Media Fact Sheet
2018 Patient-Centered Medical Home

Sep. 11, 2018

What is a patient-centered medical home?

A patient-centered medical home is a care team, led by a primary care physician, which focuses on each patient's health needs, and coordinates patient care across all settings. Patients receive the right care in the right setting, and physicians are compensated for the additional time and effort required to manage their patients' care.

What is the Blue Cross Blue Shield of Michigan PCMH model of care?

The Blue Cross PCMH model is a two-part designation process, developed with our physician partners. In the first phase, with financial support from the Blues' Physician Group Incentive Program, physicians across the state work to implement various PCMH features into their practices. The second phase involves designation as a PCMH practice. Blue Cross currently has the nation's largest network of designated medical home physicians, with about 4,630 primary care physicians in 1,700 medical practices across Michigan. Designation is reviewed annually.

PCMH-designated practices also are **Blue Distinction Total Care** providers. That means they have met nationally consistent criteria for improving health care results and lowering costs, and they offer services to patients who have health care coverage with an out-of-state Blue plan.

By the Numbers

- **1,700** BCBSM-designated PCMH practices across Michigan
- **Approximately 4,630** physicians in those designated practices
- **More than 1.25 million** BCSBM members covered by a PCMH-designated practice, totaling **close to 2 million** total patients impacted by this initiative
- BCBSM-designated PCMH practices in **80** of Michigan's **83** counties
- **$626 million** in prevented costs in program's first nine years

Program Results

BCBSM has observed that PCMH-designated doctors are succeeding in managing their patients' care to keep them healthy and prevent complications that require treatment with expensive medical services. In 2018, in comparison with non-PCMH practices, the PCMH practices had:

- 16 percent lower rate of adult ER visits
- 27 percent lower rate of adult ambulatory care sensitive inpatient stays
- 20 percent lower rate of adult primary care sensitive ER visits
- 26 percent lower rate of pediatric primary care sensitive ER visits
- 18 percent lower rate of overall pediatric ER visits

What are the features of the Blue Cross PCMH model?

The features of and criteria for the Blue Cross PCMH model were established in partnership between Michigan physician organizations and Blue Cross Blue Shield of Michigan.

Physicians focus on implementing the following elements into their medical practices:

- Developing patient registries to track and monitor patients' care over the long-term
- Providing self-management education and support to patients with chronic conditions
- Offering 24-hour patient access to a clinical decision-maker, with a multilingual approach to care. Access may include extended office hours, telephone access, link to urgent care or a combination of those.
- Working with each patient to set individualized health goals, and using a team-focused, systematic approach to track appointments and ensure follow-up on needed services
- Providing effective and timely follow-up with patients on their test results
- Coordinating patients' care across the health system through a process of active collaboration and communication between providers, caregivers and the patient
- Offering patients connections to community services, in coordination with the health system, community service agencies, family, caregivers and the patient
- Providing secured online patient resources that allow for electronic communication and provides patients with greater access to medical information and technical tools

Published Research on BCBSM's PCMH model

Health Services Research, published April 2017, showed that hospital per-member per-month cost was reduced by 17.2 percent and emergency department per-member per-month cost was reduced by 9.4 percent for Blue Cross PCMH patients with asthma, angina, diabetes, chronic obstructive pulmonary disease, high blood pressure and congestive heart failure.

Medical Care Research and Review, published April 2015. Evidence suggests that both level and amount of change in PCMH practices is positively associated with quality of care and use of preventive services after controlling for a variety of characteristics. Lower overall medical and surgical costs are associated with higher levels of PCMH implementation.

JAMA Internal Medicine , published February 2015, examined breast, cervical, and colorectal cancer screening rates for practices' Blue Cross Blue Shield of Michigan patients. Evidence suggests that implementation of a PCMH was associated with higher breast, cervical, and colorectal cancer screening rates across most socioeconomic contexts.

Health Services Research published July 2013, showed the link between the level of PCMH transformation in a practice, and the cost savings. A practice that fully implemented PCMH would have on average $26.37 lower PMPM costs than a practice that implemented no PCMH capabilities.

For more information, visit **valuepartnerships.com.**