



**Patient Partnerships in the Medical Home:
An Implementation Perspective from Maine**
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Track: How Organizations Are Using CAHPS Surveys
Session: The Role of CAHPS in the Patient-Centered Medical Home
Date & Time: April 20, 2010, 2:15 pm
Track Number: CAHPS T3_S3

Maine PCMH Pilot



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 Brings Hope for Practices: “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

PCMH Brings Hope to Patients



Your Vision for Change -Jun 09

- “They were here for me”
- “Everybody here feels like family”
- “They really help us get through the system”
- “I feel well cared for in my practice”
- “They know what I need and when I need it”
- “I don’t feel so alone or anxious anymore”
- “Wow – all my needs were met!”



ME PCMH Pilot: Implementation Steps Toward Patient Partnerships



- Core expectation that practices participating in Pilot will include at least two patient or family members in their work
- Patients and consumers members of the PCMH Pilot Working Group (governance committee)
- Patient & Family Leadership Team
- Technical assistance to participating practices on engaging patients and family members
- Baseline patient experience data for each participating practice

Core Expectations

- Inclusion of patients & families

What patients see...

- Their practice invites patients and families to participate in their practice improvement team
- They routinely ask them to complete experience surveys, join focus groups
- They routinely involve them as partners in their important health care decisions



Patients and consumers members of the PCMH Pilot Working Group



- PCMH Working Group includes consumers, providers, payers and employers
 - Provides guidance and operational oversight of the Pilot
 - Defined principles of the Pilot and helped develop practice selection process
 - Meets monthly to guide ongoing implementation
- Key Learnings:
 - Consumer involvement in Working Group has been critical to the Pilot. The consumers' voice have helped keep the patient and family at the center of every discussion and decision.
 - Stipend helps keep the consumers at the table.

Meet Kate, Consumer



Patient and Family Leadership Team



- Group of healthcare consumers developing plan to develop other patients and family members around Maine in a way that promotes meaningful change.
- Meets monthly
- This month, meeting to refine work plan and develop orientation program for newly formed advisory groups in PCMH practices
- PFLT members attend practice visits when schedule allows
- Aim to develop a core group of patients and family members in Maine to serve as internal advocates for change within physician practices and hospitals.

Patient and Family Leadership Team



- Key Learnings:
 - Taking time to get the group “off the ground”.
 - Hard to recruit consumers to be part of the group despite stipends for attending the meetings.
 - Early work with the practices has been very favorable.
 - Still a lot of work to be done and helpful to be working in partnership with the Institute for Patient and Family Leadership.

Maine Patient Centered Medical Home (PCMH) Pilot

Planning & Governance

PCMH

Working Group

¹ (22 total)

Primary Charge: Provide guidance and direction for Maine PCMH Pilot

Meets: Monthly

Conveners (MQF, QC, MHMC)

Consumers

Physicians/NP/provider reps

BH-PH integration

- Self-insured employers

- Health plans

- MaineCare

- Public Health

Evaluation & Measures Subgroup

Primary Charge: Identify measures to be used for implementation, payment, and evaluation of PCMH

Meets: TBD

Muskie/USM

Conveners

Employers

Payers

Consumers

Patient & Family Leadership Team

(Linked w/ AF4Q Consumer Grp)

Primary Charge: Provide input on development & implementation of PCMH model to ensure it meets needs of patients & families

Meets: TBD

Consumers, TBD

Consumer advocate groups

Practice Transformation Subgroup

Primary Charge: provide input and guidance on specific practice transformation support required for the Maine PCMH Pilot practices.

Meets: monthly

QI advisors from PHOs, provider groups (including MPIN)

Pilot practices

MHMC Resource Utilization Committee (RUC)

Primary Charge: Develop process for measuring costs and resource use of patient panels receiving care from primary care practices transforming to medical home model (e.g. those in Maine PCMH Pilot, BIW Primary Care initiative); develop methodology for using those measures in shared savings model

Meets: ad hoc

Evaluation Subgroup rep's

Employers, Providers, Payers

Technical Assistance



- Consultant, Quality Improvement Coaches, and Pilot staff provide technical assistance to practices to identify and effectively partner with patients and family members in practice redesign.
- Provide information and education to support patient shared decision making for preference-sensitive care.
- Key Learnings:
 - Practices recognize the importance of the work but have indicated they “have not yet started” or “have done some work with room for improvement”.
 - Demand for technical support to practices is substantial.

Meet Georges, QI Coach



Baseline Patient Experience Surveys



- Grass roots, customized survey (largely based in CAHPS survey) in partnership with local University.
- Selected because it is a national, validated tool.
- Customized
 - Shortened slightly
 - Used combination of “past 12 mos” and “last visit” questions
 - Changed “your doctor” to “your healthcare team”
 - Added the Commonwealth questions related to “med homeness”
- Creating plan for sharing survey results w/ practices via the technical assistance avenue

Baseline Patient Experience Surveys



- Key Learnings:
 - More work than we thought to do this without a vendor!
 - Issues in terms of getting practices to collect responses--capacity of practices
 - Web-based version (interesting but not being used much)
 - Initial results are exciting!

Commonwealth Questions Added

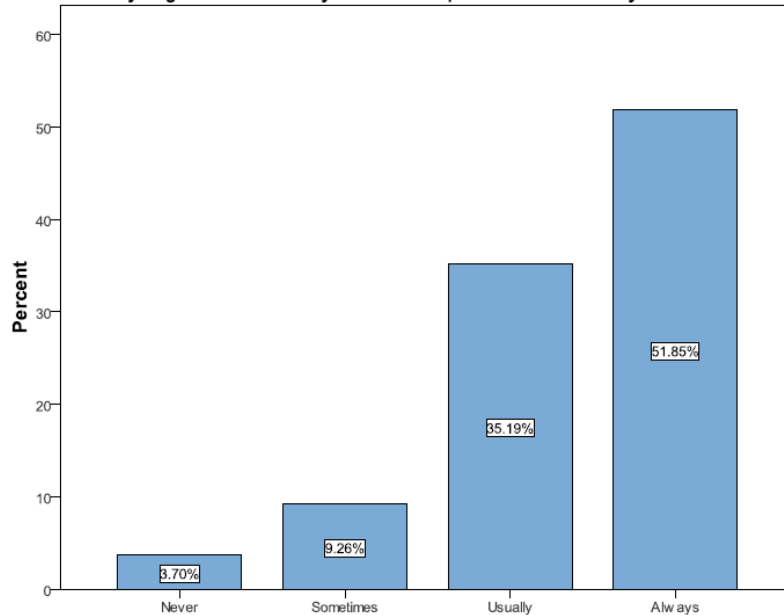


- In the past 12 months (2 years), has a doctor talked to you about exercise and having a healthy diet and weight?
- In the past 12 months (2 years), has a doctor talked to you about any emotional concerns that may be affecting your health (for example, depression or stress)?
- Has any doctor or nurse you see for your condition(s) given you a plan to manage your own care at home?

Practice Reports: Quantitative & Qualitative



In the last 12 months, when you phoned this practice after regular office hours, how often did you get an answer to your medical question as soon as you needed?



- This is by far the best physician practice that I have ever been to. It is obvious that this practice strives to achieve high standards of care for their patients.
- Very happy with the care I have received.
- When a prescription is no longer to be prescribed, a reason should be given.
- When the appointment is made tell the patient that if they are not here within 10 minutes of the scheduled time-that they will not be seen.
- When you call here you almost always have to be on hold for awhile, which is annoying.

The Patient Centered Medical Home Brings Hope

- *"The greatest compliment that was ever paid me was when one asked me what I thought, and attended to my answer."*

◉ Henry David Thoreau





Questions?