Foundational to the Medical Neighborhood

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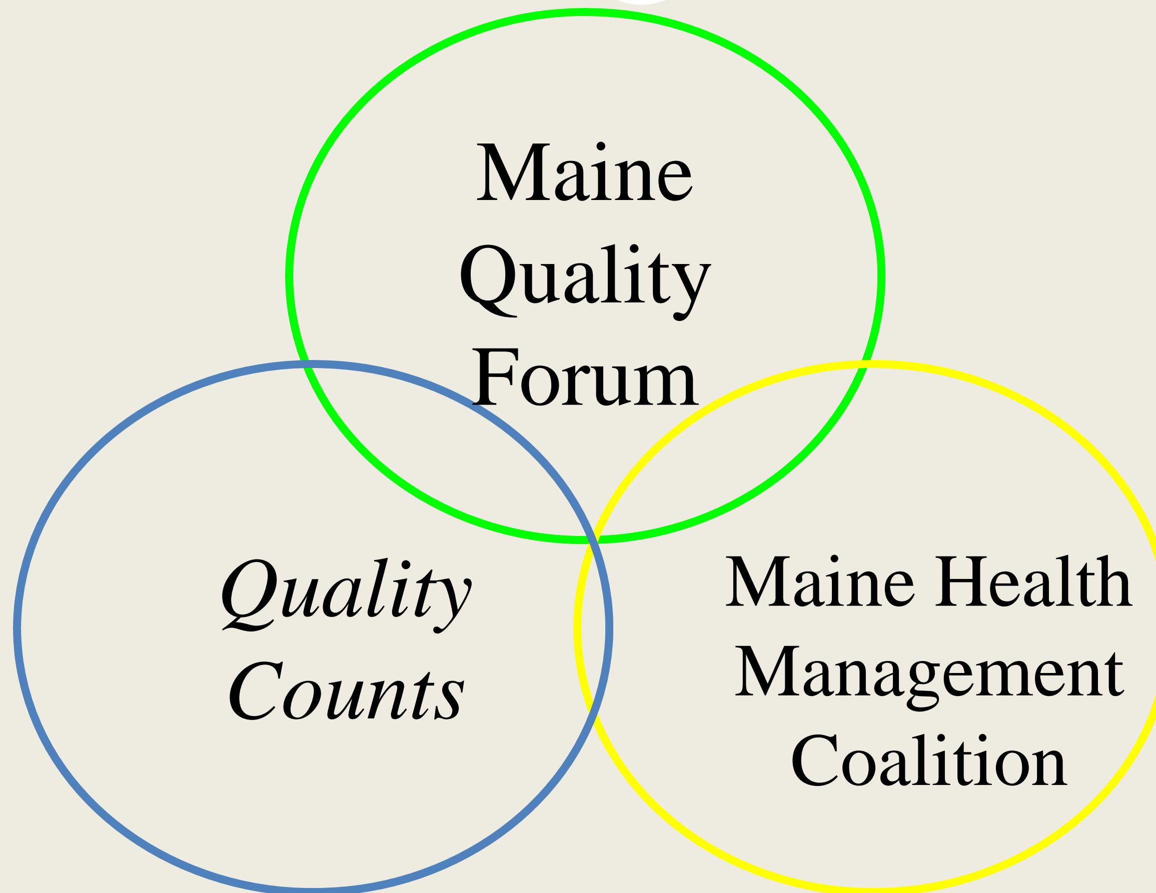
Key elements:

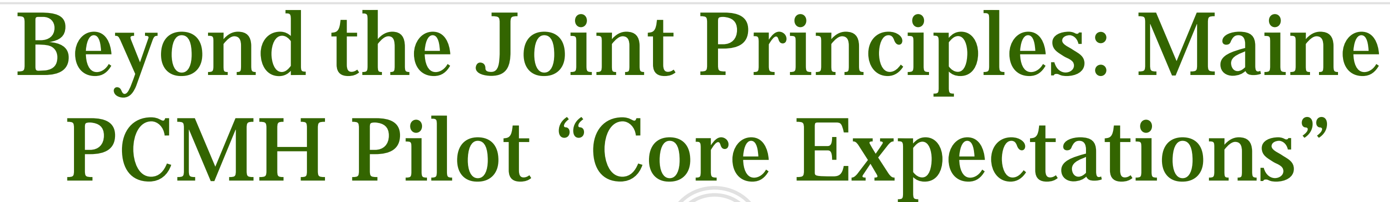
- 3-year multi-payer PCMH pilot
- Collaborative effort of key stakeholders, all major payers
- Adopted common mission & vision, guiding principles for Maine PCMH model
- Payers providing new prospective care management fee
- Selected 22 adult / 4 pedi PCP practices across state
- Supporting practice transformation & shared learnings beyond pilot practices
- Committed to engaging consumers/ patients at all levels (governance, regional, and local)
- Planning rigorous outcomes evaluation (clinical, cost, patient experience of care)

Maine PCMH Pilot Leadership



Practice Transformation-Support to Practices

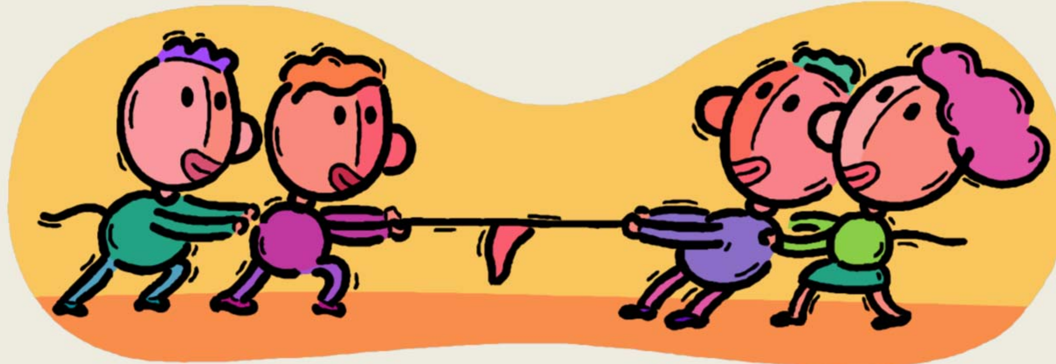
- Assistance with achieving Physician Practice Connection-Patient Centered Medical Home (PPC-PCMH) recognition from the National Committee on Quality Assurance
  - Participating practices have received NCQA PPC-PCMH recognition
    - Level I—13 practices
    - Level II – 5 practices
    - Level III – 7 practices
    - One Pending
- Learning Collaborative (Learning Sessions, Virtual)
- Coaching (Improvement using Microsystems Model frame)
- Technical Assistance (HIT, Behavioral Health Integration, Engaging Patients & Families, & other Core Expectations)



Beyond the Joint Principles: Maine PCMH Pilot "Core Expectations"

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

The Stalemate that Blocks Change



Providers unable to transform practice without viable & sustainable payment for desired services

Hospitals and specialists uncertain about what this means to them-loss of volume, influence, $$?

Employers & payers unwilling to pay for desired services unless primary care demonstrates value AND create potential to save money

Silos—lack of systems thinking

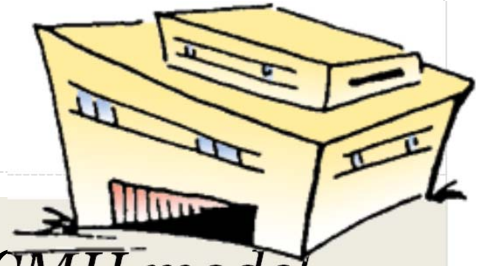
Not considering the patient as central to our cause!

The Challenge….

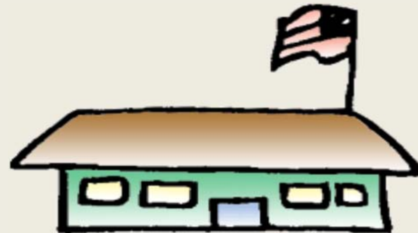
“It Takes a Village”

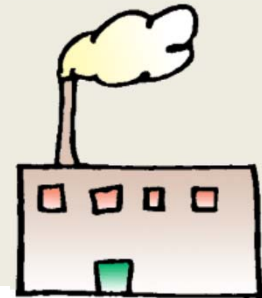
- Future of the Medical Home model is also about relationships
- The effectiveness of the PCMH model to promote integrated, coordinated care throughout the healthcare system depends on the availability of a “*hospitable and high-performing medical neighborhood.*”
    - The New England Journal of Medicine,Elliott S. Fisher, M.D., *M.P.H.*

Why a "Neighborhood"



- *"The effect on total costs of implementing the PCMH model alone could be limited, because primary care physicians have little control over other providers in the care continuum, and under the largely fee-for-service payment system, it is highly unlikely that other providers will respond to reductions in the number of referrals or admissions by allowing their incomes to fall. These limitations could be addressed most readily if the model were implemented in the context of a larger entity…"*
  - The New England Journal of Medicine, Elliott S. Fisher, M.D., *M.P.H.*





It's All About Optimization

- "I've got it, too, Omar…a strange feeling like we've just been going in circles."
    - *The Farside*

“Neighborly” Characteristics

- Trust
- Mutual Respect (property and each other)
- Safe
- Leverage services
- Safe environment
- Agreements
- Communication

What Maine is Doing

Being “Neighborly” in the Primary Care Community—Some Maine Examples

- Hospital care management working with practice care management to notify them of hospitalized patients and ED visits
- Redesigning care delivery in ED in response to improved access to PCP
- Implementing PCP and specialist agreements
- Providers assigned to nursing homes (PAs & NPs)
- Primary care practices housing daycare for Alzheimers patients

Key Drivers in Maine

- Enthusiasm and support of the 26 Maine Patient Centered Medical Home sites—in the game because it is the right thing to do
- Payers at the table
- Three major systems forming as Accountable Care Organizations (ACOs)---PCMH principles and measures are the foundation for that work and more inquiring

- How do/will we define our “medical neighborhood”? Who needs to be working with the primary care base to make this most effective?
- How will supporting the medical home model change the type and scope of the services we are providing?
- How can we get paid differently for what we really need to be doing? How can we think outside the box and beyond the current payment system?
- What is our plan to support **all** primary care practices in becoming high functioning medical homes?

- How will we support strengthened relationships and collaboration between PCPs and specialists?
- Are our health information systems as interconnected as they need to be?
- Do we engage the patient and family in our work and "really" incorporate the voice of the patient in all that we do?
- Are we doing a sufficient job of educating the community about this new model? (i.e., inappropriate use of ED, unnecessary testing, etc.)

- Building relationships within the neighborhood is challenging. Aligning goals and incentives for quality improvement require careful deliberation.
- Results are not achieved quickly. Collaborating with other “neighbors” can be problematic because of pre-existing tensions.
- The process of refining and improving “neighborhood” performance is ongoing. A “neighborhood” is a dynamic place—neighbors may move in and out so it must be led by leaders who are ready, willing and able to adapt and execute.

It is a Journey!

"It does not happen all at once. There is no instant pudding." (Dr. W. Edwards Deming (in describing, during his 4-day seminar, that there is a lag time between cause & effect)

Questions?