

*“Charting A Course Toward Improved Quality and
Financial Stability...”*

What Will It Take To Preserve Primary Care In Maine



**2008 Hanley Leadership Forum
June 5, 2008
University of Southern Maine, Portland Campus**





DANIEL HANLEY
CENTER *for* HEALTH
LEADERSHIP

Forum Report

*“Charting A Course Toward Improved Quality & Greater
Financial Sustainability...”*

What Will It Take To Preserve Primary Care in Maine?”

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EXECUTIVE SUMMARY

Primary care represents the very foundation of Maine's healthcare delivery system. Each day, thousands of Maine people count on their primary care clinicians to be ready, willing and able to respond to a wide range of often-complex and urgent medical issues. These clinicians represent a gateway to journeys that take many patients to specialists, diagnostic test sites, pharmacies and hospitals.

Today, it is widely accepted throughout Maine and across the nation that primary care is making critically important contributions to efforts to improve overall health status, better manage the care of patient's chronic illnesses and moderate the growth of costs. Despite all this, however, adult primary care in the United States appears to many to be on the brink of crisis. Practicing primary care physicians are demoralized, retiring early, and advising others not to go into the field. The percentage of recent U.S. medical school graduates and residents planning to enter primary care practice is plummeting to levels that will lead to serious physician shortages. These realities threaten access to primary care services in rural communities and urban centers across Maine.

There are many reasons for this decline. Many healthcare experts agree that one of the key causes of this problem has been a succession of dysfunctional payment systems that discourage proper delivery of primary care. Clearly, new payment models are needed for primary care to help reverse a troubling trend that could lead to greater shortages and diminished access to needed services in many communities. These new models must realign incentives and make possible the establishment and operation of accountable, modern primary care practices capable of providing the personalized, coordinated, comprehensive care essential to a well-functioning health care system.

At the request of a distinguished group of physician leaders concerned about the long term sustainability of primary care services in Maine, the 2008 Hanley Leadership Forum focused on the issue of payment reform for sustaining and revitalizing primary care, including specific payment reform issues related to the Patient Centered Medical Home (PCMH) model.

Nearly 75 health care leaders from across Maine took part in the 6th annual Hanley Leadership Forum on June 5, 2008 at the University of Southern Maine in Portland. Following a series of presentations by the Forum's national faculty, an interactive roundtable discussion, three breakout sessions and a prioritization exercise, Forum participants decided to:

- A. Move forward on six distinct recommendations aimed at building a more sustainable primary care system in Maine
- B. Identify several overall "Guiding Principles" that could shape how we act upon these recommendations
- C. Identify specific organizations to take responsibility for advancing each of these recommendations
- D. Ask the Hanley Center to re-convene Forum participants in January, 2009 to assess progress on these recommendations and determine any further action needed to move this process forward

Forum Recommendations & Action Steps

<u>Recommended Action Steps</u>	<u>Organization Responsible For Advancement</u>
1. Develop Value Proposition for Primary Care and PCMH <ul style="list-style-type: none"> • As value proposition is developed, make clear distinction between overall reform of primary care system and the PCMH (patient centered medical home) • Target audience: employers & payers 	Maine Health Management Coalition (MHMC)
2. Develop a new payment model for primary care <ul style="list-style-type: none"> • Test model in Maine through Multi Payor Pilot • Explore ways to expand the medical home model beyond the Pilot • Develop way to measure effectiveness of model 	Multi-Payor PCMH Pilot /MQF/QC/MHMC
3. Once value proposition is developed, explore public & private funding to help sustain primary care system; examples of two areas where greater funding could contribute substantially to sustainability <ul style="list-style-type: none"> • Electronic Medical Records <ul style="list-style-type: none"> - EMR's should lead to greater efficiencies, higher quality, etc. • Tuition Assistance & Loan Forgiveness <ul style="list-style-type: none"> - Needed to attract more providers into primary care 	HealthInfoNet/Maine Quality Forum Finance Authority of Maine
4. Develop value proposition for community based care management <ul style="list-style-type: none"> • Target audience: employers/payors 	Maine Primary Care Association/PHOs (MaineHealth/Maine Network for Health)
5. Explore how improved primary care system can connect with and contribute to the emerging public health infrastructure in Maine <ul style="list-style-type: none"> • Explore how PCMH could be connected to evolving public health infrastructure 	Maine Center for Public Health (fall conference) Multi-Payer PCMH Pilot
6. Form federal & state advocacy coalition to promote sustainability of primary care: <ul style="list-style-type: none"> • Support funding for steps listed in #3 above levels 	MMA/MOA

Guiding Principles for Payment Reform

The following Principles will be used to guide the **Action Steps** identified at the Hanley Forum:

- The primary goal of our efforts in Maine should be to sustain and revitalize primary care as the foundation for our healthcare system. While the “Patient Centered Medical Home” is one model for payment reform that is currently being developed and tested, we recognize it is only one model and one part of a wider payment reform effort.
- Payment reform efforts should be undertaken with a sense of collaboration and cooperation across sectors (e.g. primary care need to work in collaboration with specialists and hospitals). At all costs, we must not foster or encourage the emergence of an “us vs. them” mentality that pits primary care against specialists or hospitals, but instead focuses on our shared goals of improved patient outcomes, quality, and efficiency for the system as a whole.
- Reform efforts should be comprehensive and should promote a sense of optimism regarding the possibility for change.
- Change efforts should be made very visible and communicated widely throughout the state.
- Primary care payment reform and practice transformation must happen simultaneously; we must stop waiting for change “until the other side changes”.
- Payment reform for primary care must be broad and robust enough to support the types of changes primary care practices must undertake to provide comprehensive, coordinated patient care (i.e. “nibbling around the edges” won’t work); at the same time, enhanced payment for primary care services must be coupled with a willingness by primary care practitioners to provide value-added services (e.g. care coordination).
- Payment reform for primary care must include efforts to make changes to the current service-based reimbursement model (e.g. changes proposed as part of the medical home model), but ultimately must also address the changes needed to underlying dysfunctional payment methodologies, such as reform of the Relative Value Resource-based Units (RVRBS) system and the Medicare Sustainable Growth Formula.
- Those implementing primary care reform should work collaboratively with the specialist community, hospitals and others to reach outcomes that support improved patient outcomes, will be effective, and potentially provide opportunities for shared savings and (i.e. avoid finger-pointing or an “us vs. them” mentality)

Guiding Principles For Maine’s Multi-Payer Medical Home Pilot

Several guiding principles were also suggested specifically for the upcoming Multi-Payer Pilot of the PCMH model in Maine currently in development:

- Accept up front that this pilot is an experiment – i.e. that there is no one “right answer” for how to undertake payment reform for primary care. We should consider using more than one payment model in the pilot as a test of what types of payment can work to achieve our goals, and should carefully evaluate each model.
- Encourage a wide variety of approaches in the pilot effort, including purposeful involvement of practices at varying stages of systems development.
- Support practice transformation that promotes effective systems and processes that to serve all patients in the practice, not just patients covered by specific payors.
- Seek to include all payors in the pilot, including state and federal government payors.
- Encourage approaches that encourage and reward improvements not only for primary care practices, but also for effective partnerships with specialists and hospitals; seek opportunities to offer shared savings models that provide incentives for high quality and efficient care from specialists and hospitals.
- Seek to include mental health integration as a basic expectation of the medical home model in Maine.
- Encourage a comprehensive approach to primary care that includes physicians and mid-level providers.

FACULTY BIOGRAPHIES

ROBERT BERENSON, MD, was in charge of Medicare payment policy and managed care contracting in the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) during the Clinton Administration. Since leaving government service, Dr. Berenson has served as a Senior Fellow at The Urban Institute. He is a board-certified internist who practiced for 12 years in a Washington, D.C., group practice and is a Fellow of the American College of Physicians. He also serves as an adjunct professor at the University of North Carolina School of Public Health and Fuqua School of Business at Duke University, and co-author (with Walter Zelman) of *The Managed Care Blues & How to Cure Them*, published in 1998.

ALLAN H. GOROLL, MD, is a graduate of Brandeis University. He received his medical degree, graduating cum laude, from Harvard Medical School. Following his graduation from Harvard, Dr. Goroll trained in primary care internal medicine at the Massachusetts General Hospital (MGH) and has remained there his entire career.

Dr. Goroll is Professor of Medicine at Harvard Medical School and is engaged in teaching, practice, and reform of primary care. With his colleagues at the MGH, he established the nation's first primary care internal residency track and published the first textbook in the field (*Primary Care Medicine*), now entering its 6th edition. Dr. Goroll has held many leadership positions in organized medicine, medical education, and health care reform including Chair of the Massachusetts eHealth Collaborative. Having recently founded the Massachusetts eHealth Collaborative, he is currently working on fundamental reform of payment for primary care.

ROBERT MANDEL, MD, completed his undergraduate work at Princeton University and obtained his medical degree from the Johns Hopkins University School of Medicine. After deciding to leave full-time clinical practice, he earned an MBA from the Wharton School of the University of Pennsylvania.

As Vice President for Health Care Services, Robert has spent the past two years leading Blue Cross Blue Shield of Massachusetts' (BCBSMA) transformation agenda. Prior to assuming his current role, Robert was on loan from BCBSMA to the Massachusetts eHealth Collaborative where he served as Chief Operating Officer for one year. He has held several leadership positions with BCBSMA, including Vice President of eHealth, and spent three years as Vice President of Provider Enrollment Services. Prior to beginning his administrative career, Robert practiced ophthalmology full-time for eight years in the Harrisburg area.

CHUCK WILLSON, MD, received his BA from Princeton University and his MD from the University of Virginia. His residency in Pediatrics at North Carolina Memorial Hospital (UNC-Chapel Hill) was completed with a year as Chief Resident.

Dr. Willson enjoyed private practice pediatrics for 19 years before joining the faculty at the Brody School of Medicine at East Carolina University. He is a Clinical Professor of Pediatrics and serves as director for Health Promotion and Policy Development for the Health Sciences Division. Additionally, Dr. Willson is co-director for the Center for Children with Complex and Chronic Conditions and has helped teach first year courses in medical ethics and physician leadership/ advocacy. He also serves as the Medical Director for the Community Care Plan of Eastern Carolina, which has provided care for over 100,000 patients in 27 counties of North Carolina.

CHARLOTTE S. YEH, MD, graduated from Northwestern University with both her undergraduate degree as well as her medical degree through a 6 year, honors track program. She completed further training in Emergency Medicine and Surgery during residency at University of California.

Since coming to New England in 1982, Dr Yeh has held a number of clinical leadership positions with Newton-Wellesley Hospital, New England Medical Center Hospitals, and National Heritage Insurance Company. Additionally, Dr. Yeh has held past academic appointments with Tufts University School of Medicine and the University of California. She is currently Regional Administrator of the Centers for Medicare and Medicaid Services in Boston, Massachusetts serves on the Board of several organizations: Health Research and Educational Trust, Blue Cross Blue Shield Foundation of Massachusetts, Metropolitan Boston Emergency Medical Services Council, and on the editorial board of *ED Management*.

PAYING FOR PRIMARY CARE: IS THERE A BETTER WAY?

Robert A. Berenson, M.D.

Slide 1

Paying for Primary Care: Is There A Better Way?

And What Does the “Patient-Centered Medical Home” Have to Do With It?

Robert A. Berenson, M.D.
The Hanley Forum, Portland, June 5, 2008

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Slide 4

“The Tyranny of the Urgent”

“Amidst the press of acutely ill patients, it is difficult for even the most motivated and elegantly trained providers to assure that patients receive the systematic assessments, preventive interventions, education, psychosocial support, and follow-up that they need.” (Wagner et al. *Milbank Quarterly* 1996;74:511.)

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Slide 2

Broad Interest – To the Point of Silver Bullet Status?

- Four primary care societies have endorsed (even some surgical groups)
- Various purchasers and purchasing groups – IBM, GE, ERISA Industry Committee
- Large Insurers – various Blues, United, Aetna
- The largest insurer – Medicare demo(s)
- Democratic and Republican Presidential campaigns
- Patient Centered Primary Care Collaborative www.pcpcc.net

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Slide 5

The Pressure of the 15 Minute Visit

“Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stand still... The result of the wheel going faster is not only a reduction in the quality of care but also a reduction in professional satisfaction and an increase in burnout among physicians.” (Morrison and Smith, *BMJ* 2000; 321:1541)

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Slide 3

Problems For Which Medical Home is Offered as a Solution

- Recognized deficiencies in “patient-centered” aspects of care, e.g. respect for patient values and preferences, access, coordination, emotional support, etc.
- The growing challenge of chronic care
- Relatively poor primary care compensation – leading to a growing workforce problem

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Slide 6

How Patients are Affected

- Asking patients to repeat back what the physician told them, half get it wrong. (Schillinger et al. *Arch Intern Med* 2003;163:83)
- Patients making an initial statement of their problem were interrupted by the PCP after an average of 23 seconds. In 23% of visits the physician did not ask the patient for her/his concerns at all. (Marvel et al. *JAMA* 1999; 281:283)

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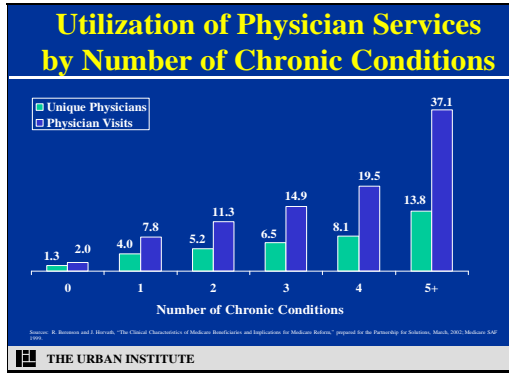
Slide 7

Recent Data on High Cost Patients

- 75% of high cost beneficiaries had one or more of 7 chronic conditions: asthma, COPD, CRF, CHF, CAD, diabetes or senility; 70% of inpatient spending was for beneficiaries with one of these – CBO, 2005
- 5% of beneficiaries accounted for 43% of total Medicare spending; the costliest 25% for 85% of spending – CBO, 2005

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Readmissions

- In Medicare, about 11% of patients are readmitted within 15 days and almost 20% within 30 days
- 50% of patients hospitalized with CHF are readmitted within 90 days
- The majority of readmissions are avoidable – declining with time from the index admission
- Half of patients discharged to community and readmitted within 30 days after medical DRG had no bill for physician services in the interval

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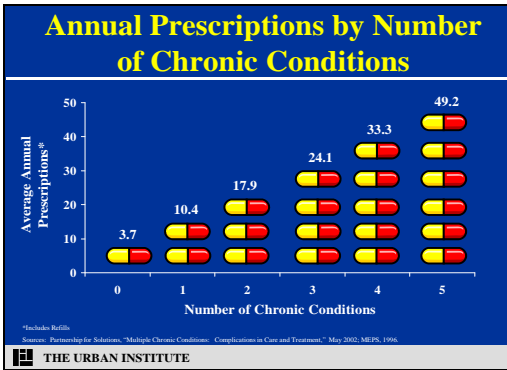
Incidents in the Past 12 Months

Among persons with serious chronic conditions, how often has the following happened in the past 12 months?

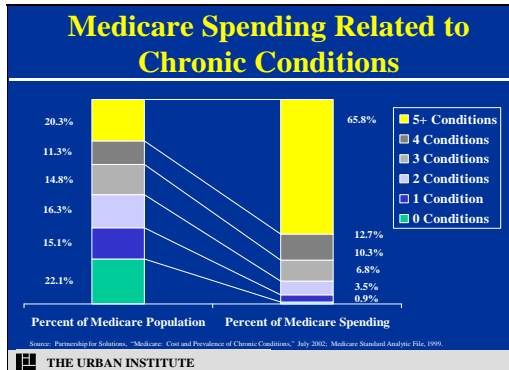
Incident	Sometimes or often
1. Been told about a possibly harmful drug interaction	54%
2. Sent for duplicate tests or procedures	54%
3. Received different diagnoses from different clinicians	52%
4. Received contradictory medical information	45%

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The Primary Care Shortage Problem and Relative Incomes


- In 1998, 54% of internal medicine residents chose general medicine; 2005 – 20% (Bodenheimer, NEJM; 355:861)
- U.S. medical school graduates entering family medicine residencies:
 - 1997 – 2340
 - 2005 – 1132 (Pugno, Fam Med; 37:555)

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Evolution (cont.)


- “Primary care case management” in commercial HMOs and a few Medicaid programs – with some success in latter and (probably in former despite disrepute); formal gatekeeper requirements in about half of OECD countries
- Practice redesign focused around EMRs and, somewhat separately, around the Wagner Chronic Care Model (which includes use of an EMR)

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Median Compensation, 1995-2004 (analysis by Bodenheimer, MGMA data)

	1995	2004	10 year increase
All primary care	133K	162K	21%
All specialties	216	297	38%
Dermatology	177	309	75%
Radiology	248	407	64%


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“A 2020 Vision of Patient-Centered Primary Care”

Karen Davis, Stephen C. Schoenbaum, and Anne-Marie Audet, *Journal of General Internal Medicine*, 2005; 20:953-957


- An excellent synthesis of these four streams into a comprehensive and plausible set of attributes and expectations

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The Evolution of the PCMH Concept – The Confluence of Four Streams

- “Medical homes” in pediatrics – 40 year Hx, oriented to mainstream care for special needs children especially needing care coordination
- The evolution of primary care deriving from WHO meeting in Alma Alta in 1978 – as summarized by Starfield core attributes are: first contact care, longitudinal responsibility for patients over time, comprehensive care, coordination of care across conditions, providers and settings

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Core Principles Agreed to by the Four Primary Care Societies in 2007

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access
- Supportive payment

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The Basic Problem with How Medicare (and others) Pay M.D.s

- The Resource Based Relative Value Scale (RBRVS)-based fee schedule has inherent limitations, even if improved (which is overdue)
- By design, the relative values of 6000+ codes are, at best, an approximation of underlying resource costs, not an attempt to determine what services beneficiaries need, that is, real value
- And, what purports to be an objective process is, despite good intentions, inherently subjective and political. It does not favor primary care.

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Bundled (“Capitated”) Payments for All Services and All Patients or a FFS Hybrid

- Don’t call it capitation, which is four letter word.
- The advantage is that all patients are included, so no practice dissonance for different patients, and risk adjustment handles the fact that different patients have different needs for chronic care management
- Can we correct the execution errors of 1990s capitation approaches related to: insurance risk, absence of risk adjustment, mechanical actuarial conversion of pmpms under FFS to a situation when more is expected of the practice?

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Fee-For-Service Is Necessarily Rooted in Face-to-Face Encounters

- There are plenty of reasons, e.g.,
 - high transaction costs, associated with non-face-to-face, frequent, low dollar transactions;
 - major program integrity concerns
 - “moral hazard” driving expenditures
- Yet, increasingly, face-to-face visits do not encompass the work of primary/principal care for patients with chronic conditions (most Medicare beneficiaries). Thus, we need to think about payment mechanisms other than FFS.

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Current PCMH Standards Emphasize Organization of the Home

- NCQA Physician Practice Connection (PPC) PCMH Standards emphasize EHRs and CCM – less on attributes of patient-centeredness
- Bridges to Excellence Office Assessment Survey similarly derive from EHR work

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Gaps in FFS Payments

- Current payment policies do not support the activities (not services) that comprise the Wagner Chronic Care Model, incl. non-physician care, team conferences, coordinating care with other physicians, harnessing community resources, using patient registries to facilitate preventive services, etc.
- N.B. This model is more than an electronic health record, which some of view as necessary but not sufficient for what a medical home needs to do

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Challenges to Adoption of the Patient-Centered Medical Home


- Lack of agreement on operational definition and emphases; alternative foci – traditional primary care or EMRs or Wagner Chronic Care Model
- Medical practice culture and structure combined with the “tyranny of the urgent,” at least in small practices
- Practice size and scope – still dominance of solo and small groups – arguably without ability, even with new resources, to adopt many elements of PCMH

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Challenges (cont.)


- Shortage of primary care physician workforce combined with more demand for services, especially if we do expand coverage a la Massachusetts
- To whom should the PCMH apply? All patients or those with special needs, e.g. in Medicare, those with multiple chronic conditions. (Note CMS has decided that up to 86% of beneficiaries qualify)
- Management challenges – even in large groups with an interest, many elements not adopted so far – but there have been no payment incentives to do so

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Pay Whom?


- All to the medical home practice, which may allocate to others?
- Separate payment streams for different parts of the medical home activities, as in North Carolina Medicaid Community Care Networks, Oklahoma Medicaid?

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Challenges (cont.)


- Should principal care physician practices, e.g. endocrinologists for diabetics, qualify?
- Is there any kind of patient “lock-in” – hard or soft?
- Unfettered expectations – every one has a favorite attribute to hang on the PCMH – shared decision-making, cultural competence, reducing disparities, detection of depression – or alcoholism – or cognitive deficits. The list goes on.

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Emerging (and Somewhat Understandable) Payer Resistance


- Skeptical about cost savings since other approaches, e.g. disease management by vendors, haven’t reduced costs – “prove it”
- Concern that PCMH is a stalking horse for more money for services practices should already be providing
- Will consumers accept this? Is this gatekeeper in drag?

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How to Pay?


- FFS/pppm/P4P?
- Reinvigorated (and renamed) capitation – “comprehensive payment” i.e. with risk adjustment, actuarially fair, etc.?
- Should care management payments be risk-adjusted?
- A role for new, targeted CPT (FFS) codes?
- Any risk-sharing by practices?

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So Some Payers May Want to Limit:

- The amount of dollars put up
- The number of patients involved – only to “complex” patients (the 5% or so that produce >50% of costs)
- The number of practices who get to play –who agree to “comprehensive redesign”
- These limitations may limit true test of concept

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A Final Cautionary Note

“Primary care could also expand beyond its more restrictive role as provider of medical care... The danger, of course, is that primary care’s new role will be even more expansive and varied than today’s already diverse activities. A redefinition of primary care must be cognizant of this risk, focus on optimizing primary care’s strengths, and avoid assuming too many peripheral responsibilities in its formulation.” (Moore and Showstack, *Ann Inter Med*, 138:244)

EVOLUTION OF THE PRIMARY CARE MEDICAL HOME IN EASTERN NC

Charles F. Wilson, M.D.

Slide 1

Evolution of the
Primary Care
Medical Home in
Eastern NC

Charles F. Wilson MD
Medical Director
Community Care Plan of Eastern Carolina
June 5, 2008

Slide 4

Crossing the Quality Chasm

- A continuous healing relationship
- Care customized to patients needs/values
- Patient is the source of control
- Information and knowledge flows freely
- Evidence-based decision making
- Transparency is necessary
- Needs anticipated
- Safety is a system priority
- Waste is continuously decreased
- Cooperation among clinicians is a priority

Slide 2

What is a Medical Home?

- Everyone has a definition
- American College of Physicians
- American Academy of Family Medicine
- National Institute of Medicine (Nat. Acad. Sci.)
- The most important definition is yours, the patient.

Slide 5

Potent Approaches

- Patient and Family Centered Care
- Care best that is closest to home
- A commitment by both docs and patients
- Open Access
- Case managers
- Data feedback
- IT: Patient Registries, EMR, RHIOs
- **NOT A GATEKEEPER**

Slide 3

Who Needs a Medical Home?

- You do! I do! We all do!
- "... sometimes you want to go where everyone knows you name, and they're always glad you came." (Cheers theme song).
- "Who are you goin' to call?" (not Ghost Busters)

Slide 6

Our Evolution in Eastern NC

- 1992* "Carolina Access" docs agree to be on-call for Medicaid patients 24/7/365.
- 1997* A county-wide network of enhanced medical homes (CCP of Pitt County)
- 2005* A state-wide program of medical homes in geographic networks. CCPEC expands to 27 counties.
- Networks serve as a template for innovation

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Making the Financial Case

- Mercer Audits:
 - 1999: \$27 million saved
 - 2003: \$60 million
 - 2004: \$124 million
 - 2005: \$218 million saved
 - 2007: \$284 million saved
 - Cost of program: \$24 million

COMPARING Primary Care with selected costs

- MRI of the head and spine: \$2500.
- Lithotripsy: \$14,000.
- Pediatric care for 20 years: \$3600.

Primary care provides best value

Slide 8

An Enhanced Medical Home

- A continuous healing relationship: patients will call
- Disease management: Asthma, Diabetes, CHF (network projects: oral rehydration, otitis media, depression, flu shots in schools, etc).
- Case managers: docs will call.
- Attention to transitions
- Data feedback

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A typical visit scenario

- Routine visit
- Medicare visit
- Medicaid visit

Payment Model	Routine visit	Medicare visit	Medicaid visit
FFS	48	28	22
Overhead	38	28	22
Ped\$	38	28	22

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Templates for Innovation

- Clinical directors group
- NC Medicaid physician advisory group
- RWJ/ABMS Grant: "Improving Performance in Practice (IPIP)."
- Statewide Healthcare Quality Alliance
- Ashe Award 2007.

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Lessons learned

- Healthcare starts locally and usually is completed locally.
- If you've seen one medical home, you've seen one medical home. (Still evolving).
- It doesn't take much to develop a partnership with physicians.
- Provide resources and data

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Threats

- Hospitalists
- Cost of a medical education (\$250,000)
- Physician work force shortages
- A profit-center approach: "No margin, no mission."
- Specialty hospitals

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Questions?

- If not in a primary care medical home, how will we provide a "continuous healing relationship?"

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Appendix 1
“Planning Process”

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DANIEL HANLEY
CENTER for HEALTH
LEADERSHIP

2008 Hanley Leadership Forum

June 5, 2008

University of Southern Maine, Portland Campus

Charting A Course Toward Improved Quality & Greater Financial Sustainability... What Will It Take To Preserve Primary Care in Maine?

AGENDA:

- 7:15 – 8:00 **Registration and Continental Breakfast**
Glickman Family Library, University Events Room, 7th Floor
- 8:00 **Welcome and Opening**
Dr. Sean Hanley, Chair, Daniel Hanley Center for Health Leadership
Dr. Lisa Letourneau, Chair, 2008 Hanley Forum Committee
- Keynote Address:** Charting A Course Toward Improved Quality & Greater Financial Sustainability...What Will It Take To Preserve Primary Care in Maine?
Dr. Allan Goroll, Harvard Medical School
- 9:00 – 10:00 **Primary Care Payment Reform:** And What Does the Medical Home Have to Do With It?
Dr. Bob Berenson, The Urban Institute
- 10:00 – 10:15 **Break**
- 10:15 – 11:15 **Innovative Public and Private Approaches to Payment Reform**
- *Dr. Chuck Willson, Community Care of North Carolina*
 - *Dr. Robert Mandel, Alternative Quality Contract, Blue Cross Blue Shield of Massachusetts*
 - *Dr. Charlotte Yeh, CMS Region One*
- 11:30 – 1:15 **Aligning Forces for Quality Announcement/Luncheon**
Abromson Community Education Center
- 1:15 – 1:45 **Afternoon Session**
Glickman Family Library, University Events Room, 7th Floor
- Update on Plans for Maine Multi-Payer PCMH Pilot
Dr. Jeff Holmstrom, Anthem Blue Cross Blue Shield of Maine
- 1:45 – 2:45 **Facilitated Roundtable Discussion** With Morning Speakers
Provocateur: *Dr. David Howes, Martin's Point Health Care*
- 2:45 **Break**
- 3:00 – 4:00 **Facilitated Discussion**
- 4:00 – 4:45 **Wrap up session** and consensus on guiding principles (focused on payment reform) moving forward—Facilitator: *Dr. David Howes*
- 5:00 – 6:00 **Networking Reception ~ Abromson Community Education Center**



April 30, 2008

Dear _____,

We're writing to personally invite you to join a group of about 60 health and healthcare leaders from across Maine at the 6th annual **Hanley Leadership Forum** on June 5 at the University of Southern Maine in Portland.

This year's Leadership Forum theme is "**Charting a Course Toward Improved Quality and Greater Financial Sustainability...What Will It Take To Preserve Primary Care in Maine?**"

At this year's Forum we will bring together the leadership of a select group of health and healthcare leaders who, like you, are deeply committed to preserving---and enhancing---vital primary care services in small and large communities throughout Maine.

Although we'll address a wide range of challenges that threaten the future of primary care, the focus of this year's Hanley Forum will be on payment reform. Through your participation in the Forum, we would like to position Maine for potential statewide multi-payer demonstration project funding by leveraging our state's pioneering efforts in chronic illness management, measurement, public reporting and electronic information-sharing. As you may know, our state's leadership on these efforts was recognized earlier this year when the federal government officially designated Maine as a **Chartered Value Exchange** or CVE.

At this year's Forum, we will:

- Build increased awareness and understanding about the vital role that primary care plays as the essential bedrock of an effective health delivery system;
- Identify the key barriers that stand in the way of the long term financial sustainability of Maine's primary care system---and build a sense of urgency surrounding the need for payment reform;
- Learn about the latest thinking relating to payment reform at the national level---and hear about strategies now being pursued by public and commercial payers across the nation;
- Focus greater attention on several leading new payment models, including the **Patient Centered Medical Home** and then identify specific ways in which adoption one or more of these models could be accelerated;
- Lay groundwork for greater alignment among organizations working to build a more financially viable primary care system; and finally,
- Develop a set of principles that would guide a process for preserving primary care in Maine in the years to come.

The faculty for this year's Forum will include several nationally-known leaders in payment reform:

- The Urban Institute's **Robert Berenson, M.D.**, former head of physician payment at CMS during the Clinton Administration;
- **Allan Goroll, M.D.**, Department of Medicine, Massachusetts General Hospital and a leader in the American College of Physicians' work on payment reform;
- **Robert Mendel, M.D.**, a key figure in an innovative payment reform model introduced recently by Blue Cross Blue Shield of Massachusetts;
- **Chuck Willson, M.D.**, a North Carolina pediatrician who has been actively involved in a nationally-recognized payment reform model involving physician networks and a new approach to Medicaid reimbursement;
- **Charlotte Yeh, M.D.**, head of the federal government's Centers for Medicare and Medicaid Services (Region One).

The Forum will open with a continental breakfast at 7:30 a.m. on Thursday, June 5 and continue all day, concluding with a reception that will go to 6 p.m. or so. This is a somewhat different schedule than previous Forums, where we started the event during the evening and reconvened the following day. **You also may be interested to know that the Robert Wood Johnson Foundation will be hosting a special luncheon at the Hanley Forum as part of a major national announcement about the next phase of the Foundation's Aligning Forces for Quality initiative.** We'll be joined for the announcement by a number of other healthcare and community leaders who are being invited separately the luncheon.

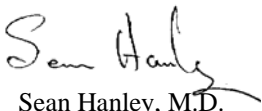
There is no charge for attending the Hanley Forum. However, advance registration is required. Please check your calendar and then email **Jim Harnar** here at the Hanley Center at jharnar@maine.rr.com with your RSVP no later than Friday, May 9. A detailed agenda and other background information will be sent to you when you notify us that you plan to attend.

If you are unable to attend---but would like to send someone else from your organization---it will be important for you to contact Jim Harnar via [via email](#) or at 523-1501. Space is limited, so we may need to limit the number of people who can attend. Jim also can answer any questions you may have about the program.

We look forward to seeing you June 5 at the 2008 Hanley Leadership Forum!

Thank you very much.

Sincerely,



Sean Hanley, M.D.

Chair

Daniel Hanley Center for Health Leadership

Lisa Letourneau, M.P.H., M.D.

Chair

2008 Hanley Leadership Forum



**Daniel Hanley Center for Health Leadership
Planning Committee**

Chair: Lisa Letourneau, M.D.

John Barry, Quality Counts
Tamara Butts, Maine Hospital Association
Josh Cutler, M.D., Maine Quality Forum
Jack Ginty, Maine Osteopathic Assn.
Sean Hanley, M.D., Hanley Center
Sheila Hanley, WellPoint
Jeff Holmstrom, D.O., Anthem Blue Cross Blue Shield of Maine
Holly Korda, Ph.D., Health Systems & Research Consultant
John LaCasse, Medical Care Development
Jim Leonard, Maine Quality Forum
Kevin Lewis, Maine Primary Care Association
Doug Libby, Maine Health Management Coalition
Andrea Maker, Martin's Point Health Care
Katherine Pelletreau, Maine Association of Health Plans
Rod Prior, M.D., MaineCare
Burgess Record, M.D., Franklin Community Health Network
Gordon Smith, Maine Medical Association



DANIEL HANLEY
CENTER *for* HEALTH
LEADERSHIP

2008 Leadership Forum

The Daniel Hanley Center for Health Leadership would like to recognize the generous support of our many donors as well as the following organizations that helped make this year's forum possible;

LEAD SPONSOR:

Martin's Point Health Care

ADDITIONAL SPONSORS:

Maine Association of Health Plans

Maine Health Management Coalition

Medical Mutual Insurance Company of Maine

PrimeCare Physician Associates



Preliminary Evaluation Results 2008 Leadership Forum

Charting A Course Toward Improved Quality & Greater Financial Sustainability...

What Will It Take To Preserve Primary Care in Maine?

We appreciate you taking the time to join us here today! Your candid responses to the questions on this form will help us to make decisions about the effectiveness of this meeting and help us to plan for the future.

Please rate the following statements on a scale from 1-5:

WHY Strengthen and Preserve Primary Care in Maine?

- 1. The Forum helped me to better understand why primary care in Maine is the bedrock of an effective health delivery system.
STRONGLY DISAGREE 1 2 3 (2) 4 (3) 5 (9) STRONGLY AGREE
- 2. The Forum helped me to appreciate why the long term financial sustainability of the primary care system in Maine is at risk.
STRONGLY DISAGREE 1 2 3 (2) 4 (1) 5 (11) STRONGLY AGREE

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HOW to Preserve Primary Care in Maine

- 3. The Forum provided insight on the latest thinking and strategies to address barriers to financial sustainability of primary care.
STRONGLY DISAGREE 1 2 3 (2) 4 (4) 5 (8) STRONGLY AGREE
- 4. The presentation of several viable payment models was useful in understanding how barriers to financial sustainability could be addressed.
STRONGLY DISAGREE 1 2 (1) 3 (4) 4 (7) 5 (2) STRONGLY AGREE
- 5. The identification of how the [Patient Centered Medical Home Model] could be adopted on a "fast track" gave me insight as to how my organization can play a role/support in this endeavor.
STRONGLY DISAGREE 1 2 (2) 3 (3) 4 (5) 5 (4) STRONGLY AGREE
- 6. The Forum demonstrated the need *and* the unique opportunities for alignment among various Maine organizations to build a more financially viable primary care system.
STRONGLY DISAGREE 1 2 3 (4) 4 (3) 5 (7) STRONGLY AGREE
- 7. The Forum's focus provides opportunities to work closely with Maine's RWJF funded Aligning Forces for Quality initiative.
STRONGLY DISAGREE 1 2 3 (3) 4 (2) 5 (9) STRONGLY AGREE
- 8. The Forum helped me to better understand the goals and plans of the Hanley Center.
STRONGLY DISAGREE 1 (1) 2 3 (4) 4 (5) 5 (4) STRONGLY AGREE
- 9. The Forum provided enough time to network with colleagues on this topic.

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10. Please give us your candid thoughts: (please print legibly)

➤ **What portion of the Forum will be most useful to you on Monday morning?**

- Conversation with Practice Manager who also attended the Wednesday meeting on PCMH
- Models of Medical Home
- Slides & Materials will help relay message to other leaders.
- All of it
- All for the PCMH Meeting Monday morning
- All portions contributed to informing my participation for Monday morning's session
- Dr. Goroll's presentation
- Dr. Willson's presentation
- Focusing on the key/select elements of PCMH questions & funding
- The morning speakers
- The afternoon Q&A with the experts
- National speakers perspectives/insights helpful
- Q&A session after lunch, lots of issues identified helped set our agenda going forward

➤ **What will be least useful?**

- Dr. Berenson's . . . on the one hand, on the other hand
- Facilitated discussion, facilitator gave preference to attendees
- Tantalizing thoughts about RBRVS reform
- Some of the afternoon discussion
- Already aware of issues in sustaining primary care. Less time could have been spent here & more time on models of funding
- Participants obviously participate in similar venues & know each other. The outcome seemed to delegate to the usual existing coalitions/organizations to continue their activities as they are already doing
- All was valuable this year

➤ **What are your suggestions for improving the Forum?**

- The most important is conversation problem solving amongst diverse leaders
- Find ways to involve more people from public health, including local leaders (they can't necessarily bill their time to their existing resources. Need to find resources to support their involvement.
- More flexibility in time for better interaction
- Great Job
- Excellent forum
- It was good, especially the balance of presentations and interactive sessions
- Stay on time, coffee at lunch
- More about the interface between primary care & public health
- This has been the best forum yet, a narrow enough subject for deep dive and great access to faculty

Moving Forward

11. What would you most like to see in the future Hanley Center leadership programs?

Follow up on the issue. Where are we in 2009. What has worked, what hasn't. New issues and concerns. What's next?

Continue focus on multi-stakeholder agendas for statewide initiatives

Like to be in it!

Public-private partnerships to spur innovations and redesign. Examining how to align state, fed & private efforts

Specialise primary care colaboratives

Maybe revisit where we are with Medical Home in a year

12. What do you think would be the best follow up from this year's Forum?

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We could create a report on the effect of each forum. What have we stimulated?

Track/Support planning, follow up on results

Continue discussion around sustainability for health care as an integrated system

A follow up meeting, update, check on progress. Tie to other efforts like Aligning forces, the multipay pilot and state health plan, rather than another separate meeting with most of the same people.

Tracking of lay players in carrying these activities forward.

Keep collaborative to reform Health Care & Primary Care going. Don't drop the ball

Tropical phone conferences every other month

Email us minutes, Powerpoint presentation

Business case/ROI in pr. centered medical homes

Invite some faculty back for six month check up on how we are doing. Maybe Gorell and Mandel since they are close.

13. How would you like to participate in the follow up to this year's Forum?

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I will attend the public health forum in October and very interested in the issue Lisa raised re aging population

Participate in follow up meetings

Will be involved in almost all initiatives.

Participant, planning contributor

Part of multi payor and this developing coalition. Aligning the Aligners

Email updates

I would love to

Keep me informed about state & fed programs

Yes

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14. Are you or your organization interested in working to help position Maine to receive funding for a Multi-payer Statewide Demonstration Grant?

Circle One

Yes No Not Sure If yes, give organization name: _____

Yes Maine Primary Care Association

Yes Maine CDC

Yes NovaHealth

Yes Mercy Health System

Yes Maine Network for Health

Yes MHMC

Not Sure Health Reach

Not Sure No organization listed

Not Sure No organization listed

Thank you!