“I am proud that MaineCare has been working in partnership with other payers to advance payment reform through greater investment in primary care to both improve outcomes for patients and reduce preventable high cost spending in emergency departments and avoidable inpatient admissions.”

–Mary C. Mayhew, Commissioner, Maine Department of Health & Human Services
After having a stroke and two heart surgeries, Wesley found daily life overwhelming. Managing 30 medications was just one of many demands that persistent memory problems kept him from meeting. When home care ended, he was left on his own to manage his complex health regimen.

Wesley needed support beyond what traditional medical care could provide. Enter the Maine Patient Centered Medical Home (PCMH) Pilot. The Pilot provides technical support and training to primary care practices and Community Care Teams that collectively serve over 600,000 privately insured, MaineCare (Medicaid), and Medicare patients statewide. In addition, the Pilot works in concert with MaineCare’s Health Homes (HH) initiative, which has built off the Pilot’s foundation. The HH initiative works with the PCMH practices plus 100 other primary care practices. The MaineCare HH initiative asks HH practices to provide intensive support and work with patients to improve chronic care and reduce health risks. The overarching goal of both the PCMH Pilot and HH initiative is to help patients regain health and stay healthy by supporting primary care physicians and practice teams to change how they deliver care, while also changing the way they are paid.

For Wesley, the Pilot became the beginning of a turnaround. He got connected to one of the Community Care Teams (CCTs), Androscoggin Home Care and Hospice (AHCH), a PCMH innovation that organizes nurses, health educators, social workers and care managers into a home-visiting team that addresses a wide range of barriers to good health. Led by CCT Manager Angela Richards, RN, team members visited Wesley’s home and helped him organize his medications – discovering a dosing error in the process. They enrolled him in a cardiac rehabilitation program, helped him plan meals and grocery shopping, and to develop strategies for managing his memory loss. They also installed an in-home blood pressure monitor that transmits data to Wesley’s care team every day.

“ If it wasn’t for them, who knows where I’d be? ”

–Wesley, patient of Androscoggin Home Care & Hospice CCT

Wesley’s is one of many patient stories that show the value that the Maine PCMH Pilot has brought to individuals and communities in Maine. Medical providers have also found the model empowering, allowing them to “focus on the patient, not the paperwork”, as one health educator described it. Patients and medical providers have used the Maine PCMH Pilot to find new ways to work together as a team, use data and technology, and connect people to resources and supports. Their stories highlight the various ways that the Pilot has helped pave new paths to better health care and better health.
The Maine Patient Centered Medical Home (PCMH) Pilot encourages maximizing the talents of every member of the care team—not only physicians and other providers, but also medical assistants, health educators, nurses, and front-office staff. In the patient-centered model, care is not limited to the doctor-patient visit; rather, it involves a multi-disciplinary professional team that proactively plans and coordinates care. The Pilot offers team-building education and supports primary care practices in expanding care management services. Using this approach, practices have new ways to apply their existing resources in addition to sometimes being able to hire new staff.

The team-based approach gives Stephanie Calkins, MD of the MaineGeneral Four Seasons Family Practice, more support for complex patients. She describes one patient with paranoid schizophrenia and diabetes who may soon need to be on dialysis. The prospect of kidney dialysis was frightening for the patient and challenging for the care team. The patient had only one place in the community where she felt comfortable meeting with people—a peer social club for mentally-ill people.

Dr. Calkins and the staff nurses had the flexibility to meet the patient at the peer social club where they discussed her needs and learned what would work best for her. They found programs and people to help her manage her new treatment. Success will entail not only arranging a ride to the dialysis center, but also close contact with the care team on side effects and social support when treatment feels overwhelming.

Another practice, Penobscot Community Health Center (PCHC), uses the PCMH Pilot to strengthen its team-based approach. Theresa Knowles, the PCHC Director of Quality, found that the biggest change in moving to the PCMH model was expanding the care team to include care-manager nurses, social workers, the Community Care Team (CCT), mental-health providers, pharmacists, and community programs. PCHC now has in-house pharmacy consultation, and student pharmacists can conduct home visits.

“The idea of bringing more people onto the team came from the PCMH model.” – Theresa Knowles, FNP-C Director of Quality, Penobscot Center for Health Care

The PCHC team approach has also encouraged team members to learn from each other. Knowles describes using data to “light the way” for tracking blood pressure and glucose monitoring. One staffer had 69 percent of his diabetic patients within a healthy blood-pressure range. Knowles gave him a real-time action plan and pointed him to a peer whose percentage was in the target range. The provider improved to having more than 80 percent of his diabetic patients within the target blood-pressure range. This is a good example of leveraging everyone’s knowledge to help improve the entire team’s performance.

Watch Dr. Calkins’ video for more
Stephanie - Patient Centered Medical Home - You...
The Maine Patient Centered Medical Home (PCMH) Pilot focuses on improving patient access to primary care provider teams and the ability of practices to respond quickly to the needs of patients and families. From answering a patient’s phone call to checking in at the front desk and following up on test results, PCMH practices have found new ways to listen to patients and families.

Willard has three chronic conditions—diabetes, high blood pressure, and high cholesterol—and he had previously suffered a stroke. When he arrived at the Dexter Family Practice, practice manager Margaret Towle learned that “He just wanted to be heard. With him and many others, listening to each patient’s needs and their particular lifestyle and concerns can make all of the difference.”

After listening to Willard’s concerns and needs, Margaret and her staff created a unique care plan that shows the creative, responsive and flexible nature of practices in the PCMH Pilot. Since making a series of changes as part of its participation in the Pilot, Dexter Family Practice starts Willard’s visits with light exercise—a walk that has increased over time from 5 to 30 minutes. He also receives diabetes education tailored to meet his ability to read and understand the information. In addition, Health Educator Lauren Gaudet has helped him budget for groceries and invited him to help cultivate vegetables in a new garden started by the practice. At harvest time, Willard was able to bring home the vegetables as a well-earned nutritional boost.

Under the Pilot, Dexter Family Practice also works with the Community Health Partners CCT and now uses home visits as another avenue to expanding access for patients and helping the practice better understand the day-to-day circumstances of patients.

Tina Charest, RN, Nurse Care Manager for the Androscoggin CCT credits the Pilot with helping her use home visits to work more effectively with patients. Tina notes that one Androscoggin CCT patient with asthma telephoned his primary care practice nearly every day and visited the emergency department once or twice each month—complaining of shortness of breath despite being on asthma medications. The hospital treated his respiratory problems and gave him instructions on using his inhaler. Still, his problems persisted. A CCT home visit, made possible through the PCMH Pilot, revealed he was not taking his medications for anxiety, a contributing factor for shortness of breath. With help from his CCT nurse, the patient was able to properly use his anxiety medications and his asthma inhaler, and he dramatically reduced his visits to the emergency department.

“We probably would not have learned why he was doing what he was doing without going into his home,” Tina said.

“I really like coming here because they treat me like family.”

—Willard, patient of Dexter Family Practice
More than Medical Care

The Maine PCMH Pilot has helped primary care providers address the many obstacles that stand between their patients and better health. Obstacles can take many forms such as traveling to the hospital, deciphering paperwork, and fall-proofing the living room. For many patients, health success requires more than medical care.

Tina C’s story is a great example of how PCMH teams address the whole person. Struggling with depression, Tina found the paperwork related to her health care and insurance coverage overwhelming. She could not afford the anti-depressant medications prescribed by her doctor at the Central Maine Medical Center (CMMC) Family Medicine Residency Practice. The practice team helped her apply for discounted drugs from the drug manufacturer and seek programs that would address other needs.

Tina is on a first-name basis with everyone on the team at her practice, and she said that seeing familiar faces each week eases her depression. She relies upon the practice for mental and physical health services, using the on-site psychologist, laboratory, and medical staff. For any services she cannot access there, the staff arranges for assistance from other resources and tracks her every step of the way.

In some cases, caring for the patient is only part of the work. Caring for the patient’s spouse or child may be another important part, and PCMH teams recognize that family members who are caregivers may need support and care themselves.

While his wife was receiving cancer treatments an hour’s drive away, Robert struggled to pay for gas so he could be by her side. Dexter Family Practice helped Robert travel to the hospital many times, giving him rides and gasoline cards. This helped both Robert and his wife; having family near can lower stress and promote healing.

Following a treatment plan is difficult when other life fundamentals are not stable. Renee Westman of DFD Russell Medical Center describes one patient who was not taking his medicines. Upon talking with the patient, she learned that his home was in foreclosure, and he had not reached out to his adult children for help. He was a frequent visitor to the emergency room and hospital as well as specialists for lung disease. The patient reconnected with his adult daughter, who was able to coordinate his primary and specialist care. Renee informed the local emergency room about his medications so that everywhere he went, he received the same message about taking his medicines. All of these supports together made the difference for the patient.

What I like is that I can get most of my services right there.

—Tina C., patient of Central Maine Medical Center Family Medicine

ACCESS: % OF PATIENTS WHO ALWAYS GOT AN APPOINTMENT AS SOON AS NEEDED

- Dexter Family Practice improved their responsiveness to patients’ immediate care needs. This is an important part of overall enhanced access.
Making Sure it Works

Referring a patient for specialist care or recommending diet or lifestyle changes are everyday events for many primary care practices. What makes practices in the PCMH Pilot different is their commitment to provide follow-through support, ensuring patients can succeed in navigating an often-complicated health care system.

Joe’s success story as a patient with heart disease and diabetes includes a specialist that is a six-hour drive away, a primary care practice, and a persistent-care manager. After heart by-pass surgery, his hemoglobin A1c level, a measure of his diabetes control, hovered at a dangerously high level of 12. With help from his PCMH team at Fort Fairfield Health Center and special attention from the practice nurse care manager, he made some important lifestyle changes, including eating better and being more active. He has since brought his diabetes control numbers down to healthy levels. He chuckles as he describes his care manager at Fort Fairfield Health Center as a “great support.” Knowing he will see her each month inspires him to eat better, watch his numbers, and follow his plan.

Joe likes having his PCMH practice keep track of his care, coordinating with the distant specialist, and providing his post-operative care. Knowing that his PCMH team understands him and his health is both a time saver and a relief.

Wesley, a patient in the care of the Androscoggin CCT, received not only a referral to a cardiac rehabilitation program, but also ongoing support and encouragement to keep going through the ups and downs of his health care. Like many heart patients, Wesley suffered depression, which was identified early in his care. Traveling to cardiac rehab and using the treadmill are much more difficult with depression weighing a person down. Having someone identify the problem and offering resources for treatment made it easier for him to treat the depression. While he continues to face many health challenges, celebrating and strengthening what he can do is an important focus for his care.

“When you are really sick, it means a lot to have somebody help you.”

–Wesley, patient of Androscoggin CCT

Listening is the first step. Responding is the next, and with the Maine PCMH Pilot, the whole team is able to respond in new, innovative and effective ways.

CARE QUALITY IMPROVEMENTS: PATIENTS WITH DIABETES

PCMH Pilot practices had more diabetes patients receiving recommended care and achieving treatment goals, such as having blood glucose lower than 8%.

[Bar chart showing improvements in various diabetes control metrics comparing 2008 and 2012 data.]
Primary care practices in the Maine Patient Centered Medical Home (PCMH) Pilot are developing new and increasingly-sophisticated technology tools such as electronic health records to identify higher-risk patients and to work with them to reduce the risk, follow treatment plans, and improve their overall health.

Using Pilot resources, Dexter Family Practice used a new assessment tool to identify patients who had a high risk for falls. Lauren Gaudet, Health Educator, then followed up with high-risk patients—conducting home visits that allowed her to see patient stairwells, walkways, rugs, and other fall hazards. She then offered guidance for removing any hazards.

Mary McDonough, RN and one of the PCMH leaders at Maine Medical Partners Portland Family Medicine, credits “data mining” of the practice’s electronic health records with helping to find patients who were having frequent hospital stays. The practice could then work with these patients to help them better understand their treatment and prevent repeat hospitalizations.

Practices have also used technology to forge a closer connection to the patient. Telehealth monitoring devices, for example, can keep both patients and providers informed. The Androscoggin CCT has used telehealth devices for patients with high blood pressure and diabetes. Chuck Smith, MSW, a social worker on the Androscoggin CCT, describes one patient with uncontrolled high blood pressure, poorly managed diabetes, and a heart condition.

The patient had visited the emergency department six times in six months. The Androscoggin CCT provided the patient with a remote glucose monitor that helped her and her team watch her blood sugar numbers daily. During home visits, the CCT team brought diabetes education to the patient in her home and helped her modify her diet. They also brought her on a “guided tour” of the grocery store to better understand how to eat healthy foods on a budget she could afford. The patient now has her health conditions under control, and rather than spending her time in the emergency department, she volunteers in her community.

By using technology, PCMH Pilot practices and CCTs are identifying patients who need support and offering them the support they need to stay healthy.

“Working at a PCMH, I feel much more appreciated because I get to know the patients. There are still time constraints, but those are a little more flexible because I’m learning what the patient truly needs.”

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By using technology, PCMH Pilot practices and CCTs are identifying patients who need support and offering them the support they need to stay healthy.
While the close ties between mental and physical health are now widely recognized, our current health care system doesn’t always help patients make the needed links. Physical illness can cause mental changes, and mental health issues can cause pain and other physical symptoms.

After his wife was diagnosed with late-stage cancer, Robert was overwhelmed with all of the information coming in from different specialists. Dexter Family Practice, a Maine Patient Centered Medical Home (PCMH) Pilot practice, helped Robert with the physical and mental health challenges that both he and his wife faced. They helped him understand his wife’s condition, identify early signs of infection, administer medication, and cope with being a full-time caregiver.

Robert considers his wife lucky to receive home visits since traveling is difficult. Having the provider visit the home also brings the staff closer to the day-to-day challenges and has given Robert much needed support as a round-the-clock caregiver. It was during a home visit that Robert learned infections affected his wife’s emotions and behavior. With all of his energy and focus on the immediate needs, he did not know that the emotional changes were a treatable side effect of her illness.

The Maine PCMH Pilot has helped practices better integrate behavioral and physical health services for their patients and family members. Several Pilot practices have now brought counselors and other behavioral health providers into the practice. The practices also now offer on-site behavioral health services that can help their patients overcome emotional, social, or physical barriers to receiving care for mental health or substance abuse issues. Through its work in the PCMH Pilot, the Fort Fairfield Health Center, which is located within a designated mental health professional shortage area, now has mental health services on site.

With support from the Pilot, some practices have started offering access to behavioral health services using telemedicine services. The DFD Russell Medical Center now offers “tele-psychiatry” services, connecting patients to psychiatrists using a remote video connection and offering their patients a connection to a service that can otherwise be very difficult to access in the rural areas that the medical center serves.

“If she were treated in Boston, she’d be a name on a piece of paper. There’s been a lot of help from the practice to keep our spirits up. They want to reach out and help.”

—Robert, patient family member, Dexter Family Practice

Watch Robert’s video for more
Getting to the Root Cause

Mental health issues may be the root cause or the side effect of a physical illness. With specialties more closely coordinated, providers can more effectively help their patients.

At Maine Medical Partners Portland Family Medicine, a Licensed Clinical Social Worker leads the team that works with patients who have frequent hospital stays. Mary McDonough, RN and Operations Administrator for the practice said the team found that a social worker is an effective coach for patients as well as an excellent connection to the primary care provider and other PCMH team members.

Having a social worker on the team encourages patients to talk about more than their medical issues and discuss other factors that may cause the need for hospital care.

I’ve seen patients come in for medical care and end up getting better with mental health services. And I’ve seen the opposite—people come in to work on mental health issues and transfer to medical issues.”

—Renee Westman, Care Manager, DFD Russell Medical Center

Renee Westman, Care Manager at DFD Russell Medical Center, describes a heart patient who became so anxious after leaving the hospital that she was not able to sleep. The lack of sleep complicated her recovery from surgery and harmed her overall health. Using DFD onsite behavioral health services, the patient eased her anxiety and paved the way for her successful cardiac rehabilitation.
Improving Access

A closer tie between behavioral and physical health providers makes it easier for patients to receive care. Patients may feel less stigmatized about receiving services when the services are readily available within their primary care office.

The Fort Fairfield Health Center has a mental-health professional on site one day per week. Though the nearest social worker was only a 20-minute drive away, providing the service on site has led to more patients receiving care according to Mary Coffin, FNP at the Center. In turn, this has helped many patients achieve their physical health goals.

Onsite behavioral health services offer many advantages that Pilot practices explored. For example, Martin’s Point Health Care, in partnership with Spurwink, located a social worker inside its primary care practice. When a teenage patient needed help with her fear of needles, the social worker could collaborate directly with the medical staff on strategies. The teen patient could also practice relaxation techniques in the very setting where she would receive her vaccinations and blood work. The behavioral health support enabled the patient to get the preventive and diagnostic services she needed.

Ali Varga, RN, a Population Health Nurse for Martin’s Point, said, “It’s phenomenal having behavioral health service onsite because right when the patient is dealing with an issue, the resource is there for them.”

Improving access to mental health services has another indirect benefit—reducing overall demand for emergency and inpatient services. One out of every eight emergency department visits nationwide involves a mental health or substance-abuse condition. These visits are two and a half times more likely to lead to an inpatient stay compared to visits that have no mental illness cited.*

With support from the Pilot, PCMH practices can integrate different types of care, providers, and services into a single, unified, patient-centered model of care.

“A diabetic patient will eat better, do his exercises, and take his meds when he is not depressed. That makes a big difference.”

Mary Coffin, FNP Fort Fairfield Health Center

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**REDUCING EMERGENCY DEPARTMENT VISITS AND HOSPITALIZATIONS**

<table>
<thead>
<tr>
<th>ED Visits</th>
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▶ EMHS’s CCT patients had a 76% reduction in ED visits in the 12 months post intervention compared to the 12 months before the intervention. Hospital admissions had an 86% reduction.

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*Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007; HCUP Statistical Brief #92
Health happens through many different connections working together—patients, families, physicians, nurses, churches, and community programs. In striving to help the whole patient, Patient Centered Medical Home (PCMH) practices and Community Care Teams (CCT) forge new connections and create new ways to bring health.

When Don was diagnosed with lung disease, his daughter Tina was soon overwhelmed with the demands of his care—from hospital stays to specialist consults to home care. DFD Russell Medical Center helped her coordinate his care, find an assisted living facility, and later on a hospice service. The medical center also helped her understand his condition and care needs. Renee Westman, DFD Russell Care Manager, was “my sanity” Tina said, helping persuade her father to follow his treatment plan.

“When he was in the hospital, he wouldn’t do what the doctors said or what the nurses needed him to do,” said Tina. “I’d call Renee, and Renee would get on the phone with him and say, ‘Don, it’s time for you to just listen—if you want to go home again. This is just what you need to do.’ Then he would agree to do what Renee said.”

The needed connections are unique to each patient. For example, a single mother who was a patient receiving care from the Androscoggin CCT could not afford heat for her home. Chuck Smith, MSW, CCT social worker, knew another patient who was chopping wood as part of his cardiac rehabilitation. He recruited a local church to pick up the wood and deliver it to the single mother’s home.

The Maine PCMH Pilot has opened up many possibilities for making new connections and creating new ways for supporting patient health. Pilot practices and CCT teams have found many different ways to make these connections and improve patients’ well-being.

“Watch Tina’s video for more”

“"The staff here was able to help me figure out the unknowns, so they became knowns. So it was less scary when my dad passed away.””

-Tina, daughter of DFD Russell Medical Center patient
efficiency

The ultimate goal of the Maine Patient Centered Medical Home (PCMH) Pilot is to improve care and outcomes by supporting the ability of patients to live well and make the best use of their medical care. This means avoiding emergency care and hospital stays when possible, and sometimes reducing the need for medications.

Rita is a patient at the MaineGeneral Four Seasons Family Practice who struggles with diverticulitis and chronic hip pain. With changes made by participating in the Pilot, the practice helped Rita work on her diet, get physical therapy, and start a regular exercise program. She now sees her care manager monthly to stay on track with her diet and exercise, and she visits the gym three times each week. As a result, she has not had a hospital stay in over two years and has reduced her need for pain medications.

PCMH Pilot practices have taken different approaches to making health care more efficient, using the strength of a team approach and using technology to its best advantage. Many have used health data to find patients who needed more help.

Robyn Beaulieu, RN at the MaineGeneral Four Seasons Family Practice watches the emergency room visit report to find members who could benefit from Community Care Team support. Ali Varga, RN Population Health Nurse for Martin’s Point Health Care, uses data tools to find patients who have gaps in their care, such as missed tests. Monique Crawford, Director of Clinical Quality at DFD Russell Medical Center, uses a referral tracking system to make sure patients get the care they need. The practice can then help patients who do not follow through on these appointments because they could not afford the appointment or faced other barriers. These pro-active steps by each PCMH reduce the need for hospital and emergency care.

“I was walking with a walker and also with a cane. I made up my mind even though I was 80 years old, I didn’t want the cane. So here I am without a cane.”

—Rita, patient, MaineGeneral Four Seasons Family Practice

Watch Rita’s video for more
As part of their work in the Pilot, many Patient Centered Medical Home (PCMH) practices and Community Care Teams (CCTs) now use HealthInfoNet (HIN), an innovative service in Maine that lets providers access health care data when patients are seen in different settings. The Eastern Maine Home Care (EMHC) CCT uses HIN to respond to patient needs as soon as possible.

Using HIN data services, members of the EMHC CCT team now know in real time when one of their patients visits the hospital or emergency room. One CCT patient visited the emergency room 56 times in a single year, and efforts to redirect her to other services had previously been unsuccessful. One day, Jaime Boyington, the EMHC CCT Coordinator, was notified through the HIN report that this patient had just been admitted for another emergency. She asked the CCT social worker to go to the hospital immediately to talk to the patient. The social worker talked with the patient during the long wait in the emergency department, and at the end of the visit, the social worker said, “I’m wondering if there is something else you would rather be doing than sitting in the hospital emergency room.”

The patient accepted this invitation and began working with the CCT to improve her life skills as well as her mental and physical health care. By working with her PCMH practice and the CCT, the patient visited the emergency room only nine times over the next 12 months—an 80 percent reduction from the previous year.

New and better data tools have helped Pilot practices and CCTs stay better informed about their patients and their overall performance. Penobscot Community Health Center (PCHC), for example, reports core measures for each of its practice sites and chooses three as focal points. The data showed room for improvement on Hba1C testing and results reporting.

Theresa Knowles, an FNP and PCHC’s Director of Quality, oversaw implementing point-of-care testing so she could monitor the improvement. Similarly, PCHC improved its workflow for smoking-cessation support based upon the data analysis. By identifying a point person and enlisting Medical Assistants, PCHC was able to offer smoking cessation to more patients.
Streamlining Discharges

Hospital discharge brings a deluge of information for providers and patients alike. Several PCMH Pilot practices have developed programs and supports for patients who have had hospital stays.

Pilot practices at Martin’s Point Health Care have created a system for generating a list of patients admitted to local hospitals each day to immediately start tracking patients and anticipating their needs after hospital discharge. The practice now calls patients within 1-2 days after they are discharged to review medications and the care plan—often finding issues poorly understood by patients in the busy rush of discharge from the hospital.

Mary McDonough, RN at Portland Family Medicine said some patients were reluctant at first to participate in a group visit. But once they experienced it themselves, they usually found the group visit very useful and helpful.

Improving health care is about improving efficiency by making the best use of all available resources—people, technology, and health care services. The Maine PCMH Pilot has helped both patients and practice teams find new ways to improve care and achieve greater efficiency.

"Physicians here find this valuable because the doctor doesn’t have time to do what the team does."

—Barbara McDonough, RN, Maine Medical Partners Operations Administrator, Portland Family Medicine

HOSPITAL READMISSION RATE

- Martin’s Point strives to reduce hospital readmissions by streamlining discharges, and supporting patients who have recently been discharged. Data reflects a portion of Martin’s Point’s patient panel covered by its parent company’s insurance program.

<table>
<thead>
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<th>% of Admissions</th>
<th>2013 Q1</th>
<th>Q2</th>
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—Ali Varga, RN, Population Health Nurse for Martin’s Point

Physicians here find this valuable because the doctor doesn’t have time to do what the team does."
Each Patient Centered Medical Home (PCMH) practice and Community Care Team (CCT) has used the Pilot in its own way to achieve many different things:

- Work together as a team in new ways: The Pilot has helped each PCMH transform its approach to teamwork within the practice, bringing everyone’s expertise to bear and enabling the practice to provide more to patients.

- Increase the range of supports offered to patients: These include expanded care management, longer office hours, and home visits.

- Apply technology to improve provider performance and to find high-risk patients: Technology helps each PCMH target quality-improvement efforts towards the staff and to patients who will benefit the most.

- Integrate mental and physical health services: The holistic approach helps patients overcome barriers to receiving mental health care and helps them succeed at following treatment plans.

In subtle and marked ways, the project has changed how providers interact with one another and with patients. The Pilot has also given providers new ways and new tools in their work with patients.

The ultimate goal of the various activities is to decrease the need for medical care, especially hospital and emergency care, by increasing patient health. From the stories we heard from providers and patients, the Maine Patient Centered Medical Home Pilot is succeeding.

The Pilot represents a significant first step toward an entirely new kind of health care, and the Pilot’s success will be demonstrated by each patient achieving his or her own unique state of well-being. The ultimate goal is a healthy, productive life with as little time spent on medical care as possible.

The Pilot plans to write more success stories like Wesley’s. He has finished two rounds of cardiac rehabilitation and now has the supports and the resources to manage daily needs. His next health goal? To spend more time fishing!

““This model is the way medical care should be.””

–Renee Westman, Care Manager, DFD Russell Medical Center

This model is the way medical care should be.
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Tina Charest, RN, Nurse Care Manager, Androscoggin Home Care and Hospice

Patients: Joe, Larry, Rita, Robert, Tina, Wesley and Willard

Report Limitations: The data summarized in graphs were not independently verified or validated. The exception is the Diabetes Quality Measures data, which were developed by the Pilot evaluator, the Muskie School of Public Service.
I'm proud to be part of empowering patients.

–Tina Charest, Nurse Care Manager, Androscoggin Home Care and Hospice