Keeping the Patient at the Center of the Patient Centered Medical Home

Maine Patient Centered Medical Home Pilot

Lisa M. Letourneau MD, MPH
Quality Counts

February 2009

Objectives

- Check in
- Brief intro to Maine PCMH Pilot
- Maine Pilot efforts to keep patients & families in center of PCMH
- Other great ideas??

PCMH Pilots

Why we are here?

Olivette

Sam

Alice

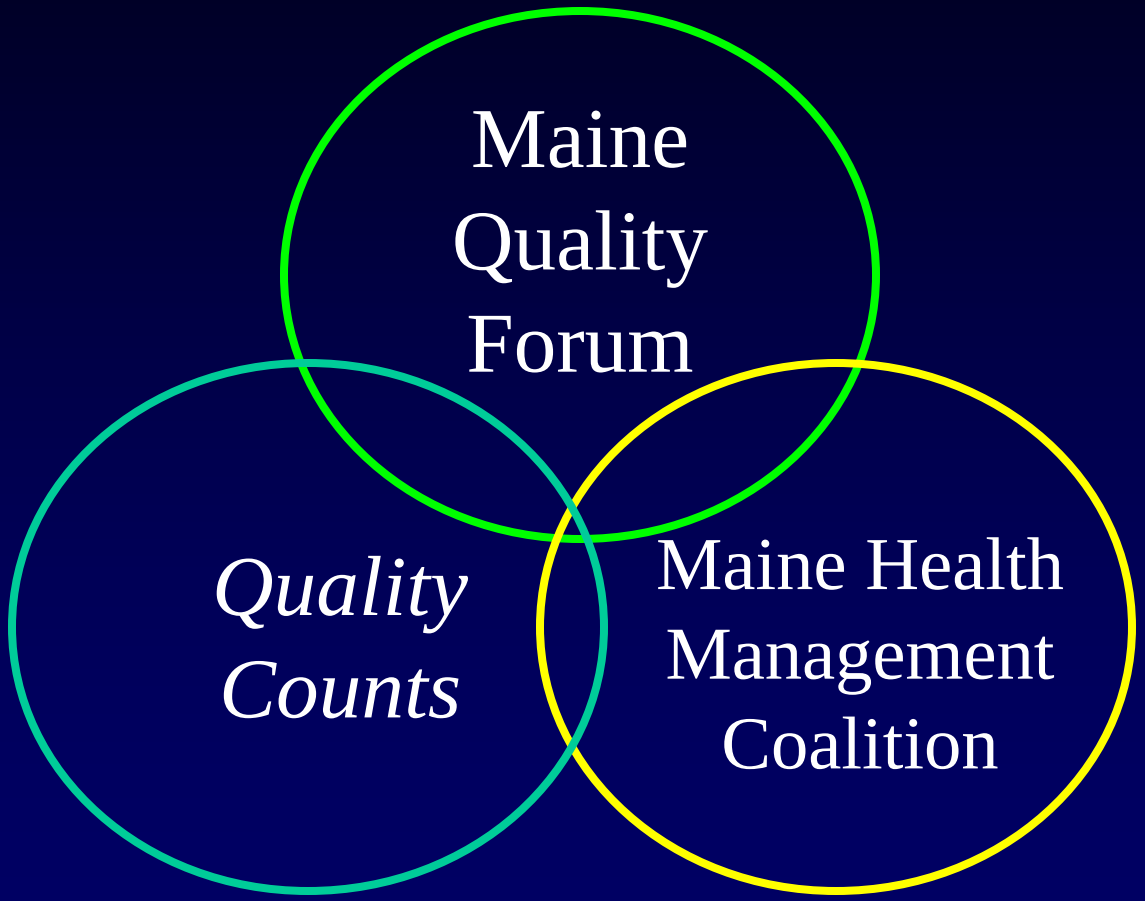
Defining Patient Centered Care

"Patient-centered care is care which is perceived as such by the patient. The patient is the only one who can deem it as such"

Margaret Murphy

WHO World Alliance for Patient Safety

Maine PCMH Pilot Leadership



(Also lead Maine AF4Q initiative)

Maine PCMH Pilot

- Led by multi-stakeholder collaborative – MQF, QC, MHMC; providers, employers, consumers involved
- Maine PCMH mission, vision, guiding principles
- Participation of 4 major private payers & MaineCare, commitment to 3-component payment model (pmpm + FFS + performance payment)
- Call for practice applications launched Jan 5, 2009
  - Will select 10-20 pilot practices across state for participation in 3-year Pilot
- Support practice transformation through PCMH learning collaborative, 1:1 coaching

Maine PCMH Pilot

- Criteria for practice application
  - Maine primary care practice (adult & pedi)
  - Completed MHIQ c/w Level I NCQA PPC-PCMH
  - Minimum panel size 1000 patients
- Agreements for participating practices (MOA)
  - Assure leadership, full participation of practice team
  - Participate in PCMH Learning Collaborative, QI coaching
  - Track, submit clinical outcomes data
  - Agree to achieve “Core Commitments” within 12 mos of start

Maine PCMH Pilot
Practice "Core Commitments"

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

Centering on Patients & Families Remembering the IOM – A Few Simple Rules

Current approach	New rule
Care is based on visits	Care is based on continuous healing relationships
Professional autonomy drives clinical variability	Care is customized according to patient needs, values
Professionals control care	Patient is source of control
Information is a record	Knowledge is shared and flows freely
Secrecy is necessary	Transparency is necessary
The system reacts to needs	Needs are anticipated

Keeping Patients at Center of Maine PCMH Pilot

- Patients/consumers included in Maine Pilot planning, governance
- Patient/consumer focus groups held as part of Maine Pilot planning
- Patient-oriented informational, educational tools being developed
- Pilot practices required to include patients in redesign efforts
- Including patient experience in evaluation
- Linking w/ AF4Q consumer engagement

Including Patients in PCMH Pilot Planning & Governance

- Two (or more) patients included in PCMH Working Group
- Support patients on group through consumer advocacy groups (CAHC)
- Provide stipends for time/travel
- Honor their voice!

Seeking Out Patient Perceptions & Experiences

- Conducted series of 4 patient/consumer focus groups across state as part of Maine PCMH Pilot planning
- Used two question sets as framework for discussion:
  - Primary care practice experience of care (modeled on NCQA PPC-PCMH standards)
  - Active & engaged patient checklist (desired patient behaviors)

Maine PCMH Focus Group Findings

- Consistently identified communication & relationship as prime importance
- Areas in primary care experience identified as needing most improvement:
  - Collaborative decision making
  - Tracking progress between visits
  - Coordination of care
  - Referring to community resources/ programs

Maine PCMH Focus Group Patient Concerns

“My doctor only tells me what she thinks is best and I don’t know the difference.”

“My doctor focuses on his own agenda. He looks at me as symptoms and not as

“The doctor always wants me to do things his way and I would like to discuss how I think my care progresses"

“Unless you know enough to say ‘what about this?’ they’re not going to discuss options with you.”

Maine PCMH Focus Group Findings

Self-evaluation of patient behaviors identified several areas for improvement:

- Following care plan: need to collaboratively set plan, identify likely barriers to following through
- Asking for more information about treatments & tests
- Bringing list of questions & concerns to visit

Maine PCMH Focus Group Findings

Recognition of time as major challenge:

"Whenever I go to the doctor it seems like his hand is on the doorknob the whole time."

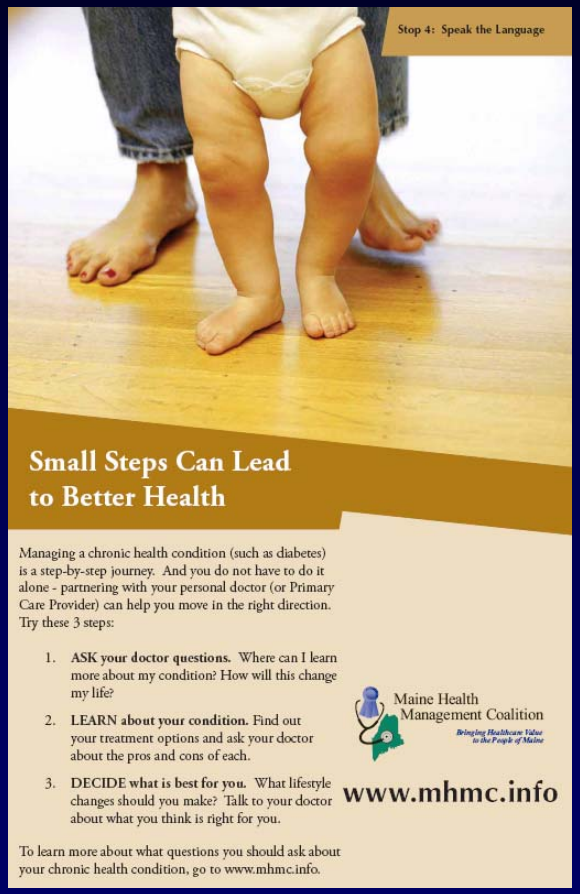
"I always get the feeling I'm on a schedule. I bring a list and when they see it they start to rush through it."

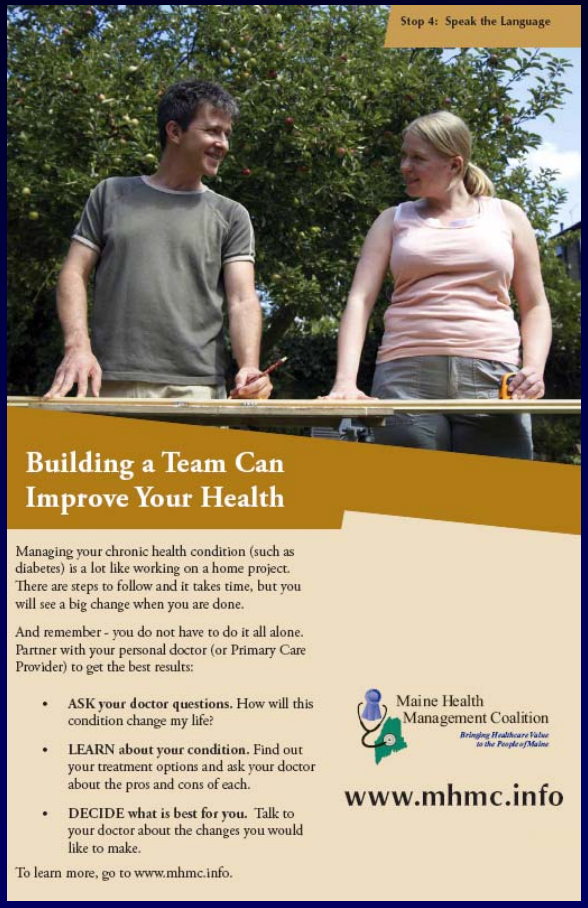
"It seems that a major challenge for the PCMH will be to find a way to offer consumers more time on the clock with their providers."

Developing Patient-Consumer Educational Tools

- MHMC posters – value of primary care, medical home
- Educational brochures on PCMH
- Written agreement for patients & clinicians in PCMH?
  - Outline expectations, agreements of both practice and patient
  - Examples?

MHMC Primary Care Posters





Educational Materials - NPWF

Getting the Most from a Medical Home

What Your Care Team Should Do

1. Learn About You

- Get to know you, your family, your life situation, and preferences. Remember these details about you every time you seek care, and suggest treatments that make sense for you.
- Treat you as a full partner in your care.

2. Communicate with You

- Give you time to ask questions, and answer them in a way you understand.
- Make sure you know and understand all of your options for care.
- Help you decide what care is best for you. Sometimes more care is not better care.
- Ask you for feedback about your experience getting care.

3. Support You in Caring For Yourself

- Make sure you leave the office with a clear idea of how to care for yourself.
- Help you set goals for your care, and help you meet your goals one step at a time.
- Give you information about classes, support groups or other types of services to help you learn more about your condition and stay healthy.

3

What You Can Do

4. Learn About Caring for Yourself

- Know that you are a full partner in your own care.
- Learn about your condition and what you can do to stay as healthy as possible.
- As best you can, follow the plan that you and your medical home team have agreed is important for your health. If you have questions, ask!

5. Communicate with Your Care Team

- Always bring a list of questions to each of your appointments. Also bring a list of any medicines, vitamins or remedies you use.
- Always tell your medical home team when you don't understand something they said. Ask them to explain it in a different way.
- Always tell your medical home team if you get care from other health professionals so they can help coordinate the best care possible.
- Always talk openly with your care team about your experience getting care from the medical home so they can make care better.

4

Patient-Physician PACT*

- Document outlining proposed roles of patients & clinicians
- Parallel patient/clinician expectations for each of ten responsibilities/behaviors
  - Sharing information
  - Shared decision making
  - Responsibility for care

*Center for Advancement of Health

Requiring Pilot Practices to Involve Patients/Families

Maine PCMH Pilot "MOA" for practices includes expectation that within 12 mos, practices will…

- Identify at least two patients or family members to be part of practice leadership team
- Use one or more mechanisms to routinely solicit input from patients and families on how well practice is meeting their needs

Including Patient Experience in PCMH Pilot Evaluation

- Specific tool(s) to be identified
- Considering validated tools:
  - Consumer Assessment of Healthcare Providers (CG-CAHPS)
  - Ambulatory Care Experiences Survey (ACES – Saffran)
  - Primary Care Assessment Tool (PCAT - Starfield)

Other Great Ideas?

- PCMH Ombudsman
- Use “reality check” before agreeing to care plans
- Health literacy training for practice teams
- Lunch & learns – with patients

Putting Patients at the Center
All the Right Reasons

Let’s get started!