding PCMH practices
- Michigan leads the nation in designated PCMH practices
- Priority Health and other payers recognize and reward physicians who have been designated as PCMH by BCBSM, NCQA and URAC
Patient-Centered Medical Home
An Idea Whose Time Has Come

- From a modest beginning 45 years ago, PCMH has exploded today into a movement that transforms medicine from the treatment of sick and injured patients to the management of the health of populations of patients
- What makes PCMH possible today that could not be done 45 years ago?
  - Technology and Payment

PCMH Technology

- Electronic Medical Record (EMR) Systems
- Electronic Prescribing Software
- Patient Registries
- Embedded Evidence-Based Care Guidelines
- Patient Portals
- Performance Reporting
- System-to-System Interfaces
- Secure, HIPAA Compliant Physician-to-Physician Electronic Communication

PCMH Payment

- BCBSM
- Priority Health
- Michigan Primary Care Transformation Project (MiPCT)
  - Molina, Aetna and many more
- Result: improved quality and outcomes
- Result: improved financial performance
- Result: improved financial performance enables practice to invest in better performance
2013 BCBSM Introduces Organized Systems of Care (OSC)

- Patient-Centered Medical Homes can now become part of a Patient-Centered Neighborhood
- More pay-for-performance
- Primary care and specialty practices work together to manage a population of patients

Michigan Primary Care Transformation Project

- Known as MiPCT, it is a CMS Demonstration Project to reward PCMH practices for performance, care coordination and population management
- Three year pilot funded by CMS and private payers
- PCMH designation a requirement for participation

PCMH in the RHC

PCMH, Quality, and Care Management
Pine Medical’s Journey

• In 2007, Pine Medical Group had quality/PGIP payments for their practice of about $80,000.00
• In 2012, those payments grew by 50%
• We were also invited into the MiPCT Project which is a Medicare Demonstration Project for PCMH practices – This also has positive ROI

Introduction to the Patient-Centered Medical Home (PCMH)

• We were first introduced to the Medical Home model by Medical Advantage Group and then Priority Health
• We had a strong team at that time
  – A forward-thinking Medical Director and Clinical Manager who were early adopters
• We also created a new position of HMO Coordinator

PCMH Assistance

• Pine Medical found a great deal of help forthcoming from both Priority Health and Medical Advantage Group
• Medical Advantage Group held our hand through the journey to become a certified PCMH and allowed us hours of seminar training
• Priority Health offered grant money that we had to apply for
  – We requested funds for a Care Manager and an order module so we could track everything and upgrade within our registry
Additional PCMH Assistance

• Of note was the first MSMS meeting I went to regarding the Medical Home, where we were told about the very first demonstration project which was done in Virginia to save Medicaid ER dollars.

Using Technology to Increase Performance and Achieve PCMH Success

• Because Pine Medical was fortunate enough to have an EMR of sorts—at the time it was a document-imaging system—they were able to put alerts in patients’ charts.

• These alerts let the provider know what sorts of things patients were due for: screening colon, mammograms, lab tests, etc.

Using Technology to Increase Performance and Achieve PCMH Success

• Pine is an independent group who pays their providers on a production-based contract. It only made sense to include these dollars in the providers’ net receipts.

• Because of our production-based contracts, everyone paid particular attention to these alert boxes.

• This increased our quality scores because we were making sure the required testing was done.

• It really was pretty simple.
Diabetic Program

- Medical neighborhood, first endeavor
- Hospital and patient advocate

Population Management in the Medical Home

- About this time, our Clinical Manager began job-sharing with another RN who happened to be a Care Manager in her previous employment
- At that point, we began managing our chronic disease patients which was our original plan and part of our Medical Home program
- Our Care Manager would make sure that she either saw the patient or called the patient to discuss what was going on with their disease, their life, whatever it took to engage the patient.
- Program encouraged by Priority Health and BCBSM

Population Management in the Medical Home

- Soon we had a registry to manage these patients and we interfaced our registry with a lab
- Shortly after that, the interface extended to our EMR and it wasn’t much longer before our EMR was certified for Meaningful Use so we could easily get that information into our registry
Advancing the Medical Home
NCQA PCMH Recognition
• During this same time period, we decided to apply for NCQA
• We only had three weeks, so we put together enough to get a Level One
• We were told if we got a One, we could re-file the same year and try for Level Three. We did just that and earned Level Three, but it certainly was a tough journey, especially for our Nursing Manager and my Administrative Assistant
• Being a Level Three allowed us to receive higher payments from some insurance companies

Advancing the Medical Home
Aligning Meaningful Use and PCMH Criteria
• Meaningful Use came along and we found that many of the things we were doing made it much easier to attest and receive the dollars offered

MiPCT and Care Management
• Ultimately, Pine Medical was invited into the MiPCT Program through Medical Advantage Group because we are a PCMH
• We manage over 9,000 patients utilizing four RNs as our Case Managers
• We manage chronic disease states such as diabetes, CHF, COPD, Asthma, etc. and follow-up referrals and discharges
Diabetes
Patient Education Topics and Talking Points
• What is diabetes?
• Complications
• Blood Glucose testing
• Insulin use
• Importance of weight loss
• Importance of exercise
• Diet: foods to limit
• Diet: foods to increase

Coronary Artery Disease (CAD)
Patient Education Topics and Talking Points
• Overview of CAD
• Risk factors
• Medication
• Lifestyle modifications
• Signs of heart attack
• Signs of stroke

Hypertension
Patient Education Topics and Talking Points
• Explanation of hypertension
• Know your numbers
• Lifestyle changes may help
• Use of self-monitoring BP
• Medications
CAD/HTN/Hyperlipidemia

**Patient Education Topics and Talking Points**

- The importance of exercise
- Low fat diet
- Low salt diet (for CAD/HTN)
- Taking medications
- Cholesterol

Congestive Heart Failure (CHF)

**Patient Education Topics and Talking Points**

- Explanation of CHF
- Patient will be able to list the following signs/symptoms of CHF
- Implementation of treatment plan
- Diet
- Daily weight record
- Smoking cessation referral
- Plan of care

Asthma

**Patient Education Topics and Talking Points**

- Asthma overview
- Medication
- Inhalation device
- Classification
- Peak flow
- Spirometry/PFT
- Home environment
- Allergies and asthma
- Smoking cessation
- Action plan self-management goals
COPD
Patient Education Topics and Talking Points

- What is COPD?
- Causes
- Symptoms
- Diagnosis
- Treatment/management

Management of Diabetes Mellitus

- Periodic assessment
- Laboratory tests
- Education, counseling and risk factor modification
- Medical recommendations

Screening and Management of Hypercholesterolemia

- Risk assessment
- Risk stratification
- Education and risk factor modification
- Pharmacologic interventions
Medical Management of Adults with Hypertension

- Initial assessment
- Patient education and non-pharmacologic interventions
- Goals of therapy
- Pharmacologic interventions
- Monitoring and adjustment of therapy

Adults with Systolic Heart Failure

- Evaluation
- Pharmacological management
- Education, counseling and risk factor modification

General Principles for the Diagnosis & Management of Asthma

- Diagnosis and management goals
- Assessment and monitoring
- Education
- Control environmental factors and comorbid conditions
- Medications for age-specific guidelines
- Referral
Tobacco Control

• All patients 12 years of age and older (regardless of prior use status)
• All patients identified as current smokers/tobacco users

Questions?

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