Year ONE
INTRODUCTION

Dr. John Yindra prepared to see his next patient, who was referred to him because of a leg infection. He saw that she had diabetes, but he didn’t have any other information because her records had not yet arrived. He called the hospital that referred her, but could not get through, and ran out of time because the patient had arrived.

The infection was diabetes-related, so when the patient arrived, Dr. Yindra asked if she was keeping up with her diabetes medication. “Sometimes,” she said quietly. He reviewed the medications with her, and referred her to a diabetes educator at the hospital who would show her how to measure her blood sugar and manage the diabetes. He also referred her to a counselor for depression. He wasn’t confident she would make these appointments, but he had neither the skills nor the time to help her with these things himself.

Primary Care in Trouble
Good primary care can improve health outcomes and lower health care costs. It increases the likelihood that patients will get standard preventive care and manage their chronic diseases. At its best, primary care is a lynchpin that coordinates all of a patient’s health care.

But as the above story shows, primary care is in trouble in Maine and across the United States. On average, patients receive about 55% of the chronic, acute, and preventive health care recommended by current guidelines. Primary care doctors face overwhelming workloads and lower pay than their specialist colleagues, and do not have the time to address a patient’s varied needs. With lower pay, long hours and slow salary growth, primary care appeals to fewer doctors in training. This hits rural states like Maine particularly hard, as they have always struggled to attract enough doctors to the state in general, and remote areas in particular.

Why a Patient-Centered Medical Home Model?
There has never been a better time to introduce a patient-centered medical home (PCMH) model in Maine. A “medical home” is not a building or place, but a team of health professionals who work together to provide a central point for coordinating care to help people become as healthy as possible. A new model for primary care is desperately needed, and PCMH offers an exciting option because it makes changes needed both to the way we deliver and the way we pay for primary care. A PCMH model is more possible than it’s ever been before, as information technology tools like electronic medical records can make care coordination a reality.

PCMH – A National Movement
In March 2007, four national physician membership organizations came together to support the PCMH model and released the “Joint Principles of the Patient-Centered Medical Home.” These organizations represent more than 333,000 pediatricians, family physicians, internists and osteopathic physicians from across the country (American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association).

The Joint Principles endorsed by these groups highlight 7 key characteristics of the PCMH model: (1) relationship with a personal 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. The resulting “PCMH model” of care has been widely promoted by employers, health plans, payers (including Medicaid and Medicare), healthcare professionals, quality improvement organizations, and others as a way to improve outcomes, increase quality, and lower costs in our healthcare system. Since this national endorsement, more than 20 states across the country have launched PCMH pilots to test the model with groups of willing doctors and payers.

Maine’s Response
In the fall of 2007, the Maine Legislature convened the Commission to Study Primary Care Practice to examine the issues facing primary care and ways to stabilize and support it. In the 2008-2009 State Health Plan, the Governor’s Office for Health Policy and Finance identified the need to promote primary care as the foundation for our state’s health system. Both recommended a key strategy for making primary care viable in Maine: a patient-centered medical home (PCMH) Pilot in Maine.
ABOUT THE PILOT

The Maine PCMH Pilot
Supported by these recommendations and the interest of key payers and employer groups, several organizations came together to develop a Maine Patient Centered Medical Home Pilot. The Dirigo Health Agency’s Maine Quality Forum, Quality Counts, and the Maine Health Management Coalition convened stakeholders from across the state to guide the effort and ensure all voices were represented. They formed the PCMH Working Group, which includes consumers, providers, employers, payers, public health, and state government representatives who work through a process of consensus to guide the Pilot.

PCMH Mission and Vision
The vision of Maine’s 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. The mission of the PCMH Pilot is to develop and implement a patient-centered delivery system and payment model that will support this vision.

Guiding Principles
Maine’s PCMH Working Group has adopted the national PCMH principles for its own PCMH Pilot, with a few adaptations. First, the Maine PCMH Pilot will be more inclusive in its vision of practice staffing and leadership, recognizing the importance of the entire practice team including nurse practitioners, physician assistants, office managers, and support staff. Second, while the original principles focus on medical care integration, the Maine PCMH Pilot will work to bring public health and behavioral health together with medical care. Finally, while the Principles recognize the need for PCMH practices to be fairly paid for all services they provide to patients, Maine PCMH acknowledges that practices must also do their part to ensure that they are as cost-effective as possible.

HIGHLIGHTS FROM 2009

Identifying Practices
Primary care practices around the state were invited to apply for participation in the Pilot in January 2009, and over 50 primary care practices from around the state responded -- 10% of the primary care community in Maine. Practices completed an online
application to describe their practice structure, demographics, and how many PCMH elements were already in place. Applicants also completed an online “Medical Home IQ” self-assessment that predicted whether they could reach national recognition as a medical home, a designation that requires them to reach Level 1 or higher on the National Committee for Quality Assurance (NCQA) Patient Physician Connection-Patient Centered Medical Home Recognition Program.

The PCMH Working Group Selection Subcommittee, made up of providers, consumers, payers, and employers, evaluated practices on these criteria: demonstrated commitment to the principles of the PCMH model; diversity of practice size, location, and ownership; ability to use existing improvement opportunities across the state; and commitment to teaching. They selected a diverse group of 22 adult and 4 pediatric practices from across the state for participation in the three-year Pilot.

Helping Pilot Practices Transform Care

In addition to committing to achieving national medical home recognition, all Pilot practices have committed to making a specific set of 10 changes (or “Core Expectations”) that patients and other experts have identified as critical to delivering more patient-centered care. The box lists these 10 Core Expectations.

It will be challenging to make these changes, so the PCMH Pilot offers practices support to help them transform to a patient-centered model. Leadership teams from each of the Pilot practices participate in a PCMH “Learning Collaborative,” where they meet with each other and national experts every few months to learn about best practices and share experiences. Practice teams also receive technical assistance and one-on-one coaching for quality improvement from a network of external coaches supported by the Pilot.
Changing Payment

Payers are another important stakeholder group in the journey towards more patient-centered care. Current fee-for-service payment for primary care pays mostly for office visits and tests. It does not pay for many 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 Joint Principles recognize that payment for primary care must change to reflect the added value of this model.

In recognition of that need to change payment, most of the major health insurance payers in Maine have agreed to pay the Pilot practices differently, including MaineCare, Anthem BCBS, Aetna, and Harvard Pilgrim Health Care. CIGNA is not participating as a payer in the Maine PCMH Pilot, although they are working with other provider groups in the state at the request of several large employers to conduct primary care payment reform demonstrations that are modeled on the patient centered medical home concept. The payers participating in the Maine PCMH Pilot have 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 that recognizes excellent performance by the practice, whenever possible. Payers are using the NCQA recognition program as the standard for making PCMH payments to the participating practices.

The payers have also worked with employers and providers in the Pilot to identify standards for measuring the success of the Pilot, including differences in patient experience of care, improvements in clinical quality outcomes, and changes in costs and use of health care resources.

Working with Consumers

Working with consumers (patients) to improve care is the third important area of work in the Pilot. Patient feedback is a part of this effort that will also include consumers and their families in the design, implementation, and evaluation of the Pilot. Maine is unique in this way; few other PCMH pilots have brought consumers into the process to this degree.

The Pilot will build on previous work done to gather input from patients and families to ensure that the model responds to the needs of Maine people. Quality Counts, with support from the Maine Health Access Foundation, has already conducted consumer focus groups to better understand the needs and perspectives of Maine health care consumers.

Consumers have participated in the planning of the Pilot from the beginning. The PCMH Working Group identified two consumers to be regular members, and provides consumers with a stipend for participation. The Pilot also asks practices to involve patients and families directly in their work to redesign care within the practice, and provides practices with help to identify and engage patients in that work. The Pilot has also convened a “Patient and Family Leadership Team” that includes several consumers and providers who will provide direction for the Pilot. Patients and families will be invited to participate in leadership training so they can be more effective in these roles.

Resources to Support the Pilot

Many organizations have stepped forward to support the planning and implementation of the Maine PCMH Pilot. Very importantly, the Maine Legislature in 2009 approved $500K in the state budget to provide new Medicaid (MaineCare) payments to practices in the Pilot. Major funding to support the work of running the Pilot comes from the Maine Health Access Foundation, the Maine Quality Forum, and Harvard Pilgrim Health Care, with additional support provided by Quality Counts, the Maine Health Management Coalition, Martin’s Point, and Anthem BCBS of Maine. The Robert Wood Johnson Foundation provides additional support through its Aligning Forces for Quality Initiative. Funding to support an independent evaluation of the Pilot has been secured from several private foundations, including the Davis Family Foundation and the Betterment Fund, with additional requests currently in process with several other foundations.
LESSONS LEARNED
The conveners and stakeholders of the Pilot have already learned much in the early stages of the project during the last year:

- **Collaboration is key.** The changes required by the PCMH model are complex and multi-faceted and collaboration with stakeholders of all types is the only way these changes are possible. We provide opportunities for collaborative learning among practice teams through the PCMH Learning Collaborative and team calls. We have fostered collaboration among the quality improvement coaches through workshops and regular meetings. We also collaborate with our peers in other states that are conducting PCMH pilots, including an active New England PCMH Collaborative.

- **Change is hard.** As the American Academy of Family Physicians once said about their 2006 National Demonstration Project, “Change is hard enough; transformation to a PCMH requires epic whole-practice re-imagination and redesign. It is much more than a series of incremental changes.” We have witnessed the challenges of these changes in the Pilot practices, especially the challenges of creating culture change and establishing leadership to guide practices during this time of change.

- **Including patients is essential.** From the beginning of the Maine PCMH Pilot, we have maintained a strong commitment to finding meaningful ways to include patients and families. We include consumers in the governance and oversight of the Pilot. We have convened a Patient and Family Leadership Team to provide input during the Pilot’s implementation. Practice teams will include patients and family members in their local redesign efforts, and experts skilled in working with consumers will assist practice teams with this. While the process can be challenging for consumers and stakeholders alike, this work has been tremendously rewarding and has helped to keep us focused on our “true north” – keeping the patient in the center of the medical home.

THE JOURNEY BEGINS: GOALS FOR PILOT YEAR 1 (2010)
Supporting Continued Practice Change
Making these changes while delivering high quality care to hundreds of patients each day has sometimes been compared to trying to fix the wing of an airplane while in flight. Practices need time, support, and resources if they are to continue moving towards a more patient centered model of care. Over the coming year, we will continue to bring leaders from the 26 Pilot practices together regularly to share progress updates and hear from experts from around the country who are working to make similar changes. Quality improvement coaches will continue to work individually with these practices to help them make and monitor changes. And we will help them work with the real experts: patients and their families.

“**We have lost sight of what is most important in the search for answers that will fix everything. We have to shift our lens from our present practice and re-establish the connection to patient-centeredness.**”

Deb Emery, Consumer Advocate

**Evaluation**
Evaluation is always important, and for a pilot of this nature, it is critical. The Maine PCMH Pilot is committed to conducting a rigorous evaluation of the Pilot. We are partnering with experienced researchers from the University of Southern Maine’s Muskie School of Public Service to conduct an independent evaluation using both quantitative and qualitative methods. The evaluation is essential. It will give insight into the overall results of the Pilot, and will help us to understand how to adjust the program to make it better as we. The evaluation will use 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. It will evaluate changes in four key areas:

- Patient experience of care at the PCMH Pilot practice sites
- Clinical quality measures, in areas like diabetes care, cardiovascular care, and preventive health
- Overall health care costs, and use of expensive resources such as hospital admissions, high tech imaging (like MRIs and CT scans), and emergency department use
- Systems of care in the PCMH Pilot practices. This looks at how well the practice involves family and community into care.
Maine PCMH and Other Efforts
The Maine PCMH Pilot will continue to look actively for ways to collaborate with partners, including participants in other PCMH pilots. We have formed strong partnerships with similar pilots in New Hampshire, Vermont, and Rhode Island, regularly sharing ideas and lessons learned. We are collaborating with the New Hampshire’s PCMH pilot to build a web-based system for collecting clinical quality data. We are working with OnPoint Health Data (formerly the Maine Health Information Center) to develop a tool that will connect this web-based system with practice electronic medical records and data reporting systems. Maine’s Pilot is also an active participant in the New England PCMH Collaborative, a group formed over the past year that promotes learning across the five New England pilots. 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.

Maine PCMH and the Medicare Advanced Primary Care Practice Demonstration
There is one critically important payer that is not yet part of the Pilot: Medicare. Medicare payment is governed by federal policy and legislation, and current Medicare payment policy does not allow payment under the PCMH model. However, in Fall 2009, the federal Secretary of Health and Human Services announced its intention to invite states with multi-payer PCMH pilots to apply for participation in a national Advanced Primary Care (APC) demonstration, in which Medicare would participate as a payer in selected states.

It will be critical for Medicare to support the PCMH model, so we are actively tracking plans for the APC initiative. Many details of the project remain to be announced, but Maine appears well-positioned to apply for participation. We believe Medicare will likely reform its payment structures over the next three to five years, and practices that make changes to deliver care in a way that is consistent with the PCMH model will ultimately be in the best position to succeed under new forms of payment.

IN CLOSING

Dr. John Yindra prepared to see his next patient, who was referred to him because of a leg infection. Access to her electronic medical records allowed Dr. Yinda to review her medical history quickly. While he reviewed the records, the practice’s medical assistant brought the patient back to a room on time, took her temperature and blood pressure, and showed her how to use a glucometer to check her blood sugar.

When Dr. Yindra entered the examination room, he asked the patient if she was keeping up with her diabetes medication. “Sometimes,” she said quietly. After reviewing the medications with her, Dr. Yindra told her that she seemed down, and thought she might want to talk with a counselor. He walked her over to the counselor, who learned that her depression was due in part to financial problems that kept her from purchasing her medications. The counselor called in the social worker, who helped the patient find financial assistance for medication. Before the patient left she saw the nurse educator, who helped her explore ways to control the diabetes with nutrition and exercise.

This is primary care transformed. Welcome to the medical home.

The time for transforming primary care is now! With the national health care reform law recently passed and access to care about to expand, it’s more important than ever to improve access to and efficiency of primary care practice. These are the goals of the PCMH Pilot. The example of Massachusetts has taught us that expanding health insurance coverage will create more demand for health care services, starting with more demand for primary care. It is unlikely that there will be a significant increase in the number of primary care practitioners in the near future, so current primary care practices must become better organized, more efficient, and more patient-centered if they are going be able to meet rising demands with high quality and cost-effective care.

There is a risk that increased access to care may come with dramatic increases in health care spending. A solid primary care base will provide basic health care services and facilitate wise choices about the use of expensive services and technology. The PCMH model and Maine PCMH Pilot are much-needed innovations in this “brave new world” of health care reform. They can and must become the cornerstone of our delivery system if we are to address the country’s health care needs. Once again – Maine leads!
“Maine’s Patient Centered Medical Home Pilot project is an important first step in reforming how we pay for health care- to be sure we reward quality, prevention and effective primary care, especially for adults and children with chronic illnesses.”

Trish Riley, Director, Governor’s Office of Health Policy and Finance