



April 21, 2009

FACT SHEET

Patient-Centered Medical Home Program

What is a Patient-Centered Medical Home?

A system of care based on the relationship between a patient and their personal primary care physician. The primary care physicians (pediatricians, internists, family practice doctors) lead a proactive health care team to provide long-term coordination and management of their patients' health 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.

The concept of a "medical home" was initially introduced by the American Academy of Pediatrics (AAP) in 1967. In March 2007, the AAP, the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), and the American Osteopathic Association (AOA) issued the "Joint Principles of the Patient-Centered Medical Home" in response to several large national employers seeking to create a more effective and efficient model of health care delivery.

The Michigan Blues and providers in Michigan have just agreed that these principles need to be implemented on a wide-spread basis across the state.

What is the Blue Cross Blue Shield PCMH Program?

The Michigan Blues' PCMH program will be the nation's largest network of designated medical home physicians, with more than 1,000 physicians in about 300 medical practices across Michigan.

More physicians will be designated as they implement more of the features required for the PCMH program. Designation will be reviewed annually, and the number of designated physicians is expected to increase.

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



What are the features of the Michigan Blues' PCMH program?

Physicians are working on implementing the following elements into their medical practices:

- Capabilities to report practice- and physician-level patient outcomes, efficiency of service, and patient satisfaction.
- Clearly discussing with the patient the roles and responsibilities of the doctor and patient, and documenting this discussion.
- Offering 24-hour patient access to a clinical decision-maker, with a multi-lingual approach to care. Access may include extended office hours, telephone access, linkage to urgent care, or a combination.
- 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.
- Providing patients with active counseling, screening and education on preventive care.
- Coordinating referrals to specialists, and providing specialists with patient information needed for proper care, such as lab work and test results.
- Offering patients connections to community services, in coordination with the health system, community service agencies, family, caregivers and the patient.
- Providing self-management education and support to patients with chronic conditions.
- Developing patient registries to track and monitor patients' care over the long-term.
- Providing an online patient portal system that allows for electronic communication and provides patients with greater access to medical information and technical tools.

By the Numbers

- **1,000+** physicians will be designated as Patient-Centered Medical Home Primary Care Physicians.
- **Approximately 300** PCMH practices spread throughout the state
- **More than 300,000** members currently have access to PCMH doctors.
- **3,800** physicians working on implementing at least one PCMH feature.
- **Nearly 2 million** patients could be affected by this initiative.