



RURAL POLICY RESEARCH INSTITUTE  
Center for Rural Health Policy Analysis

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## Rural Innovation Profile

### *Rural Accountable Care Organization Care Coordination*

**What:** Care coordination within a rural accountable care organization (ACO) that blends the expertise and services of a health care system with local wisdom and resources.

**Why:** The movement of patients within healthcare settings and among community organizations is complex. Understanding and managing these movements through community-wide care coordination will help ensure patient care needs are met.

**Who:** MaineHealth ACO, Portland, Maine.

**How:** Integrating regionally based care coordination teams that include those within the healthcare system, as well as those at other community organizations.

### Key Points

- Identify regional/community health and social services organizations and have a clear understanding of their services, how and when services are delivered, and who is served.
- Enhance, don't duplicate, resources already positioned and trusted within rural communities.
- Define the scope of the patient population to be served so teams can stay focused and not become overwhelmed.
- Establish a communication portal that supports sharing stakeholder information, patient information, and care plans.
- Dedicate staff to program planning, development, communications, management, implementation, and measurement.

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## OVERVIEW

MaineHealth, a not-for-profit, integrated, healthcare delivery network, established the MaineHealth Accountable Care Organization (MHACO) to engage the Centers for Medicare & Medicaid Services and other payers in various ACO contracts. Under the ACO focus of better care for lower cost, MHACO works with MaineHealth members and community partners to make their communities “the healthiest in America.” Through many process and care improvements at the system level, within regions and extending into communities, MaineHealth is transforming its healthcare delivery model.

## DESCRIPTION

Established in 2011, MHACO has over 52,000 assigned beneficiaries under the Medicare Shared Savings Program. MHACO represents 8 member hospitals, 3 affiliate hospitals, and 1,400 employed and independent healthcare providers—one-third of whom are primary care providers. The MaineHealth service area predominantly covers the southern part of Maine and includes rural regions as well as the state’s largest city, Portland.

Prior to the advent of ACOs, MaineHealth, through its Physician-Hospital Organization (PHO), established two programs that have been important to improving community health. The PHO RN Care Management Program embeds nurse care managers within primary care, and the Chronic Illness Registry gathers patient-specific data on the system’s patients. From 2003 to 2012 the RN Care Managers, though centrally employed, functioned as an integral part of their respective practice care teams and used the registry to identify and manage patients with diabetes, depression, and other chronic conditions.

Beginning in 2012, the PHO shifted the care management focus to patients who had a complex medical profile and who represented a financial risk to the system. MaineHealth believed this vulnerable patient population would benefit from improved care coordination via the emerging field of complex care management. Thus, MaineHealth leveraged 10 years of its PHO experience caring for patients within primary care and additional complex care management training to enable care management for this high-risk population.

MHACO then organized complex care managers into regional teams to engage in region-specific conversations and build community-specific resources. Communities were encouraged to invite local partners, such as Area Agencies on Aging, behavioral health providers, and home health providers, to the discussion and to develop relationships and workflows to improve collaboration, communication,

**“Enhancing and improving care coordination is not a project or initiative, it’s a life-long quest.”**

***Jeff Aalberg, MD, Chief Medical Officer for MHACO***





and coordination. MHACO held conversations between central and regional leadership to ensure consistency throughout the system. MHACO also created regional forums to share and capitalize on emerging innovation occurring within particular regions that could easily be spread to others.

Each region has a process for assigning patients requiring care management to system, regional, and local resources. Using a chronic disease registry and other patient data, patients are matched with the best resource available. In some communities, the matching occurs through a team member who acts as an “air traffic controller” and decides which patient goes to which resources based on agreed-upon algorithms. In other regions, the matching occurs as a result of a team meeting where team members review patients and decide among themselves who will connect best with the specific patient. An advantage of the team meeting is the opportunity to discuss patient needs, use the team for clinical consultation, collaborate on approaches to removing system barriers, and conduct warm hand-offs during the matching process. In rural communities, where resources are often scarce and more geographically dispersed, this approach is particularly important to sustain the care management team.

As MHACO develops this model, features are added to fill identified program needs. A 30-hour care management training program was designed so that patients can expect a high level of competency from either a complex care manager or a regional care manager. Training consists of disease-specific condition education, motivational interviewing, and other patient engagement strategies. Training also involves didactic presentations, role playing, and a skills lab. MHACO is examining new population health management tools, such as a single care plan for each patient that can be accessed by all system providers, regardless of electronic health record availability. MHACO is also further refining patient risk identification processes and metrics for evaluating care coordination success.

#### **NEXT STEPS**

Care coordination will continue to develop and be integrated across the care continuum. Since each region is at a different phase of development, each will continue to evolve based on the community resources available, partnerships that are made, and both population and patient needs.

**“Rural communities trust their neighbors and their neighborhood organizations. As an ACO, we want to fully access and integrate those trusted community resources into the care team and into the care we provide our patients.”**

***Cindy Tack, Senior Director, Clinical Initiatives***





MHACO has identified the following focus areas to advance its care coordination approach:

- Define care management team roles and responsibilities, and engage the practice team in ensuring that every patient has access to care coordination services.
- Build a shared care plan for each patient using a universal, electronic care planning tool that can be accessed throughout the continuum of care.
- Practice informed decision making where healthcare providers in partnership with patients make meaningful decisions based on current health information.

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