VALUE Partnerships
Improving Health Care in Michigan

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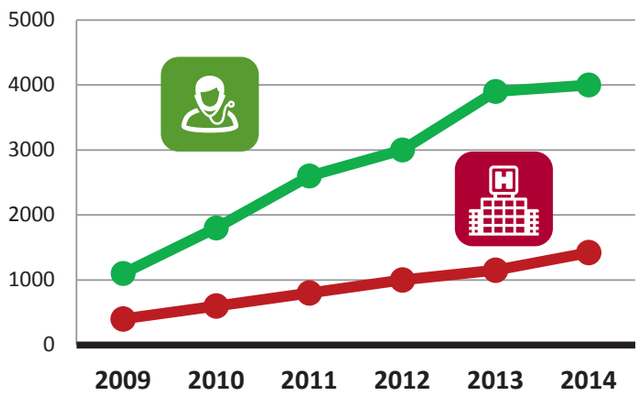
Blue Cross Blue Shield of Michigan's Patient-Centered Medical Home grows to more than 4,000 physicians.

There are **1,422 practices** with more than **4,000 physicians** in Michigan today.

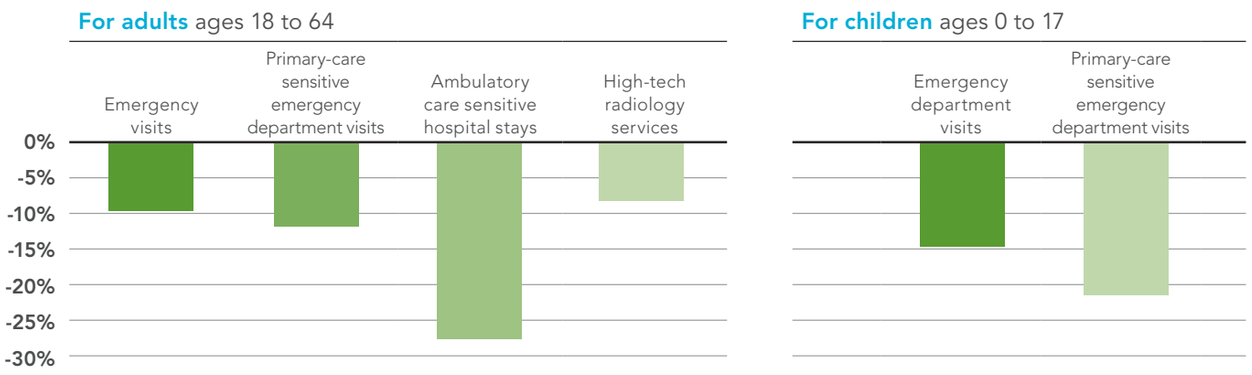


What is a patient-centered medical home?

Through patient-centered medical homes, primary care physicians work with patients to establish individualized health goals. Through ongoing collaboration, improved reporting and efficient coordination of care across providers, PCMH doctors and teams help patients meet these goals and spend more time with individual patients to keep them healthy.

Patients of Blue Cross PCMH practices are less likely to visit the ER or be hospitalized than patients of nondesignated practices.

Blue Cross PCMH-designated practices compared to nondesignated practices



Blue Cross PCMH patients also report higher-quality care, more preventive care and reduced costs.

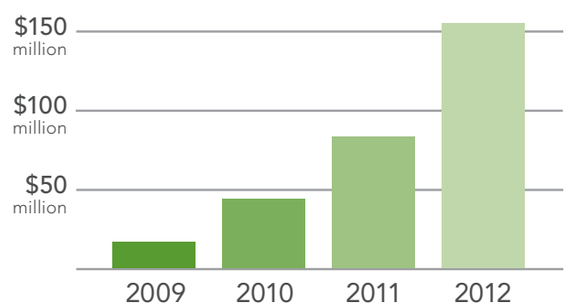
3.5% higher quality measure for adults

5.1% higher preventive care measure for adults

$26.37 lower per member per month cost for adults

12.2% higher preventive care measure for children

Savings associated with the Blue Cross PCMH model



Blue Cross PCMH-designated practices are in 78 of Michigan's 83 counties.

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Data as of July 2014

R031802

That's all it would take right? A simple discussion.

Debra Graetz, MD, Traverse City, MI
Northern Physicians Organization, Inc.
PCMH-designated practice since 2011

When I heard of BCBSM's Patient Centered Medical Home (PCMH) program several years ago and looked into the requirements, I literally shouted, "We are already doing this!"

I bounced around the office and called every BCBSM number I could find to move forward. That's all it would take right? A simple discussion?

That's where the learning curve started. I learned I had to make and use "the binder" and suddenly the excitement about quick designation melted away into a fear of overwhelming paperwork. I had to dig in and move from concept to reality.

Plan, Do, Study, Act.

This was a beautifully stated approach to many of the challenges. I don't hear it much now as I interact with PCMH but it is the basis we can return to for improving patient care. I started by tracking the occurrence of a PCMH conversation with patients. I made a plan of using a v-code in the assessment portion of the patient plan.

I tried it out and fell flat on my face.

All my billings were rejected that week due to an invalid v-code. Circling back to the concept of "**Plan, Do, Study, Act**" allowed me to quickly rebound and communicate to staff how and why we were going to try something new. It gave me a framework to stay on task and feel like I had a successful study of a plan in hand, instead of a failure of a good idea.

I thought I had excellent follow-up on my diabetics – after all, we already had systems in place. Reports that notified me of both my gaps in care and performance ratings forced me to notice every single hole. I remember my shock when I learned that a male patient undergoing chemotherapy was receiving entirely inadequate diabetes care. Without this intense paperwork required by PCMH, I would have missed it.

Maintaining PCMH is hard work, but there is a benefit to the process.

For me, that benefit is that patient who finished chemo two weeks before his daughter's wedding and being able to celebrate because we helped him be at his best for that day. PCMH helped this patient in many ways, from training me on working with self management goals, to identifying him as my gap in care.

I appreciate that BCBSM's PCMH program guided me towards reaching that goal.