



MAINE
Patient Centered
Medical Home Pilot

**Learning Session 8:
Best Practices for Improving Access
& Coordination of Care**

**Fitting the Pieces Together:
PCMH Pilot, MAPCP, & First STEPS**

February 10, 2012


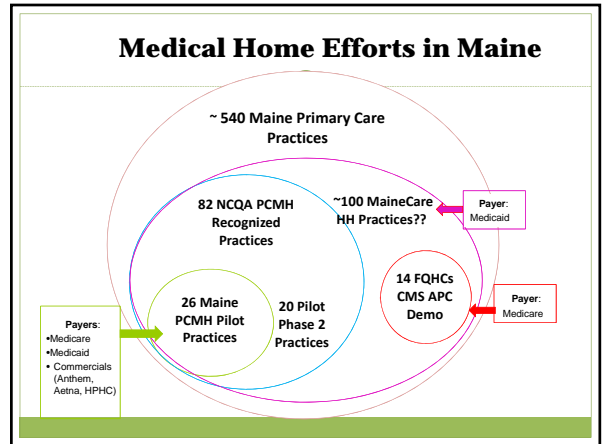
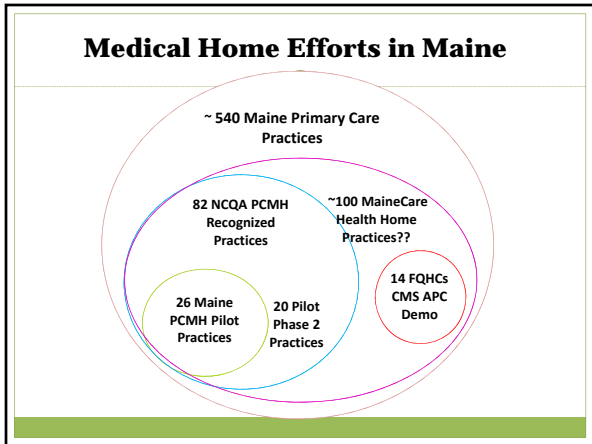
Objectives

- Revisit Learning Session “ground rules”
- Getting grounded – why we’re here
- Putting the pieces together
 - Maine PCMH Pilot, MAPCP Demo, & CCTs
 - First STEPS
 - Coming soon: MaineCare Health Homes initiative
- Revisit PCMH Pilot “Core Expectations”
- Plan for the day

Learning Session Ground Rules

- Be respectful - always
- Limit side conversations
- Keep phone conversations out of meeting room
- Respect confidentiality of conversations
- Encourage everyone to contribute
- Respect all opinions
- Meet someone new!
- Keep patient records confidential (check with staff for space for confidential computer work or calls)

Why We’re Here

Defining Medical Home Model

“A **medical home** is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.”

- American Academy Pediatrics (1964)



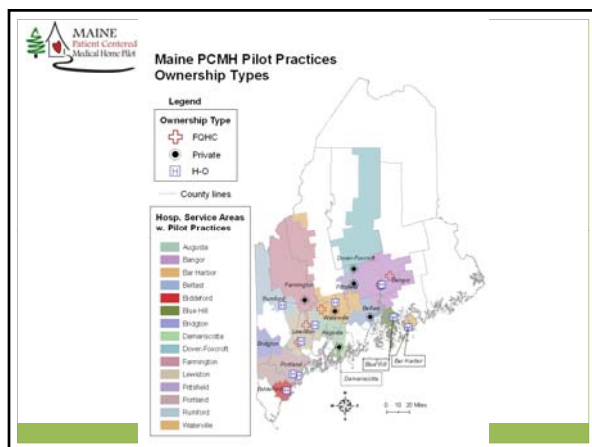
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Maine PCMH Pilot

Key elements:

- Convened by MQF, Maine Quality Counts, MHMC
- Originally, 3-year multi-payer PCMH pilot (now 5 yrs)
- Collaborative effort of key stakeholders, major payers
- Adopted common mission & vision, guiding principles for Maine PCMH model
- Selected 22 adult / 4 Pediatric PCP practices across state
- Supporting practice transformation & shared learnings beyond pilot practices
- Committed to engaging consumers/ patients at all levels
- Conducting rigorous outcomes evaluation (clinical, cost, patient experience of care)



Maine PCMH Pilot Practice “Core Expectations”

1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Enhanced access to care
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community / local HMP
9. Commitment to waste reduction
10. Patient-centered HIT



Maine PCMH Pilot Payment Model

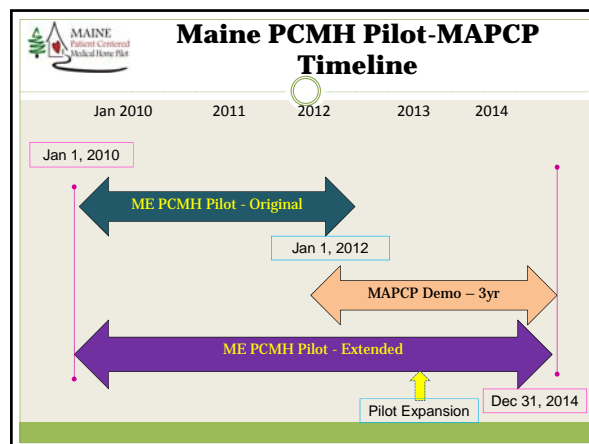
- Major private payers participating: Anthem, Aetna, HPHC, Medicaid & Medicare (MAPCP)
- Using “standard” 3-component payment:
 - Prospective (pmpm) care management payment – approx \$3pmpm commercial & Medicaid; \$7 pmpm Medicare
 - Ongoing FFS payments
 - Performance payment for meeting quality targets (existing P4P programs)

Medicare Med Home Demo (MAPCP)

- CMS Multi-Payer Advanced Primary Care (MAPCP) demo
- Maine selected as one of 8 states to have Medicare participate as payer
- Additional provider payments, for expectation of budget neutrality:
 - \$6.95 pmpm to providers,
 - \$2.95 pmpm for community-based care management
- Maine projections to achieve budget-neutrality
 - 6-7% decreases in inpatient admissions (CVD & Resp)
 - 5-9% decrease in ED visits, specialty consultations

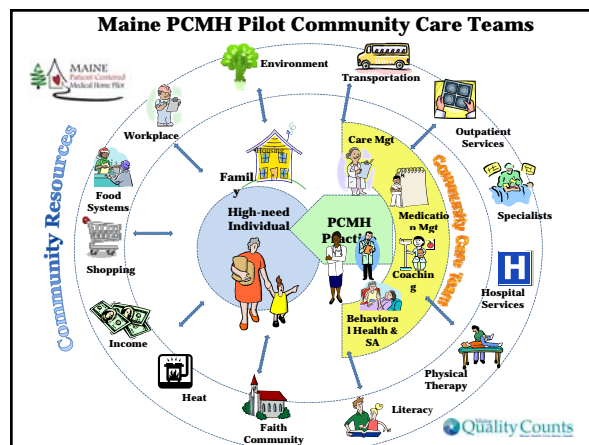
MAPCP – Implications for Maine Practices

- Renewed commitment to PCMH Pilot by multiple stakeholders, extended timeline
- Places stronger focus on reducing waste & avoidable costs – particularly readmissions
- Provides payment for Community Care Teams
- Creates opportunity for 20 additional adult practices to join “Phase 2” of Pilot (Jan 2013)



Community Care Teams

- Multi-disciplinary, community-based, practice-integrated care teams
- Build on successful models (NC, VT, NJ)
- Support patients & practices in Pilot sites, helping patients overcome barriers to care, improve outcomes
- Receive pmpm payments from Medicaid, Medicare, commercial payers
- Key element of cost-reduction strategy, targeting high-cost patients to reduce avoidable costs (avoidable ED use, admissions)



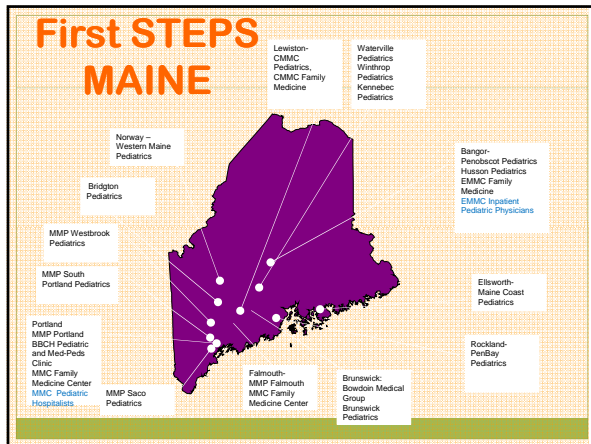
ME PCMH Pilot CCTs

- Androscoggin Home Health
- Coastal Care Team (Blue Hill FP, Community Health Center/MDI, Seaport FP)
- Community Health Partners (Newport FP, Dexter FP)
- DFD Russell
- Eastern Maine Homecare
- Kennebec Valley (MEGenI)
- Maine Medical Center
- Penobscot Community Health Care

First STEPS Learning Initiative

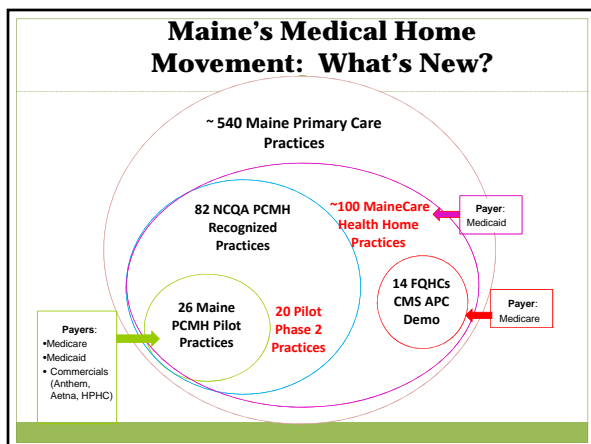
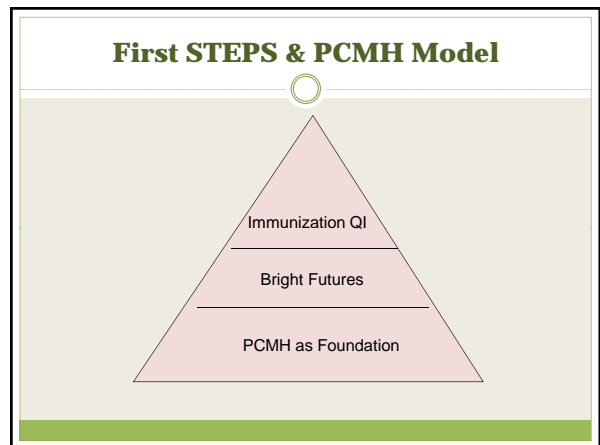
- Funded by federal CHIPRA grant, Maine’s Improving Health Outcomes Children (IHOC) initiative
- First STEPS = 3 year QI effort focused on improving children’s health care & improving preventive health (EPSDT) screenings
 - Phase 1: Childhood immunizations
 - Phase 2: Developmental, autism, and lead screening
 - Phase 3: Healthy weight and oral health
- Promotes use of AAP Bright Futures screening guidelines
- Includes 24 clinical teams (7 in PCMH Pilot!)





- ### First STEPS Practices
- 24 clinical teams
 - 22 outpatient groups
 - 2 inpatient hospitalist groups
 - 96 physicians
 - Collectively provide care to 30,666 children with MaineCare coverage (Aug 2010 numbers)
 - Can participate in 1, 2, or all 3 phases of First STEPS

- ### Initial Focus: Closing Quality Gap for Childhood Immunizations
- Maine is 41st (worst) in nation in immunization rates (Commonwealth Fund, 2010)
 - Need to move from thinking about each patient immunized in practice last week, to managing entire population of patients (PCMH?!)
 - Need to streamline office systems, efficiencies
 - 19/22 First STEP ambulatory practices participate in state ImmPact 2 registry



- ### Pilot Phase 2 Expansion
- 20 new adult practices to be selected for participation in multi-payer Pilot
 - Will enter Pilot (with payment) Jan 2013
 - Expectations:
 - Strong leadership for change
 - NCQA PCMH recognition (Level 1 or higher)
 - Fully implemented EMR
 - Commitment to implement Pilot Core Expectations

CMS Health Homes – ACA Section 2703

- CMS will provide 90/10 match for Health Home services to eligible members for eight quarters
- CMS must approve Medicaid “State Plan Amendment”
- Health Homes may serve individuals with:
 - » Two or more chronic conditions
 - » One chronic condition and who are at risk for another
 - » Serious mental illness
 - Adults with serious & persistent mental illness (SPMI)
 - Children with severe emotional disturbance (SED)
- Must include dual eligible beneficiaries

CMS Health Homes – ACA Section 2703

Chronic conditions include:

- Mental health
- Substance abuse
- Asthma
- Diabetes
- Heart disease
- Overweight (BMI > 25) & Obesity
- Other – to be proposed by state (& approved by CMS)

CMS Health Homes – ACA Section 2703

Required Health Home services include:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings
- Individual and family support
- Referral to community and social support services
- Use of health information technology (HIT)
- Prevention and treatment of mental illness and substance abuse disorders
- Coordination of and access to preventive services, chronic disease management, and long-term care supports

CMS Health Homes – Required Measures

- Core Set – Quality Measures
 - Adult BMI assessment
 - Ambulatory Sensitive Condition admission rate
 - Care transitions record transmitted to PCP (within 24hrs)
 - Follow up after mental health admission
 - All-cause 30 day readmission rate
 - Depression screening & follow up
 - Initiation & engagement of treatment for alcohol/drug dependence
- State-Specific Goals & Measures
 - State must set HH measurable goals (e.g reduce ED visits)
 - Must identify measures to operationalize those goals

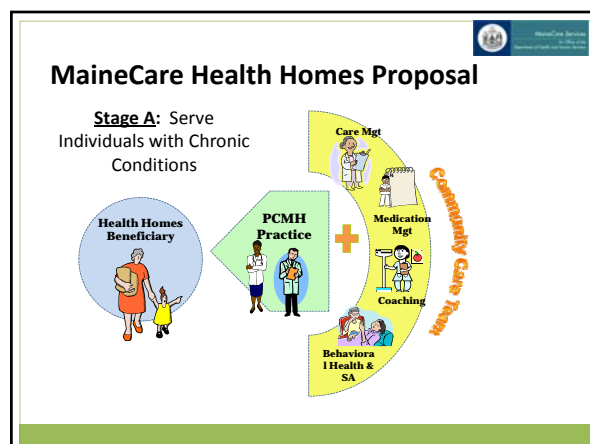
Maine Health Homes Proposal

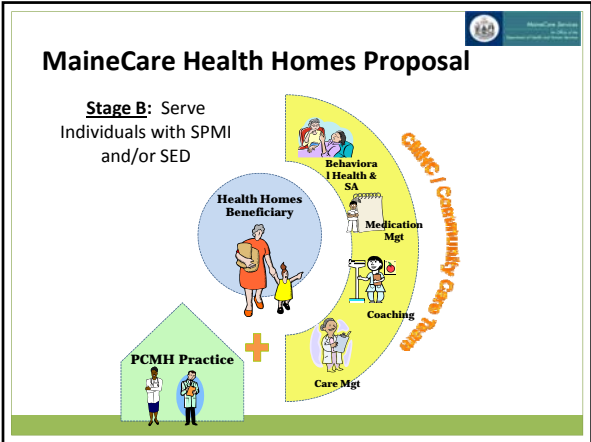
Stage A:

- Health Home = Medical Home primary care practice + CCT
- Payment weighted toward medical home
- Eligible Members:
 - » Two or more chronic conditions
 - » One chronic condition and at risk for another

Stage B:

- Health Homes = Community Mental Health Center (CMHC) CCT + Medical Home primary care practice
- Payment weighted toward CMHC CCT
- Eligible Members:
 - » Adults with Serious and Persistent Mental Illness
 - » Children with Serious Emotional Disturbance





Pilot Expansion & Health Homes Joint Application Process

- Interested practices apply through joint PCMH Pilot/ Health Homes online application
 - http://www.surveymonkey.com/s/ME_PCMH_Pilot_Phase2_Expansion_Applic
 - Due by March 31, 2012
- 20 practices will be selected for multi-payer PCMH Pilot Phase 2 expansion
- All other practices meeting basic qualifications will be eligible to become MaineCare Health Home
- CCTs will be selected through separate application process (May-June 2012)

Pilot Expansion & Health Homes Application

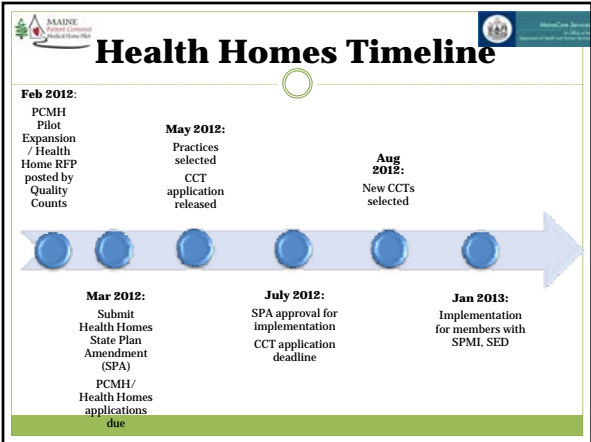
Eligibility – MaineCare Health Homes:

- Pediatric or Adult Primary care practice site with at least one full-time primary care physician or nurse practitioner
- NCQA PCMH recognition (Level 1 or higher) by time of selection (May 31, 2012)
- Fully implemented EMR
- Commitment to meet Maine PCMH 10 Core Expectations
- Commitment to provide CMS-mandated Health Homes services
- Agreement to identify Maine PCMH Pilot Community Care Team (CCT) to partner in managing high-needs patients

Pilot Expansion & Health Homes Application

Eligibility – Maine PCMH Pilot Expansion:

- Practice meets MaineCare Health Home requirements
- Adult primary care practice site with at least one full-time primary care physician or nurse practitioner
- Practice site does **not** currently participate in the CMS FQHC Advanced Primary Care (APC) Demonstration
- Minimum patient panel of 1000+ patients enrolled in Pilot health plans (Anthem BCBS, Aetna, Harvard Pilgrim Health Care, MaineCare, and Medicare)
- Completion of Maine PCMH Pilot Phase 2 Expansion "Memorandum of Agreement" (MOA)



Maine PCMH Pilot Practice "Core Expectations"

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Core Expectation #5: Enhanced Access to Care


- Practice commits to preserving access to their population of patients
- Practice has system in place that ensures patients have same-day access to their healthcare provider using some form of care that meets their needs – e.g.
 - Open-access scheduling for same-day appointments
 - Telephonic support
 - Secure messaging
- Time to 3rd next available appointment is consistently tracked and measured at zero

What Arlene Sees...

Core Expectations

5. Same day access

- When she has a problem, can get access to someone in the practice *that day* if desired
- When she calls for appt, staff asks her, “What would work for *you*?”
- She can get questions answered by phone or email, or can get in for visit if needed—even on weekends
- All members of her team have access to her info through the EMR, which she can also access at home



Pre-LS 8 Survey Results

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Please rate the following in terms of your interest in learning more about these strategies to improve access:

Answer Options	Not Interested at All	Somewhat Interested	Very Interested	Rating Average	Response Count
Balancing demand and supply	2	11	14	2.44	27
Reducing backlog	7	10	9	2.08	26
Simplifying appointment types and time	6	12	7	2.04	25
Reducing demand for unnecessary appointments	2	11	12	2.40	25
Contingency planning	3	12	12	2.33	27
Optimizing the care team	1	7	18	2.65	26
Secure messaging	4	7	15	2.42	26
Nurse/physician phone times	1	9	16	2.58	26
Group visits	2	10	15	2.48	27
Other (please indicate below)	4	0	0	1.00	4
Other (please specify)					2
			answered question		27
			skipped question		0

Share Your Experience & Best Practice Ideas!

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- Balancing supply & demand
- Reducing backlog
- Reducing demand for unnecessary appts
- Alternative strategies – e.g. secure messaging, calls, group visits



Plan for the Day!!

8:00 **Joint Session: Welcome & Introductions**

8:30 **Joint Session: Engaging Patients & Families to Improve Access & Care Coordination** – Jeannie McAllister

9:15 **Split Session:**

- Practice Teams: Improving Access – Catherine Tantau
- CCTs: Best Practices for CCTs – Randy Messier

10:00 **Break**

10:15 **Split Session:**

- PCMH Teams: Improving Access
- First STEPS Teams: Becoming a PCMH
- CCTs: Building your CCT

11:00 **Split Session:**

- PCMH Teams: Improving Access
- First STEPS Teams: Becoming a PCMH
- CCTs: Building your CCT

12:00 **LUNCH & Networking**

1:00-3:00 **Split Sessions:**

- PCMH Teams: Breakouts, Panel, Practice + CCT Breakout
- First STEPS Teams: Group Check-in, Breakouts, Parent Partner track
- CCTs: Risk Stratification, Tips & Tools, Practice + CCT Breakout

3:45 **Recap & Wrap-Up**

3:30 **Adjourn**

www.mainequalitycounts.org



The screenshot shows the website interface with a navigation bar, a main content area titled 'Patient Centered Medical Home', and a sidebar with 'PCMH Labs'. The main content area features a 'PCMH Learning Session 6: The Medical Home Run' announcement.



Contact Info / Questions

- Maine PCMH Pilot: www.mainequalitycounts.org
 (See "Major Programs" → "PCMH Pilot")
 - Lisa Letourneau MD, MPH: LLetourneau.lisa@mainequalitycounts.org
- PCMH: Nancy Grenier: ngrenier@mainequalitycounts.org
- CCTs: Helena Peterson: hpeterson@mainequalitycounts.org
- MaineCare Health Homes
 - Michelle Probert: michelle.probert@maine.gov
- First STEPS Learning Initiative:
 - Amy Belisle MD: belisleamy@gmail.com
 - Sue Butts Dion: sbutts@maine.rr.com