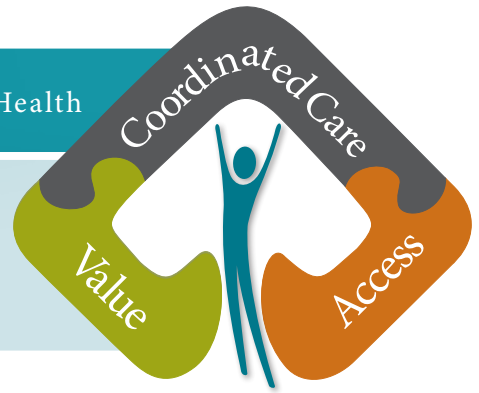


# LEAD THE WAY

Transforming America's Health

We envision a nation with an affordable health care system that leaves no one behind. To achieve this vision, we must continue working together toward a health care system that delivers high value and clinical excellence across the continuum of care.



## How is Trinity Health Transforming Health Care Delivery?

Trinity Health is transforming health care delivery in a number of ways, including its focus on the patient-centered medical home (PCMH). Coordinating care through this highly integrated, team-based approach benefits patients, creates cost efficiencies and is an essential building block of Accountable Care Organizations (ACOs). Therefore, the PCMH is a best practice model in Trinity Health's plan to transform America's health.

Trinity Health is a leader in the number of physicians participating in PCMH initiatives. In the state of Michigan, alone, more than 80% of our employed physicians are practicing in the PCMH model of care. This model is among the most promising delivery system reform opportunities because it has the potential to bend the health care cost curve while also improving quality of care and patient outcomes.

Patient-centered medical homes:

- Reduce emergency department visits and avoidable hospital readmissions
- Aid in the prevention and management of chronic conditions, such as diabetes and heart failure
- Strengthen the patient-physician relationship
- Improve clinical and utilization outcomes, yielding an excellent return on investment

## KEYS TO A SUCCESSFUL PCMH

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>▶ Physician-directed, team-based care focused on the whole patient</li> <li>▶ Coordinated care across the health system</li> <li>▶ Enhanced patient access to services</li> </ul> | <ul style="list-style-type: none"> <li>▶ Payment recognizing the value added</li> <li>▶ Health IT tools to track patients</li> <li>▶ Clinical protocols and practice guidelines</li> <li>▶ Performance reporting and benchmarking</li> </ul> |
|--|--|

## What Can Policymakers Do to Support Patient-Centered Medical Homes?

Medicare, Medicaid, and commercial health plans are piloting the PCMH and Michigan was recently selected by the Centers for Medicare and Medicaid Services (CMS) to participate in the Multi-Payer Advanced Primary Care Practice Demonstration. All states now have the option of enrolling Medicaid beneficiaries with chronic conditions into a health home, and, when they do, will receive an enhanced Federal Medical Assistance Percentage of 90 percent.

To promote the PCMH as a winning strategy for improving primary care, policymakers should:

- Provide appropriate Medicare and Medicaid reimbursement to providers implementing PCMHs
- Foster PCMH expansion in Medicaid programs to achieve higher value — particularly for high-risk populations
- Lead by convening all stakeholders around the development of consistent PCMH certification standards, payment methodologies, and performance outcome measures
- Create quality performance measures — both financial and clinical — that measure patient outcomes and align with the work of the National Committee for Quality Assurance, National Quality Forum and other CMS quality reporting programs
- Ensure that the PCMH payment structure supports the adoption and use of health information technology and the development of state-wide health information exchanges
- Address the primary care professional shortage, including providing Medicare and Medicaid reimbursement for testing and implementing the PCMH in graduate medical education training programs
- Provide PCMH incentive payments for state employee health coverage and public health programs