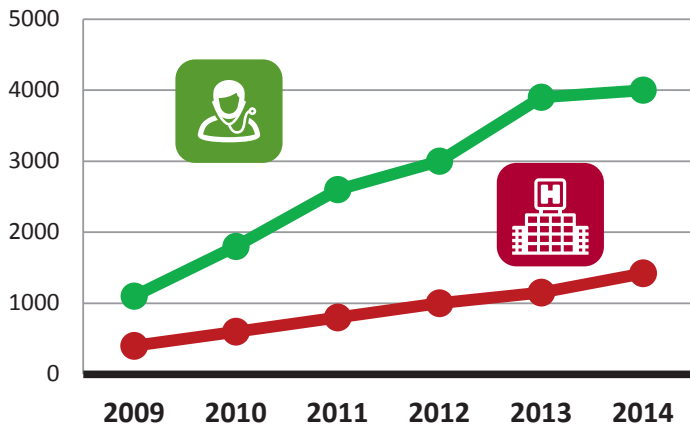


# Blue Cross Blue Shield of Michigan's Patient-Centered Medical Home grows to more than 4,000 physicians.

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



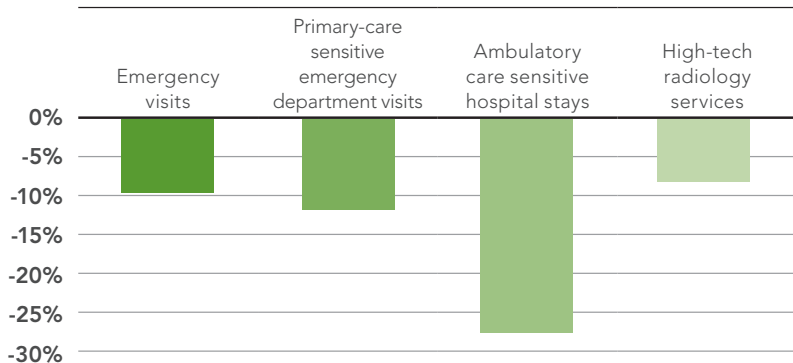
## What is a patient-centered medical home?

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.

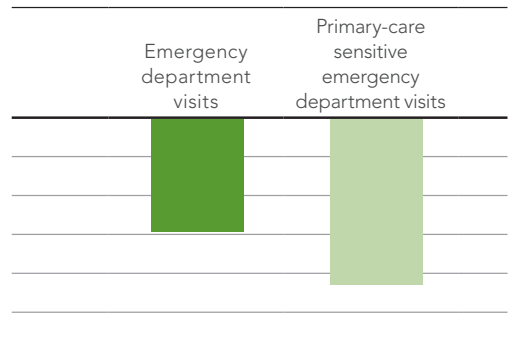
## Patients of Blue Cross PCMH practices are less likely to visit the ER or be hospitalized than patients of nondesignated practices.

### Blue Cross PCMH-designated practices compared to nondesignated practices

#### For adults ages 18 to 64



#### For children ages 0 to 17



## 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

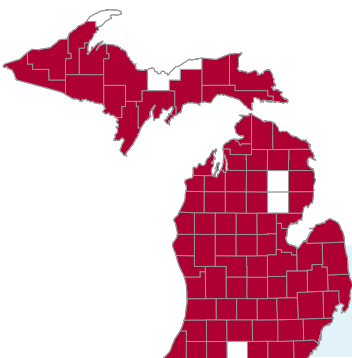
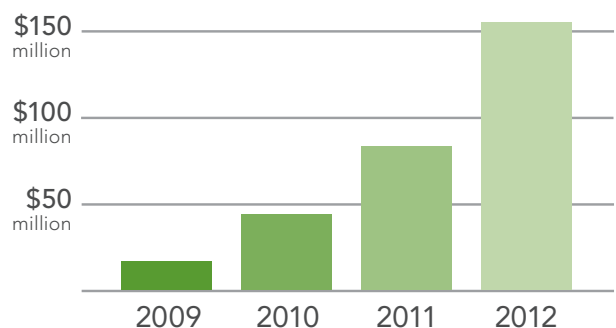


\$26.37 lower per member per month cost for adults



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

# The Patient Centered Medical Home: Meeting the patient's needs

**Karla Smith, MD, Traverse City, MI**  
**Traverse Area Pediatric and Adolescent Clinic**  
**PCMH-designated since 2013**



After over 15 years of practice, I had the opportunity 3 years ago with 3 other physicians to open a new pediatric practice. Our goal was to provide state of the art pediatric care and foster a practice environment of compassion and availability to our patients and their families.

We began the application process for designation as a patient centered medical home shortly after opening our new office. We found that the PCMH structure helped us to organize our office and formalize our policies and procedures to meet our goal of quality care and availability to our patients and their families.

The PCMH structure promotes close monitoring of all patient medical care, whether that care is provided in our office, in the emergency room, in urgent care clinics or in the offices of subspecialists. As part of the PCMH capabilities, we review each incident of care for a given patient that has been performed outside of our office. After working with this system I am certain that the PCMH structure applied to our office procedures helps me to have a much more thorough knowledge of the issues and needs of individual patients.

We contact families by phone after each emergency room visit, each urgent care visit, and each hospitalization. The follow up of visits to emergency rooms and walk in clinics by phone sends the message to patients that we are aware of their medical problems, concerned about their progress and available for their ongoing medical needs.

We have learned how helpful the PCMH structure is in caring for our medically complex patients. We track this care in our Chronic Care Registry. We have assigned nurse managers to work with complex patients and their families. Identifying a primary care provider and a “go to” nurse for our chronically ill complex patients has improved the quality and efficiency of care we give to these patients. Our nurse managers get to know the patients and their families, and nurses and ancillary care providers who care for these patients at other institutions as well. This helps us to meet the patients’ needs in all areas of their ongoing care.

The PCMH model also employs patient registries for population management. We identify, through quarterly review of the performance reports taken from information in these registries, areas where improvement in our care is needed to meet quality standards.

The PCMH model has given us the structural foundation to deliver care based upon quality measures. This model also helps us to be available to provide comprehensive care to our individual patients. As medicine moves from recognition of quantity of care to recognition of quality of care I believe that our adaptation of this model will help us to move forward and meet the challenges of medicine in the future. I would strongly encourage any practices to consider the value of the PCMH system in enhancing the delivery of comprehensive, quality care to their patients.