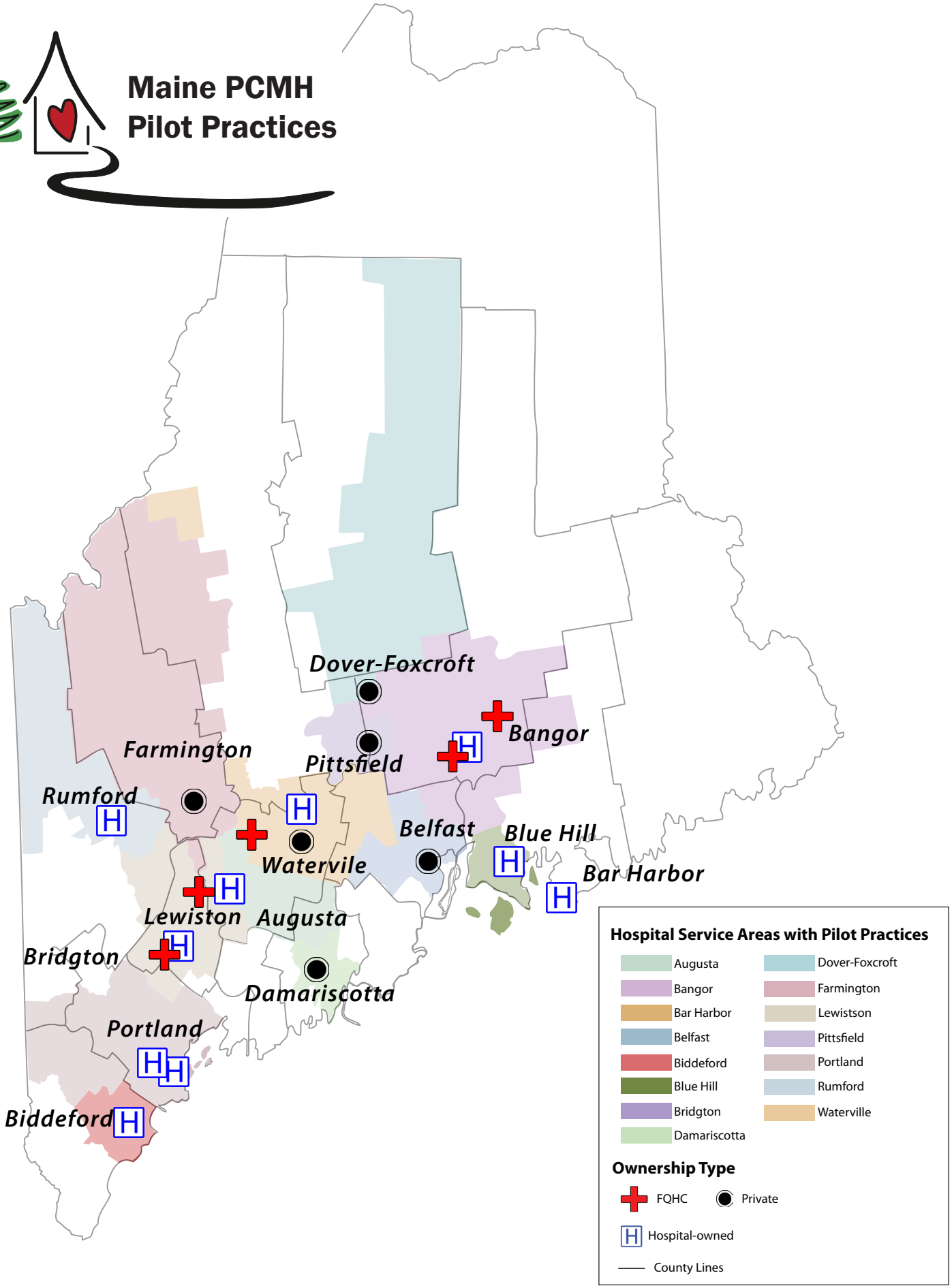
MAINE
Patient Centered
Medical Home Pilot

HalfWAY

2011




Maine PCMH Pilot Practices



ONE. The Medical Home: Maine's Path to Improvement

Introduction

For decades, Mainers have been plagued by preventable chronic diseases such as diabetes, cardiovascular disease, cancer, and depression. As a state, we face dramatically rising health care costs associated with these conditions, and as individuals, we face the challenges of fragmented care and timely access to primary care providers, especially in rural areas. Effective prevention and better coordination of care can dramatically change this picture, improving outcomes, creating a better experience of care, and lowering costs in the process.

Since 2009, Maine has led the way with the innovative Maine Patient Centered Medical Home (PCMH) Pilot as a way to forge a solution to this crisis in our health care system. The Maine PCMH Pilot makes the better health care we've hoped for a reality. It delivers on the promise of healthier lives for Mainers. This report provides an update on the progress of the Maine PCMH Medical Home Pilot as it crosses the "half-way" mark in its original 3-year timeline.

What is a Patient-Centered Medical Home?

A "medical home" is not a building or a place, but a team of health professionals who work together to better coordinate care for their patients. The Maine PCMH Pilot builds on Maine traditions of collaboration and innovation, creating patient-centered solutions based on what we know works best in our communities. This work aligns with other exciting developments -- including the use of interconnected electronic medical records throughout Maine--so that doctors and nurses working together can better manage care, and patients have an active voice in their improving their health.

A National Movement

The Maine PCMH Pilot aligns with a national movement to provide high quality and cost effective primary care by supporting investments in better primary care. In March 2007, four leading physician membership organizations (American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association) came together to support the PCMH model. They subsequently agreed on seven key model principles. (see below)

Since then, more than thirty states across the country have launched PCMH pilots to test the model with groups of willing doctors and payers. Building better support for primary care and the PCMH model is also a major strategy of federal health reform efforts, encompassed in the 2009 Patient Protection and Affordable Care Act.

Nationwide PCMH Success

The Maine PCMH Pilot is based on solid national evidence of the excellent quality and cost outcomes associated with this model. A 2010 national review of efforts to improve primary care and the medical home concludes:

"Investing in primary care patient centered medical homes results in improved quality of care and patient experiences, and reductions in expensive hospital and emergency department utilization. There is now even stronger evidence that investments in primary care can bend the cost curve, with several major evaluations showing that patient centered medical home initiatives have produced a net savings in total health care expenditures for the patients served by these initiatives." [1]

Primary Care and PCMH Pilots: Results from Around the Country

- **Integrated Delivery System Model: HealthPartners Medical Group, Minnesota**
  - **An integrated model of enhanced primary care resulted in a 39 percent decrease in emergency department visits and a 24 percent decrease in hospital admissions per enrollee between 2004 and 2009.**
  - **Overall costs for enrollees in HealthPartners Medical Group decreased from being equal to the state average in 2004 to 92 percent of the state average in 2008, in a state with costs already well below the national average.**
- **Private Payer-Sponsored PCMH Initiative: BlueCross BlueShield of North Dakota-MeritCare Health System**
  - **In a study of PCMH efforts from 2003 to 2005, hospital admissions decreased by 6 percent and Emergency Department visits decreased by 24 percent in the PCMH group, while increasing by 45 percent and 3 percent, respectively, in the control group. In 2005, PCMH patients experienced an average of 13 inpatient admissions per one 100 patients per year, compared with just over seventeen per year in the control group. PCMH patients experienced an average of 20 emergency department visits per 100 members per year, compared with 20 per year among control patients.**

1 Kevin Grumbach, MD, et al." The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies." *USCF Center for Excellence in Primary Care* (Nov. 2010): http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf (Accessed October 20, 2011).

- In 2005, total costs per member per year were $530 lower than expected in the PCMH group based on historical trends.

► **Medicaid-Sponsored PCMH Initiative: Community Care of North Carolina**

- Under North Carolina's model of enhanced primary care and nurse care management, participating practices demonstrated a cumulative savings of $974.5 million over six years (2003-2008). For patients with asthma, the state demonstrated a 40 percent decrease in hospitalizations and 16 percent lower Emergency Department visit rate.

► **Colorado Medicaid and SCHIP:**

- The Colorado model of primary care case management showed median annual costs of $785 for children cared for under a PCMH model, compared with $1,000 for controls. In an evaluation specifically examining children in Denver with chronic conditions, children in the PCMH model had lower median annual costs ($2,275) than those not enrolled in a PCMH practice ($3,404).

MODEL PRINCIPLES

1. relationship with a personal (primary care) physician
2. use of team-based care
3. whole-person orientation
4. coordination and integration of care across all settings
5. quality and safety as hallmarks
6. enhanced access to care; and
7. payment that appropriately recognizes the added value to patients of a patient-centered medical home.

Providers *reflect on their experiences, their successes and their challenges:*

Julian Kuffler MD

Community Health Center, Mount Desert Island

Here on Mount Desert Island, we're building on long-standing interest in coordinated care, especially for high-risk patients. We've always felt the local community best understood consumer and community needs –what patients want, not only when they're here in the practice and in the hospital, but when they go home. When the Maine PCMH Pilot came along, it dovetailed perfectly with this approach.

We are working toward the development of a comprehensive oral health care system, targeted toward kids from birth to age 20. Change takes time, but the school system piece is ready to go. All the kids on the island's schools will be enrolled, so they will have access to prevention and treatment services. We work closely with the schools and serve kids from families with and without insurance. We've also developed open access—40 percent of appointment slots are open—and we call patients more between appointments to see how they're doing.

As a result, we've cut our "no-shows" down to almost nothing. Before this, people called when they had a need, but we often couldn't give them an appointment for a week or two. They'd get better and forget to cancel the appointment or they'd end up in the emergency department. Now we have enough open slots that people show up, which is very positive.

The Pilot means transition for patients and the practice. Now we have a much more team-based approach, with shared responsibility and tracking mechanisms, so referral and diagnostic information is readily available.

Change takes time. For our practice, seeing improved outcomes and efficiency, behavioral/primary care integration and culture change are all Pilot successes. We're also seen as a success in the community. We've gotten busier—the community views us as doing more than the "regular primary care." Working with other practices is helpful for all of us, but the main thing is that we're providing patient-centered care.

We're also excited about the Community Care Teams that are part of the MAPCP [Medicare] demonstration. This will really help us address the needs of patients who have the most complex medical and psychosocial problems. We'll be going into the community, meeting them on their own turf.

The system nationwide is broken. It's not patient-centered. This kind of intervention needs to be supported."

THREE. Maine Leads the Way: The Maine PCMH Pilot

In 2007, the Maine Legislature convened the Commission to Study Primary Care Practice to examine the issues facing primary care and to identify ways to stabilize and support it. Subsequently, the 2008-2009 State Health Plan endorsed the medical home model as a key strategy for making primary care viable in Maine. Payers and employer groups strongly supported these recommendations. Following this direction from the State, the Dirigo Health Agency's Maine Quality Forum, Maine Quality Counts, and the Maine Health Management Coalition—a purchaser and employer-led multistakeholder collaborative working to improve quality and control costs—came together to launch the Maine Pilot, and convened a multi-stakeholder group to direct its efforts. This steering group includes consumers, providers, employers, payers, public health, and state government representatives who work through a process of consensus to guide the initiative.

Maine PCMH Pilot Mission and Vision

The vision of Maine's Maine PCMH Pilot is to provide effective, efficient, and accessible health care supported by appropriate payment, and to deliver sustainable value to patients, providers, purchasers, and payers. Its mission is to develop and implement a patient-centered delivery system and payment model that will support this vision.

Guiding Principles

The Maine PCMH Pilot adopted the national PCMH principles, with a few adaptations. First, the Maine Pilot is more inclusive in its vision of practice leadership, recognizing the importance of the entire practice team, including not only physicians but also nurse practitioners and physician assistants. Second, while the original principles focus on medical care integration, the Maine PCMH Pilot works to bring public health and behavioral health together with medical care, thus aligning with Maine's health policy efforts over the past decade.

While the Principles recognize the need for practices to be fairly paid for all services they provide to patients, Maine PCMH also acknowledges that practices must also do their part to ensure that they deliver cost-effective care and help to control rising health care costs. Pilot practices not only come up with their own solutions to improve quality and reduce costs, but contribute in-kind resources to this effort as well.

Changing Payment to Improve Care and Control Costs

Changing payment for primary care is a critical step in the journey towards supporting the PCMH model and delivering more patient-centered care. Current "fee-for-service" payments for primary care pay mostly for office visits and tests, not for services needed to provide more patient-centered care, like extra time with patients to explain their condition and treatments, or time for nurse care managers to help coordinate care and support patients as they make behavior changes. The PCMH Guiding Principles recognize that payment for primary care must change to reflect the added value of this model.

As part of the Maine PCMH Pilot, the major health insurance payers in Maine agreed to pay practices differently for better care. These payers include MaineCare (Maine's Medicaid program), Anthem BCBS, Aetna, Harvard Pilgrim Health Care, and many of Maine's major employer groups. The payers endorsed a three-component payment model that includes (1) a new, up-front "per member, per month" care management fee paid to PCMH practices, (2) continued fee-for-service payments, and (3) payment

Employers *give their perspectives on why they support the Pilot, what they hope for and how they're engaging employees as active participants in health care:*

Frank Johnson

State of Maine Employee Health Commission

"**The Pilot provides an opportunity** to demonstrate that that the Patient-centered Medical Home model works if there are resources to support it. We got involved because looking at claims data, we discovered that fewer dollars were going to primary care than we thought should be. Along with other employer members of the Maine Health Management Coalition (MHMC), we concluded that payers were offering the wrong incentives to providers, with the result being fragmented and expensive care. As a large employer, the State wanted to provide support, even if relatively modest, to this model. The Maine PCMH Pilot establishes meaningful reform of the delivery system with a focus on primary care. We hope for all of the following in this reform--expanding of access in the practices through expanded hours, coordinated management of patients with chronic conditions, improved utilization of preventive care. Of course we hope most for an enhanced patient experience. The Pilot calls for changes in clinical outcomes and we look forward to seeing that data. The premise is that the Pilot practices will decrease utilization in Emergency Department and hospitals admissions/ readmissions as well as other variables. We're looking to see practice transformation as our return on investment. That will allow for sustained reimbursement. State employee plans have long required designation of a primary care provider—now we want to look carefully at variations in practice quality.

We hope to see patients involved as partners in health management. With this model that we can align our benefits toward rewarding those practices that get patients engaged as partners with providers in improving their health."

that recognizes excellent performance by the practice, whenever possible. Payers used the National Committee on Quality Assurance (NCQA) recognition program as the standard for recognizing practices qualified to receive these new PCMH payments. [2]

Pilot leaders worked with providers, consumers, and payers to identify measures of success, including changes in patient experience of care, clinical quality outcomes, and health care costs as well as the use of expensive health care resources, such as hospitalizations and use of emergency care.

Participating Practices and Expectations for Practice Change

Following an open call for participation, a diverse group of 26 primary care practices—22 adult and four pediatric practices—were selected to participate in the three-year Pilot beginning in January 2010. The Pilot practices are demographically representative of Maine, representing 14 out of 16 counties and collectively providing care for over 150,000 people throughout the state.

In addition to committing to achieving national medical home recognition, all Pilot practices are responsible for implementing 10 key practice changes. These are the "Core Expectations" that patients and other experts have identified as critical to the delivery of more patient-centered care. These 10 Core Expectations, which Pilot practices have committed to fully putting into place by the end of the Pilot, are listed elsewhere in this report.

Halfway There: Highlights of the Maine PCMH Pilot's First 18 Months

Helping Practices Improve Care

Looking to lessons learned from similar efforts across the country, leaders of the Maine PCMH Pilot recognized that making these changes in a busy primary care practice can be extremely challenging, and made a commitment to help practices make these changes and transform to a more patient-centered model of care, using a range of supports:

- **PCMH Learning Sessions**
  Since the start of the Pilot in January 2010, leadership teams from each of the Pilot practices have been participating in a PCMH "Learning Collaborative". This Collaborative is a program of structured learning that includes day-long educational "Learning Sessions" where teams from each practice come together to learn from each other and from subject matter experts every few months thereby learning about best practices and sharing experiences. In the first half of this effort, Pilot leaders sponsored six Learning Sessions, each featuring these nationally- recognized experts, who share lessons learned and best practices concerning a wide array of improvement topics. The Learning Sessions receive high marks from practice teams, with over 100 members of the Pilot practice teams, including patients, attending each of the Learning Sessions to date.

- **Quality Improvement Coaches.**
  Pilot practices are provided with many resources to help them improve care for their patients. Building on the education and support they receive in the Learning Sessions, practice teams receive tailored technical assistance and one-on-one coaching for quality improvement from a statewide network of external coaches, who receive training and support from Pilot staff and from the Maine Practice Improvement Network, a network supporting education and development of quality improvement coaches. Between Learning Sessions, coaches work directly with Pilot practices to identify areas for improvement, develop plans for change, and help assess their impact on the practice.

2 A private nonprofit founded in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

Patient *insights on the Pilot and the role of patients and families:*

Judy Ward

Winthrop Family Practice (PCMH Pilot Practice) and Chair, Winthrop Patient Family Advisory Council

"**I've been a patient at my practice for seventeen years.** My mother and daughter are patients, too. Visiting the practice is a pleasant experience. I see friendly familiar faces and sitting in the waiting room is brief. I expect I'll come out having a full understanding of why I'm not feeling well, testing results and possible options for treatment. It's also important for me to understand what is happening with my mother and I can reach out and talk with her nurse or doctor if I need further information.

The team approach of the practice allows you to get an appointment with someone on a team assigned to your healthcare. When you call for an appointment you can either ask for your personal physician or a member of his/her team. I have no hesitation about seeing any team member for my care. And due to the nature of illness, seeing someone on the same day as my call is great.

I enjoy participating in the patient/family council. It's exciting to discuss and suggest possible changes to all aspects of patient/family interaction with the practice staff and other consumers and family members. It's necessary that people realize their individual responsibility in their health care and that's what the council is there to help do. Being the Chair of the Winthrop Council is a position I am proud to hold."

State Leaders *give their perspectives on why they support the Pilot, what they hope for and how they're engaging employees as active participants in health care:*

Karynlee Harrington

Executive Director,
Dirigo Health Agency

"**The Dirigo Health Agency's Maine Quality Forum has been a key leader** of the Maine PCMH Pilot since its outset, and remains highly committed to supporting the Pilot through its duration. We have been encouraged by the initial work of the Pilot practices, and are very pleased to support Maine's participation in the Medicare medical home [MAPCP] demonstration. We feel there is strong evidence to support enhanced primary care systems as fundamental to wider efforts to transform health care delivery and payment, are eager to see the PCMH model spread to additional practices and patients"

- **Technical Assistance and Data Feedback Reports**
  Help doesn't stop there. In addition to Learning Sessions and coaching, Pilot participants are provided with many other support and education activities, including regular conference calls, regional meetings with their peers, site visits, webinars and a user-friendly web site offering a wide array of resources. Practice teams can tap into technical assistance experts in key areas, such as finding ways to better coordinate behavioral health needs for their patients and ways to directly engage patients in their improvement efforts (see the Patient Family Leadership Team, below). Practices also receive performance reports that compare their performance with peers, focusing on key utilization measures and areas for improvement.

The Pilot has also engaged Health Dialog to develop performance reports that give practices a more complete view of their performance, report on cost and utilization of health care services, identify specific opportunities for improvement, and provide a clear display of practice performance in relation to peers. Discussion of the performance reports has become a focus of technical assistance and training activities.

Making Progress!

While the Maine PCMH Pilot is only at the half-way mark of its original three-year duration, many successes can already be identified. One of the cornerstones for Pilot practices was a requirement to achieve national (NCQA) recognition as a medical home. To date, 100 percent of practices have achieved NCQA recognition, with nine Pilot practices achieving the highest level of recognition (Level 3).

Pilot practices are also making progress on putting in place the key changes needed to move to a more patient-centered model of care. Practices are expected to implement the 10 Core Expectations that are the foundations of practice culture change and the foundation for improving the patient experience and clinical quality while reducing waste and controlling costs. Leaders of the Pilot established a goal that all practices would meet the most important elements of the Core Expectations in Year 1, and at least 80 percent of the remaining minimum participation requirements. Of the 26 practices, 24 have met or exceeded this goal. In addition, all practices have shown improvements in all Core Expectations since the Pilot's inception, especially in the areas of integrated care management, connecting with community partners and better engaging patients in practice work.[3]

Current assistance to Pilot practices and improvement activities center on renewed commitment to implementing the 10 Core Expectations, and additional activities to reduce avoidable costs and wasteful health care spending –i.e. work to improve coordination of care to reduce avoidable hospital admissions and readmissions, Emergency Department (ED) visits, and duplicative or unnecessary testing and imaging.

Engaging Consumers

Finding better ways to engage patients in practice changes and care improvement has been an ongoing focus of the Maine Pilot. Even before the Pilot formally began, focus groups were held to understand the primary care patient experience. These were held around Maine, with one centering on the experience of MaineCare recipients. The groups highlighted opportunities for improved engagement between providers and patients in the development of the Pilot. We found that consumers wanted to know more about treatment options and how to track their progress between office visits. Patients wanted help in following a care plan, to actively participate in decision-making and to see themselves as part of a team with providers. We also found that they wanted to access community prevention resources and to understand the concrete benefits the PCMH would bring to them.

When the Maine Pilot started, staff and stakeholders made a commitment to include consumers in decision-making. We invited consumers to be full members of the steering group. More recently, the Maine

3 At the end of Year 1, more than two-thirds of the practices had met 80--100 percent of expectations. Five had perfect scores.

Providers *reflect on their experiences, their successes and their challenges:*

Laura Van Dyke
Lead LPN,
Husson Pediatrics

Our practice got involved in the PCMH Pilot because we believe in family-oriented care. We've made some big changes! We've changed appointments to "open access;" we have appointments that are open daily. Parents can call in the morning and get an appointment that works best for them. In addition, we've linked with Eastern Maine Medical Center's "Walk in Care" facility on Union St. This practice extension allows patients to be seen the same day if we run out of office appointments.

As a result, we're hearing a lot of positive feedback from parents, who don't have to wait so long for appointments. "Well care" appointments for children can be scheduled much more quickly since these changes have opened up the schedule.

We continue to examine our work processes so we can better serve our patients. They're always first in our minds. We've expanded patient education concerning the Electronic Medical Record. We also have a very active Parent Advisory Group (PAG). It's wonderful to be able to sit down with parents, hear their feedback, and get new ideas. Sometimes we have something in place that we think is working well and we find our parents have a different perspective. A parent advisor is helping us make our web site more informative and user-friendly. The PAG works well for giving us new ideas and it's a wonderful avenue for us to receive feedback.

The Maine PCMH Pilot has changed the way I feel about practicing primary care. It's important to not just focus on the "numbers." I've been in nursing a long time and it feels right to be able to focus on the families and patients--to know that we provide them with the best care we can."

PCMH Pilot created a Patient and Family Leadership Team (PFLT), which includes consumers, advocates and quality improvement professionals. The PFLT provides patient and family engagement support to the practices, encouraging them to take a leadership role in the design and delivery of patient-centered care. The PFLT provides a range of technical assistance services, including: customized recommendations to practices on consumer engagement, as well as mini-grants for the same purpose, practice change recommendations through a "tip of the month," facilitated discussions at the PCMH Learning Sessions, monthly patient engagement calls, and other mechanisms.

PFLT members recently interviewed all Pilot practices regarding their progress in substantively engaging patients in improvement efforts. The interviews revealed that 75 percent of the practices have either established a patient advisory group or planned to do so in the near future. The remainder noted that they planned to do so with coaching and support. Having a practice champion, finding a focus and devoting staff time all help engage patients.

Assessing the Impact: Evaluation of the Maine PCMH Pilot

Leaders of the Maine PCMH Pilot have committed to conducting a rigorous formal evaluation of the Pilot. They have contracted with the University of Southern Maine's Muskie School of Public Service to conduct an independent evaluation, focusing on changes in four areas: 1) patient experience of care, 2) clinical quality, 3) cost and efficiency of care, and 4) changes made by Pilot practices.

Patient Experience

The Pilot is committed to evaluating not only changes in care provided in Practice sites, but, just as importantly, patients' experience of it. In 2009, Pilot practices conducted a baseline survey of patient experience using a national survey tool and a standardized method of data collection. Baseline survey results showed that while patients overwhelmingly believed that their providers cared about them as people, listened and explained care well, patients sometimes experienced difficulties in making appointments and getting access to practices by phone, particularly after hours. Many patients did not recall receiving preventive advice on healthy diet/weight issues, depression/stress and self-management concerns – all potential areas for improvement.

Pilot leaders are working with the practices to use these results to improve care, and are expected to work directly with patients and families to identify specific ways to improve patient experiences. A follow-up survey of patient experience will be conducted at the end of the Pilot's original three-year timeline.

Clinical Quality

Leaders of the Pilot are also committed to measuring changes in the clinical quality of care delivered to patients in Pilot practices. They have identified a set of thirty-one clinical quality measures that assess quality of care for chronic conditions such as diabetes and cardiovascular care, and preventive health, such as immunizations and cancer screening. The evaluation team will be looking at changes in these measures over time, comparing practice performance at baseline and at the end of the three-year Pilot period.

The Maine PCMH Pilot has collaborated with the New Hampshire PCMH Pilot to build a web-based system for collecting clinical quality data. Working with the University of New Hampshire's Regional Computing Center, they have built a web-based tool that allows practices to directly report data on these measures from their practice electronic medical records and data reporting systems.

Cost and Resource Use

Leaders of the Maine Pilot have also identified a set of cost and resource use measures that will be used to examine changes in health care costs, particularly the use of expensive resources such as hospital

Employers *give their perspectives on why they support the Pilot, what they hope for and how they're engaging employees as active participants in health care:*

Tom Hopkins

University of Maine Employees

We support the Pilot because we've always believed in coordinated, community-based care that focuses on integration, especially building mental health management into primary care practices. We also believe that people need to work closely with their primary care physician and team in managing their care.

We'd like to see improvement in clinical measures. But it may be even more important to see people engaged in a way that doesn't end when they walk out of the doctors' office. We'd like to see fewer readmissions and lower utilization of the emergency department, but we also want to see people healthier at their worksite.

Many strides have been made. With other employers in the Maine Health Management Coalition (MHMC), we are adopting a quality-based network approach, using the MHMC criteria for our providers, providing a discounted co-pay for those who go to providers who are rated "good" to "better" [using MHMC criteria]. We're making other plan design changes to encourage people to participate more with their doctor and their local care managers.

The Maine PCMH Pilot is the right thing to do for our employees. It's a seed for change throughout the state."

admissions, Emergency Department use, and high-tech imaging, including MRIs and CT scans. The evaluation team will use data from Maine's All-Payer Claims Database to compare changes in these measures from the baseline period to the end of the intervention period.[4] The team has received all-payer claims data and a baseline report will be released in early 2012.

Practice Changes

The last component of the Pilot evaluation examines the processes that practices have used to effect change during the course of the Pilot, and factors that may contribute to their success in achieving its goals, including the practices' organizational culture and staff stress levels. Results from a baseline survey of practices showed strengths in teamwork, use of health information technology, knowledge and use of community resources, openness/ability to change, and patient safety-oriented culture. Over the first eighteen months of the Pilot, all practices have reported progress, and many have made substantial gains in a short period. Practices have identified learning from each other as critical to this growth and change.

Resources

Substantial resources have been invested to support the Maine PCMH Pilot. Beginning in 2009, the Maine Legislature approved $500,000 to provide new Medicaid (MaineCare) payments to Pilot practices. Commercial payers have also made new payments to participating practices. Pilot leaders have secured over $500,000 in additional funding to support the work of running the Pilot from multiple sources, including the Maine Health Access Foundation, the Dirigo Health Agency's Maine Quality Forum, and Harvard Pilgrim Health Care, with additional support provided by Maine Quality Counts, the Maine Health Management Coalition, Martin's Point, and Anthem BCBS of Maine. An additional $235,000 in funding to support independent evaluation of the Pilot has been provided by several private foundations, including the Bingham Program, the Davis Family Foundation and the Betterment Fund. The Robert Wood Johnson Foundation's "Aligning Forces for Quality" initiative has provided support for development of the Patient Family Leadership Team.

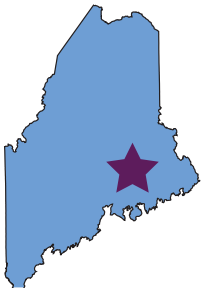
Participating practices have also contributed substantially through in-kind resources that complement direct project funding. These have included: staff time, technology, care management, behavioral health care services, and staff training on integrative care management. In some practices, providers associated with PHOs received support in the form of increased staff time, new staff, and quality coaches.

4 The evaluation uses nationally-recognized measures that reflect the six aims of quality care identified by the Institute of Medicine: safe, effective, timely, efficient, equitable, and patient-centered.

FOUR. Finding What Works

Practices Make Changes to Get Results

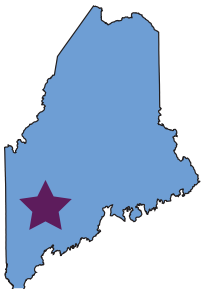
Our enthusiastic Pilot practices actively identify specific changes to improve patient care. In the stories below, three PCMH Pilot practices describe what transformational change looks like "on the ground:"



Penobscot Community Health Center, Bangor, ME

Penobscot Community Health Care (PCHC) is a comprehensive FQHC serving Bangor. As part of their Pilot participation, PCHC also took a hard look at ED use rates across their population, working with local hospitals to get daily information about when and why their patients were using the ED. The PCHC team became more proactive in reaching out to their patients to try to prevent avoidable visits. It also offered expanded hours and created a new call center to redirect patients to the right care venue. Other changes included: establishing two walk-in clinics, making follow-up calls to patients using the ED, and improving medication management for patients on multiple medications to improve safe prescribing and reduce unwanted complications from overlapping medications.

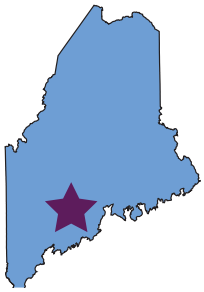
The PCHC team has learned the importance of data-driven improvement. They credit much of their success to getting and using more timely information from hospitals and payers, particularly from MaineCare, which allowed them to know which patients visit the ED most often, and how much this costs. PCHC intends to expand their examination of ED and hospital use, continuing to improve efficiencies and quality while reducing avoidable costs.



DFD Russell Medical Center Turner, Leeds & Monmouth, ME

The DFD Russell Medical Center a federally qualified health center (FQHC), serves the residents of Leeds and six surrounding towns. Even before the Pilot, the practice team suspected that a substantial number of their patients were experiencing Emergency Department (ED) visits and hospital admissions that could potentially be avoided, and translated to an expenditure of time and resources for care that could be better delivered by the primary care practice, with better outcomes for patients and families.

Since participating in the Pilot, the Center has used a number of best practice changes to reduce hospital readmissions and ED use, including developing systems for more timely collection of data, making outreach calls to patients, scheduling primary care visits within a week of hospital discharge, expanding office hours, and offering more proactive patient education. By making these substantial alterations to practice workflows and other changes, the Center has reduced expensive patient visits to the ED by 50 percent.



Central Maine Medical Center (CMMC)
Topsham Family Medicine, Topsham, ME

Topsham Family Medicine's diverse practice serves patients from Topsham, Lewiston, Poland and Mechanic Falls. After surveying staff and patients about opportunities for improvement, the practice team identified phone systems as a major opportunity for improving access to care. Internal studies showed that they needed to improve the flow of patient calls within the practice, and the number of times a phone message was "touched." Their aim was to decrease the number of time a message was handled by 50 percent. The practice team made several changes, including developing a standard phone script and a better process for managing phone requests. After making these changes, the team showed a notable reduction in callbacks and improved handling of messages, though the number of calls increased. The practice surpassed their own goal by decreasing the number of times a message was touched by over 70 percent and the number of patient callbacks declined by 80 percent.

The Journey Continues

The Road Ahead

In 2011-12, the Pilot practices will continue to build on their accomplishments to date, and continue to make changes to improve care. The baseline evaluation of the Pilot indicates that many practices have strengths in their medical home practice culture, including the ability to effectively deal with the inevitable stresses of culture change. We hope to share these lessons learned, as well as promising practices in patient engagement, with the larger Maine community. We will also explore and expand what has proven to work well for practice staff and patients, including the Learning Sessions and providing data and feedback. Pilot staff will continue to provide tailored support to practices with challenges on the practice culture or work place stress measures and will seek to understand more about how the Pilot affects people in different professional roles.

Moving forward, the Dirigo Health Agency's Maine Quality Forum, Maine Quality Counts, and the Maine Health Management Coalition will continue to lead the Maine PCMH Pilot as a first step in the overarching goal of achieving statewide implementation of the PCMH model. As the PCMH model and the promise of improved care continue to attract the attention of payers and policymakers, the Maine PCMH Pilot is poised to link with several other upcoming opportunities, including the following:

Maine PCMH Pilot and Medicare Advanced Primary Care Practice Demonstration

The PCMH model has met with strong support from Mainers and is now also the focus of new efforts by the federal Centers for Medicare and Medicaid (CMS). In 2011, Maine was selected by CMS as one of only eight states in the nation to take part in the Medicare "Multi-Payer Advanced Primary Care Practice" (MAPCP) demonstration - a new federal project that brings Medicare in a payer to support the PCMH model to improve the delivery of patient-centered care. As a participant in this demonstration, Medicare will join Medicaid and the commercial payers to participate as a payer in the Pilot. Beginning in January 2012, CMS will provide Medicare enhanced fees to Maine PCMH Pilot practices –estimated to total up to $28 million over the next three years—for providing medical home services to their Medicare patients. In exchange for enhanced payments, Medicare also sets an expectation that Pilot practices will demonstrate improvements in clinical care and efficiency, and has targeted an expected 6-7 percent decreases in avoidable inpatient admissions and 5 percent decreases in avoidable emergency department visits, specialty consultations and imaging use resulting from improved primary care and better coordination of care.

Maine's participation in the MAPCP demonstration allows for significant expansion of the Pilot, adding a projected additional 20 new practices to the Pilot in 2012, and extends the timeline of the original Pilot from three to five years (through 2014).

Community Care Teams

The MAPCP demonstration introduces a new care component: Community Care Teams (CCTs). CCTs are multi-disciplinary, community-based, practice-integrated care management teams that will work closely with PCMH Pilot practices to provide enhanced care management services for the most complex, most high needs patients in the practice. CCTs are envisioned as a vital strategy for improving quality and reducing costs in the MAPCP demonstration, providing care coordination for these high needs patients to improve care and reduce costs by decreasing avoidable services such as hospital admission and readmissions an Emergency Department visits. Under the MAPCP demo, Medicare, Medicaid, and commercial payers will

provide payment to a set of eight CCTs that have come together to serve the needs of PCMH Pilot practices and patients.

CCTs will work with practices to identify patients at high risk and/experiencing high levels of hospitalization or ED use who could benefit from additional support, and will link them to additional services in the larger health system or in the community. Such patients often present multifaceted needs, so the CCT will link and refer patients to community-based agencies, transportation services, behavioral health, medication management, and education services to complement the care they are currently receiving. In this way, patients and providers will work together to meet patients' health improvement goals, achieve quality outcomes and reduce avoidable costs.

COMMUNITY CARE TEAMS

Androscoggin Home Health

Coastal Care Team

CFD Russell Medical Center

Eastern Maine HomeCare

Kennebec Valley

Maine Medical Center

Community Health Partners

Penobscot Community Health Care

National PCMH Collaboration

The Maine PCMH Pilot continues to identify new ways to collaborate and leverage the use of scarce resources. We have formed strong partnerships with similar PCMH pilots in New Hampshire, Vermont, and Rhode Island, regularly sharing ideas and lessons learned. The Maine Pilot also actively participates in the Multi-State PCMH Collaborative, a national group that promotes learning across several other statewide PCMH pilots from around the country. The group is exploring additional opportunities for collaboration, including potential methods to share data, conduct research, and impact policy changes needed to support the PCMH model.

Accountable Care and Other Payment Reform Efforts

MaineCare (Medicaid) Value Based Purchasing and Health Homes

As one of the largest payers in the state, Maine's Medicaid program (MaineCare), has been an active participant in and supporter of the Maine PCMH Pilot from the outset. MaineCare participates as a payer, and efforts have been made to identify the unique needs of MaineCare members within Pilot practices. MaineCare has identified the PCMH model as a key component of its recently-announced "Value Based Purchasing" strategy moving forward. In its efforts to identify mechanisms for improving quality and controlling costs, MaineCare has moved away from previous plans to contract with commercial managed care entities, and instead is looking to Maine providers to build their capacity for improved care management, including the PCMH model. Under federal health reform efforts, Maine also has an opportunity to develop a federally-approved "Health Homes" initiative that will build on the current PCMH Pilot, and expand thr mofrl to additional primary care practices to improve care and control costs for more MaineCare members.

Accountable Care Organizations & PCMH

Both private and public payers are actively exploring the opportunity to expand payment reform efforts beyond primary care, and support the development of Accountable Care Organizations (ACOs) – provider organizations that agree to improve the delivery of care for specific populations of patients in exchange for new payment models that reward high value care. ACOs are a type of payment and delivery reform model that seek to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. Within the ACO model, a group of coordinated health care providers come together to provide care to a group of patients, and agree to be "accountable" for a defined set of population outcome measures.

Experts agree that successful ACO models will need to be built on a foundation of robust primary care, and will need to expand PCMH payment reform and performance measurement to a wider set of partners within the local health care community. Given the Maine PCMH Pilot experience, the state and local provider systems in Maine are well-positioned to take advantage of emerging ACO opportunities, and to build on the work done to develop high-functioning primary care practices and the PCMH model as a foundation to this wider work.

Lessons Learned

At the halfway point of the Pilot, conveners and stakeholders recognize that Pilot practices have made great progress towards addressing the complex cost and quality problems that affect Mainers' health care. While there is still have substantial work ahead, the Pilot has already demonstrated many lessons:

- **Collaboration is central.** Collaboration through sharing information and support is key—not only between practices, but within them. Learning collaboration sessions and regional meetings provide opportunities to experience support and learn through data feedback and best practice exchange. Within practices, it is important to understand the concerns of staff in different professional roles to maximize positive impacts; our evaluation found that physicians and other clinical personnel experience practice change differently than administrative staff. Understanding and open communication among providers can address the "change fatigue" that can come along with health system innovation.

- **Flexibility is essential to change implementation.** Change is not without challenges. We have found that is essential to listen and continually gather input from Maine PCMH Pilot practices to see what works well and what does not. Data feedback and learning sessions appears to work best for providers, while coaching and conference calls may need to be reworked to better meet provider needs.

- **Consumer engagement works.** The Maine PCMH Pilot practices know the meaningful inclusion of consumers in practice improvement is vital to success. Practices have designed a number of user-friendly efforts to better ascertain and address patient needs. In the remainder of the Pilot, we will work to better understand consumer engagement and share best practices. The Patient and Family Leadership Team will continue to provide technical assistance to better engage consumers statewide.

- **Progress is possible in a relatively short period.** By the halfway mark of the Pilot, all practices had made progress in Core Expectations and most Pilot practices strengthened their improvement efforts. Practice teams learned from each other and showed particular interest in data-driven performance feedback.

- **Once trained and coached in quality improvement methods,** practices are taking the next steps to substantively address issues like phone access, emergency department visits and hospital readmissions, which have powerful quality and cost impacts.

- **Success leads to success.** The Pilot practices have experienced a great deal of change in recent years, particularly with the inception of electronic health records and statewide health informatics efforts. Nevertheless, they continue to "step up to the plate" to improve care delivery. Their success is evidenced in continued payer support and in the selection of Maine for participation in the CMS MAPCP demonstration, as well as other cutting edge initiatives.

Closing

Through the hard work and efforts of Maine providers, patients, policymakers, employers and payers, the Maine PCMH Pilot is making significant progress in improving care for patients in the state. The Pilot has captured the attention of key stakeholders in the state and nationally, and holds great promise for reaching its goals of providing effective, efficient, and accessible health care supported by appropriate payment, and delivering sustainable value to patients, providers, purchasers, and payers. There is much still be accomplished to build on these early investments, but once again, Maine leads!

Core Expectations

Pilot practices are committed to achieving the following Core Expectations:

1. Demonstrated physician leadership for improving care & implementing the PCMH model in the practice
2. Team-based approach to care
3. Population risk stratification and management of patients who are at risk for adverse outcomes
4. Practice-integrated care management
5. Enhanced access to care
6. Behavioral-physical health integration
7. Inclusion of patients & families in implementation of PCMH model
8. Connection to community – connect with local Healthy Maine Partnership and other community resources to help patients meet goals
9. Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services
10. Integration of health information technology (HIT) to support improved communication with and for patients

PARTICIPATING PRACTICES

Practice Name	City
Adult Practices	
Belgrade Regional Health Center	Belgrade
Blue Hill Family Medicine	Blue Hill
Central Maine Family Practice	Topsham
Community Health Center	Southwest Harbor
Dexter Family Practice	Dexter
DFD Russell Medical Center	Leeds
EMMC Center for Family Medicine	Bangor
EMMC Husson Internal Medicine	Bangor
Four Seasons Family Practice	Fairfield
Lifespan Family Healthcare, LLC	Newcastle
Maine Medical Partners Westbrook Internal Medicine	Westbrook
Mid-Maine Internal Medicine North Vassalboro	Vassalboro
Newport Family Practice	Newport
PCHC Helen Hunt Health Center	Old Town
PCHC Penobscot Community Health Center	Bangor
Seaport Family Practice	Belfast
Second Street Family Practice	Auburn
SMMC Prime Care	Biddeford
Wilson Stream Family Practice	Farmington
MMC Family Medicine - Portland	Portland
Swift River Health Care	Rumford
Winthrop Family Practice (MGHA)	Winthrop
Pediatric Practices	
EMMC Husson Peds	Bangor
Maine Medical Partners Westbrook Peds	Westbrook
PCHC - Penobscot Peds	Bangor
Winthrop Pediatric & Adolescent Med	Winthrop

"The Maine PCMH Pilot is the right thing to do for our employees. It's a seed for change throughout the state."

Tom Hopkins, University of Maine

MAINE
Patient Centered
Medical Home Pilot

DHA Connecting You to Health Coverage & Health Quality

Maine Quality Counts
Better Health Care. Better Health.

Maine Health Management Coalition Foundation

www.mainequalitycounts.org