Maine Multi-Payer Pilot of the
Patient Centered Medical Home
Mission & Vision

Mission: **The Maine Multi-Payer Patient Centered Medical Home (PCMH) Pilot Project will develop and implement patient centered delivery system and payment models that will provide and support effective, efficient, and accessible health care.**

Vision: The Patient Centered Medical Home model will provide effective, efficient, and accessible health care supported by appropriate payment, and will deliver sustainable value to patients, providers, purchasers, and payers.

Definitions of Success - The Patient Centered Medical Home will:

➢ **Improve the health, well-being, and experience of care for all patients and families by…**
- Transforming the experience of care for all patients in the practice, and strengthening the caring relationship between patients and their healthcare provider
- Providing quality care that is safe, timely, effective, equitable, efficient, and patient-centered
- Providing care that recognizes and integrates all of the patient's healthcare needs, including integrating behavioral and physical health needs
- Educating and empowering patients to work in partnership with the practice team to achieve optimal health and promote preventive care
- Giving patients more opportunities to be active and engaged in improving their care and their health (e.g. e-visits, group visits, community supports) without creating barriers to needed care
- Connecting patients and families with community resources that support improved care and healthy behaviors, and are linked to Maine's emerging public health infrastructure (e.g. HMPs)

➢ **Sustain & revitalize primary care by…**
- Encouraging primary care practices to take responsibility for the health needs of the entire population of patients in the practice who have agreed to partner with the practice team to receive care.
- Enabling primary care providers to serve as leaders of practice change and advocates for their patients in a system of patient-centered care (i.e. not "gatekeepers")
- Improving the efficiency of the practice and the satisfaction of the entire practice team
- Providing a sustainable payment model that appropriately recognizes the value of primary care, supports the infrastructure and systems needed to deliver high quality care, rewards cost effective care, positive patient experiences and desired outcomes, and can be expanded statewide
- Redefining the job of primary care and demonstrating how primary care can be an attractive form of practice that encourages medical students to choose training in primary care
- Highlighting pilot practices as "best practice showcases" to help other practices learn how to transform to the medical home model and to promote spread of the model statewide

➢ **Promote an efficient integrated system of care by…**
- Creating a system that enables people to be healthier and more productive.
- Working with payers and purchasers to develop benefit designs and payment methodologies that support the mutual goals of the medical home
- Bringing community stakeholders (e.g. primary care, specialists, hospitals) together to work towards shared goals and community benefit
- Reducing overall costs of care (or at a minimum slowing the rate of healthcare cost increases) by reducing inappropriate utilization (e.g. avoidable Emergency Department use & hospitalizations) and decreasing unwarranted variations in care
- Measuring outcomes that demonstrate the value (ROI) of the new model, broadly defined in terms of quality, experience of care, and costs/resource use

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