



# Monthly Program Report

May 2012

## ***Bangor Beacon Community Partners***

Eastern Maine Healthcare Systems

The Acadia Hospital

Community Health and Counseling Services

Eastern Maine Community College

Eastern Maine Homecare

Eastern Maine Medical Center

HealthInfoNet

Maine Primary Care Association

Penobscot Community Health Care

Ross Manor

St. Joseph Healthcare

Stillwater Healthcare

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## **Collaborative Highlights**

The Bangor Beacon Community (BBC) held its Finishing Strong Retreat on May 8. Carol Beasley from the Institute for Healthcare Improvement (IHI) facilitated the meeting. Information gathered from the retreat will help comprehensive workplan for the last year of the grant.

The Bangor Beacon Patient Advisory Group convened its second meeting on May 30, 2012. Participants consistently commented on how much they value being part of the Bangor Beacon conversation. The next meeting is scheduled for the end of June.

James Raczek, MD, vice president and chief medical officer at Eastern Maine Medical Center (EMMC) and CoP Lead for Clinical Transformation, was selected as our Bangor Beacon Community health IT and meaningful use champion to attend a special White House Health IT Town Hall event on June 19. This event gives us the opportunity to highlight the positive impact of health IT on healthcare in our community and the role our program has played.

Cathy convened the Community of Practice (CoP) Leaders on May 29 to discuss Bangor Beacon governance for the final year. The group added a few members so that each partner has a representative. This CoP Leads group will make the decision during the final year of the grant, including developing the sustainability model.

## **Patient Centered Strategy**

*Performance Improvement* – Eastern Maine Medical Center’s (EMMC) Family Medicine of Brewer practice is piloting a statin protocol. Medical assistants will use the protocol to adjust statin dosages in patients with chronic conditions such as diabetes and coronary artery disease to proactively address high cholesterol readings. Penobscot Community Health Care (PCHC) and St. Joseph’s Healthcare will pilot the protocol as well.

*Care Management* –The next Care Manager Forum is scheduled for June 21, 2012 at PCHC. Provider interviews regarding care management models have been completed and a report will follow soon. Care managers at EMMC practices are moving to the practice offices to allow more integration with the patient care team.

*Health Information Technology & Meaningful Use* – BBC is working on some final issues of data exchange between practices and HealthInfoNet (HIN). Issues are being resolved, validated, and tested with all practices. Community Health and Counseling Services (CHCS) users will have view only access to HIN in June.

*Home Care Transition of Care Project* – The homecare group is now extending enrolment for the tele-monitoring project to referrals from care managers at the primary care practices.

*Mental Health* – The Mental Health Task Force is investigating successful models of behavioral health integration in primary care practices for further discussion and review with BBC partners and forum participants. The group is planning to hold another forum in the fall.

*Workforce Development* – Centricity servers were installed at Eastern Maine Community College and faculty training continues. Implementation of the health information technology curriculum is scheduled to begin in Fall 2012.

### **Challenges/Opportunities**

*Sustainability* – Cathy Bruno and Mike Donahue presented BBC’s Sustainability ideas to the ONC Sustainability Community of Practice Leader meeting on May 25, 2012.

*Dissemination* – Barbara Sorondo, MD, and EMMC’s Clinical Research Center has submitted several abstracts to Academy Health for a number of targeted publications. BBC is featured as a *Story from the Field* on the ONC’s website.

*Submitted by Catherine Bruno, Executive Sponsor*



**Clinical Transformation**-James Raczek, MD-Lead, Robert Allen MD-Alt  
**Data and Performance Measures**-Barbara Sorondo, MD MBA -Lead, Frank Bragg, MD-Alt

## Performance Improvement Intervention

- Reviewed 90 day plans for Asthma/COPD from Year 2, Q1.
- The Performance Improvement Committee discussed how to improve the Bangor Beacon Immunization rates. The recommendation is to look at other Beacon Communities experiences. Dr. Sorondo will follow up with registration to see if we can add a line to the appointment reminder letter for patients asking them to let providers know about their influenza vaccine status for input into Centricity.
- EMMC is test piloting an LDL Statin Protocol at Family Medicine of Brewer. PCHC and St. Joseph's will also pilot the protocol. The Medical Assistants will use the protocol to adjust statin dosages in patients with chronic conditions such as Diabetes and Coronary Artery Disease.
- St. Joseph Internal Medicine (SJIM) continues working on the transition to Centricity EMR. For instance, they have noted that the data collection in the old EMR was based off of billing codes, while the new one is based off of ICD-9 codes. This has affected the number of patients who are marked as Beacon patients, and requires manual cleanup.
- The Performance Improvement Committee recommended discussing the changes in the healthcare system with the Patient Advisory Committee, mainly "How do you feel about receiving care from a team of clinical staff as opposed to the provider?"

### Bangor Beacon Community Measures Progress ALL BEACON REPORT

■ Meets BBC Criteria  
■ Meets NCOA Criteria. Where no NCOA criteria exists, interim goal is 10%  
■ Does not meet any criteria

| COPD Quality Measures                              | Baseline<br>September 2010 |       |     | Q1<br>March 2011 |       |     | Q2<br>June 2011 |       |      | Q1<br>March 2012 |       |     | Interim | BBC   | Statistical<br>Significance         |                     |
|--|----------------------------|-------|-----|------------------|-------|-----|-----------------|-------|------|------------------|-------|-----|---------|-------|-------------------------------------|---------------------|
|  | Num                        | Denom | Pct | Num              | Denom | Pct | Num             | Denom | Pct  | Num              | Denom | Pct | GOALS   | GOALS | P-Trend                             | Time Period         |
| Smoking status documented                          | 2295                       | 2557  | 90% | 2176             | 2269  | 96% | 2192            | 2198  | 100% | 2839             | 2864  | 99% | >=89%   | >=99% | p=0.0000                            | Baseline to Q2 2011 |
| Tobacco free                                       | 1310                       | 2557  | 51% | 1216             | 2269  | 54% | 1199            | 2198  | 55%  | 1685             | 2975  | 57% | >=50%   | >=60% | p=0.0001                            | Baseline to Q1 2012 |
| Tobacco free or smoking cessation advice given     |                            |       |     | 2088             | 2269  | 92% | 1977            | 2198  | 90%  | 2826             | 2975  | 95% | >=85%   | >=95% | p=0.0000                            | Q1 2011 to Q1 2012  |
| *Depression screening (PHQ-2) within last 365 days | 1171                       | 2557  | 46% | 1290             | 2269  | 57% | 1211            | 1849  | 65%  | 1410             | 1870  | 75% | >=70%   | >=80% | No trend due to lack of data points |                     |
| BBC COPD Bundle                                    | 658                        | 2557  | 26% | 847              | 2269  | 37% | 919             | 2198  | 42%  | 1468             | 2975  | 49% | >=30%   | >=40% | No trend due to lack of data points |                     |
| Influenza vaccine (> 18 yo)                        |                            |       |     | 1434             | 2269  | 63% | 1435            | 2198  | 65%  | 2046             | 2975  | 69% | >=70%   | >=80% | p=0.0000                            | Q1 2011 to Q1 2012  |
| 2011-2012Influenza (8/16/2011-8/15/2012)           |                            |       |     |                  |       |     |                 |       |      | 2036             | 2975  | 68% |         | >=80% | No trend due to lack of data points |                     |
| Pneumovax vaccine (≥ 18 yo)                        |                            |       |     | 1768             | 2268  | 78% | 1807            | 2198  | 82%  | 2636             | 2975  | 89% | >=70%   | >=80% | p=0.0000                            | Q1 2011 to Q1 2012  |

(PCHC & EMMC Crystal Report. SJIM internal report)

(PCHC & EMMC Meridios Active patients. SJIM internal report)

(PCHC & EMMC Meridios - BBC defined patients seen within previous 12 months. SJIM internal report)

|  |   |  |
|--|---|--|
| <b>COPD BUNDLE</b><br>(must meet all conditions) | Pneumovax vaccine<br>Influenza vaccine<br>Smoking status documented | Tobacco free OR smoking cessation advice given<br>Depression screening within last 365 days (PHQ2)<br>edited 5/15/12 |
|--|---|--|

**Bangor Beacon Community Measures Progress**  
**ALL BEACON REPORT**



| ASTHMA Quality Measures                        | Baseline<br>September 2010 |       |     | Q1<br>March 2011 |       |     | Q2<br>June 2011 |       |     | Q1<br>March 2012 |       |     | Interim<br>GOALS | BBC<br>GOALS | Statistical<br>Significance         |                     |
|--|----------------------------|-------|-----|------------------|-------|-----|-----------------|-------|-----|------------------|-------|-----|------------------|--------------|-------------------------------------|---------------------|
|  | Num                        | Denom | Pct | Num              | Denom | Pct | Num             | Denom | Pct | Num              | Denom | Pct |                  |              | P-Trend                             | Time Period         |
| Smoking status documented                      | 6329                       | 7270  | 87% | 5453             | 6041  | 90% | 5176            | 5209  | 99% | 4754             | 4916  | 97% | >=89%            | >99%         | p=0.0000                            | Baseline to Q2 2011 |
| Tobacco free                                   | 4992                       | 7270  | 69% | 4045             | 6041  | 67% | 3614            | 5209  | 69% | 4719             | 6490  | 73% | >=70%            | ≥80%         | p=0.0000                            | Baseline to Q1 2012 |
| Tobacco free or smoking cessation advice given |                            |       |     | 5108             | 6041  | 85% | 4466            | 5209  | 86% | 5976             | 6490  | 92% | >=85%            | ≥95%         | p=0.0000                            | Q1 2011 to Q1 2012  |
| BBC Asthma Bundle                              | 1404                       | 7270  | 19% | 1024             | 6041  | 17% | 1091            | 5209  | 21% | 1996             | 6490  | 31% | >=20%            | ≥30%         | No trend due to lack of data points |                     |
| Influenza vaccine (> 18 yo)                    |                            |       |     | 2282             | 6041  | 38% | 2285            | 5209  | 44% | 3458             | 6490  | 53% | >=70%            | ≥80%         | p=0.0000                            | Q1 2011 to Q1 2012  |
| 2011-2012 Influenza (8/16/2011-8/15/2012)      |                            |       |     |                  |       |     |                 |       |     | 3438             | 6490  | 53% |                  | ≥80%         | No trend due to lack of data points |                     |
| Pneumovax vaccine (> 18 yo)                    |                            |       |     | 2848             | 6041  | 47% | 2911            | 5209  | 56% | 4456             | 6490  | 69% | >=70%            | ≥80%         | p=0.0000                            | Q1 2011 to Q1 2012  |

(PCHC & EMMC Crystal Report. SJIM internal report)  
 (PCHC & EMMC Meridios Active patients. SJIM internal report)  
 (PCHC & EMMC Meridios - BBC defined patients seen within previous 12 months. SJIM internal report)

|  |   |  |
|--|---|--|
| <b>Asthma BUNDLE</b><br>(must meet all conditions) | Pneumovax vaccine<br>Influenza vaccine<br>Smoking status documented | Tobacco free OR smoking cessation advice given |
|--|---|--|

edited 5/15/12

Care Management Intervention

- Care managers continue to enroll new patients into care management and track patients who are currently enrolled.
- The Clinical Research Center has begun to do an interim analysis of the six month control group data. The initial analysis has helped us to determine what information we are missing so we can collect that information.
- Provider interviews about the care management model have been completed. Transcriptions of the interviews are currently being done, with a report to follow completion of the transcription.
- The EMMC care managers have begun to change locations so that they are physically in the practice that they are assigned, rather than all in one location outside of the practices.
- PCHC continues to increase the number of care managers and support staff for their care management model, including health coaches and social workers to service the growing needs of their patient population.

**Current Enrollment Numbers for Care Management Project**

| Organization                           | Enrollment ending 9/30/11 | New enrollment | Total Enrolled to Date | Target Enrollment |
|--|---------------------------|----------------|------------------------|-------------------|
| Penobscot Community Health Care        | 541                       | 22             | 563                    | 600               |
| Eastern Maine Medical Center           | 476                       | 23             | 499                    | 600               |
| St. Joseph Internal Medicine           | 155                       | 15             | 170                    | 300               |
| <b>TOTAL Beacon PCP Provider Group</b> | <b>1172</b>               | <b>60</b>      | <b>1232</b>            | 1500              |
| Community Health & Counseling Services | 12                        | 0              | 12                     |                   |
| The Acadia Hospital                    | 33                        | 5              | 38                     |                   |
| <b>TOTAL Integration Project Group</b> | <b>45</b>                 | <b>5</b>       | <b>50</b>              |                   |
| Control Group                          | --                        | --             | 321                    |                   |
| <b>TOTAL Control Group</b>             | --                        | --             | <b>321</b>             |                   |

**310 patients withdrawn/discharged/lost to followup  
SJ (7), PCHC (120), EMMC (97), Acadia (6), Control (80)**

**Homecare Transition of Care Project**

- Enrollment for the Beacon telemonitoring project has reached 12 patients through 2 months of enrollment.
- The homecare group is coming up with processes to increase the number of patients receiving telehomecare services, including referrals from the care managers at the primary care practices.

**Immunizations Committee**

- The Immunization Committee continues to run into the barrier that influenza and pneumococcal vaccination reporting is not mandatory for those places who administer immunizations, and vaccination is not mandatory for the population. The immunization committee will continue to discuss methods for collecting immunization data for the Bangor Beacon patients.

**Mental Health Care Committee**

- Based on feedback from the initial Mental Health Forum the Mental Health Task Force will be scheduling a second forum in early Fall to continue discussions around confidentiality and communication between providers.
- The Mental Health Task Force is investigating successful models of Behavioral Health Integration in the Primary Care Practice for further discussion/review with Beacon partners and forum participants.

# Clinical Transformation

## Legend

Completed Milestone ●  
Milestone in progress ○

March 2012-March 2013

### Practice Level Performance Improvement Initiative

March- Year 2, 1<sup>st</sup> quarter data of DM Data presented ●  
 March- Year 2, 1<sup>st</sup> quarter DM 90 day plans updated and set ●  
 April- Year 2, 1<sup>st</sup> quarter CVD data presented ●  
 April- Year 2, 1<sup>st</sup> quarter CVD data 90 day plans updated ●  
 May- Year 2, 1<sup>st</sup> quarter Asthma/COPD data presented ●  
 May- Year 2, 1<sup>st</sup> quarter Asthma/CO PD data 90 day plans updated and set ●  
 June- Year 2, 2<sup>nd</sup> quarter DM data presented ○  
 June- Year 2, 2<sup>nd</sup> quarter DM data 90 day plans updated and set ○

### Care Management Program

March- Distribute supplies to beacon patients ●  
 April- Care Manager Forum at Acadia Hospital ●  
 April- Care managers start discussion on best practices ●  
 April- Palliative Care presentation for care managers ●  
 April- Point of Care A1C meters delivered to EMMC practices ○  
 May- Ending new enrollment for Beacon care management ○  
 May- Completion of provider forum interviews for care management evaluation ●  
 May- St. Joseph Hospital discharge summaries in HIN, available for EMMC care managers for the first time ●  
 May- Collect addresses for GIS mapping to help identify hotspots for high risk/high cost patients ●  
 June- 9<sup>th</sup> Care Manager Forum ○  
 June- Presentation of Care Manager Performance Numbers to Care Managers ○

### Immunization Compliance

March- Complete distribution of Employee Immunization records to PCP's ●  
 March- St. Joseph Health immunization data reported through Meridios, all three organizations reporting through same reporting tool ●  
 May- Determination of activities to achieve the finishing strong objectives; provider education of HIN, improve reporting of immunizations to pcp ●  
 August- Complete collection of flu immunization data from BBC for data analysis with baseline immunization rates ○  
 Mar 13'- Get FQHC Bucksport Regional Medical Center aligned with Beacon Immunization efforts ○

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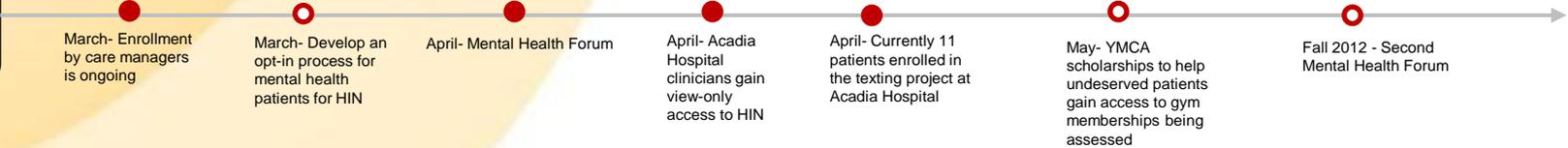
# Data & Performance Monitoring

**Legend**

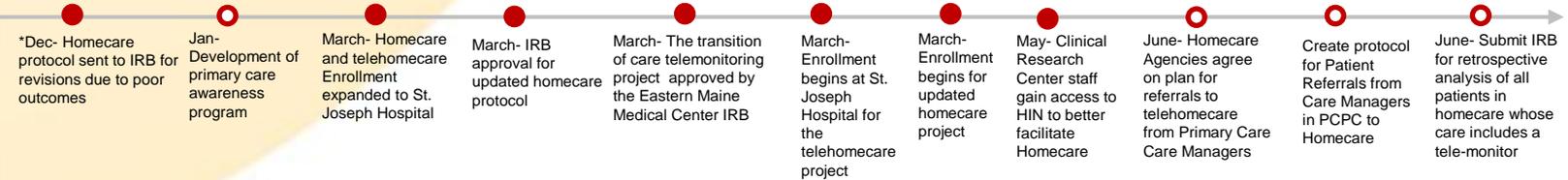
- Completed Milestone ●
- Milestone in progress ○

March 2012-March 2013

## Mental Health Pilot



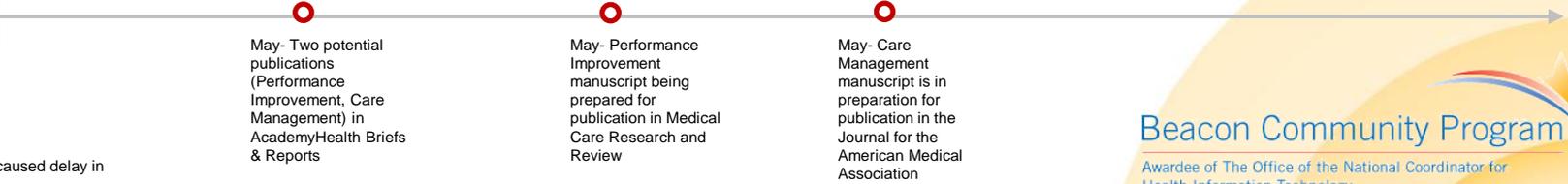
## HomeCare Collaborative



## Community Measures



## Publications



\*Denotes activities which caused delay in project progress





Dev Culver-Lead  
Bob Kohl-Alt

The Bangor Beacon Community endeavors to enhance patient care and reduce healthcare costs through the utilization of Health Information Technology and Health Information Exchange. The current reporting period shows continued progress toward these goals as detailed below.

#### Health Information Exchange (HIE):

- **EMMC Ambulatory Practices:**

EMHS and HIN are currently working on the exchange of the following data:

- Immunizations –EMHS is waiting for GE Centricity to resolve the issue of duplicate immunizations interfacing
  - Office Visit Notes and Walk-In Care notes: Interface export from Centricity currently still in TEST phase. Target go-live date is slated for July 2012.
  - Additional Data Elements–
    - Height, Weight, Chief Complaint, Blood Pressure, Smoking Cessation & Counseling: EMHS has built the flowsheet and is currently testing the export. Target go-live date is slated for July 2012.
    - Primary Insurance Plan: EMHS is currently sending TEST messages to HIN. Target go-live is slated for July 2012.
  - Problems: Final User Acceptance Testing for problem lists is expected to be completed in early June, with a Go LIVE date planned for early June 2012, as well.
- **PCHC** and HIN are actively validating ADT and Office Visit Notes and targeting June 25, 2012 to Go Live with these two data types. PCHC's reference lab data from Affiliated Laboratory, Inc. is not flowing into HIN. PCHC and HIN will work to define a timeline for Phase 2 data exchange, to include Immunizations, problems, Vitals, in-House Labs, and Radiology.
  - **Northeast Cardiology Associates** is working to configure its Centricity system to exchange Demographic information and Office Visit Notes. Target Go Live is the end of June 2012.
  - **St. Joseph Ambulatory Care** and HIN are actively validating Centricity ADT and Office Visit Note, targeting June 18, 2012, to be live with these two data types. **St. Joseph Hospital** is implementing a new pharmacy system and expects to start sending test immunization messages by early June 2012.
  - Technical efforts continue to enable data exchange from **Acadia Hospital** and HIN. Target for this data exchange is August 2012.
  - **Community Health and Counseling Services (CHCS)** provided HIN with an initial list of users to receive view only access to HIN, and these users will be created in HIN by June 1, 2012. CHCS and HIN will schedule training events to educate users on access and navigation of HIN.
  - **Data Repository activities**: Revised totals provided on April 30, 2012, to BBC Evaluation reflected unduplicated Emergency Department visits. BBC Evaluation group validated and accepted this data. Phase 2 reporting for BBC Evaluation will include data from dates of enrollment and between multiple visit dates. HIN staff members are drafting the script to run the requested data once the final list of enrolled members are received.
  - **Secure Messaging (HIN)**: Once the Surescripts secure messaging service is activated in June 2012, CHCS will be added to this new portal service which will share the same Health Information Service Provider (HISP) solution as Kryptiq/GE Centricity.

#### Electronic Medical Records (EMR):

Eastern Maine HomeCare completed End User Training on May 25, 2012, and are preloading patient data into the McKesson system. EMR Go Live is scheduled for 6/4/2012 in the Hancock County Home Care division. EMHC and HIN are reviewing a proposed home care summary document to be available in the exchange. A formal interface specification document will be developed in June 2012.

#### FQHC/HRSA Integration:

HealthInfoNet has scheduled kick-off meetings with each FQHC HRSA awardee. Kick-off meetings are face-to-face meetings with each facility's full executive and clinical leadership team to introduce HealthInfoNet and how it works, as well as the key phases, events, and timeline for the connection project plan.

- Katahdin Valley Health Center expects their public IP address to become available by the week of June 4, 2012, for establishing VPN connectivity with HIN. A training session for view only users is scheduled for June 5, 2012.
- Health Access Network (HAN) has established VPN connectivity with HIN. HAN's vendor, EHS, will provide to HAN cost, timing and technical specifications for HL7 exchange of specified data elements.
- HIN is processing Bucksport Regional Health Center's VPN Tunnel Configuration Form received on May 21, 2012. Connectivity is expected by June 15, 2012.
- Sebasitcook Family Doctors (SFD) went LIVE with view only access to HIN on May 23, 2012. SFD expects to have its interfaces installed by June 1, 2012, so data exchange efforts can begin.

#### Workforce Development:

The Centricity servers for Eastern Maine Community College (EMCC) are installed, and faculty training was completed May 18, 2012. Implementation of Health Information Technology curriculum is scheduled for Fall 2012.

#### Meaningful Use:

Preliminary Meaningful Use Metrics for Bangor Beacon have been reported to the Office of the National Coordinator (ONC). ONC has processed these metrics and reports Bangor Beacon Community at 66% for attainment of Meaningful Use. The BBC goal was 60%.

#### Issues/Risks:

- NECA has not implemented the Orders module in Centricity to record discrete diagnosis and procedure code information. Therefore, this data is not available in Centricity to submit to HIN. NECA is contacting its practice management vendor, FLEX, to determine if they can interface this information to HIN and at what cost.
- Bangor Beacon administration is reviewing the proposal from MPCA administration to determine next steps for MPCA.
- Bucksport Regional Health Center does not have an EMR implemented at this time. HIN and BRHC are working together to determine if ADT and lab results can be exchanged through existing systems.

Next Meetings:

BBC HIT/MU Committee Meeting  
Acadia-HIN Pilot Meeting  
EMHC EMR Implementation  
EMHS – HIN Meetings

June 13, 2012  
June 11, 2012  
Weekly  
Weekly

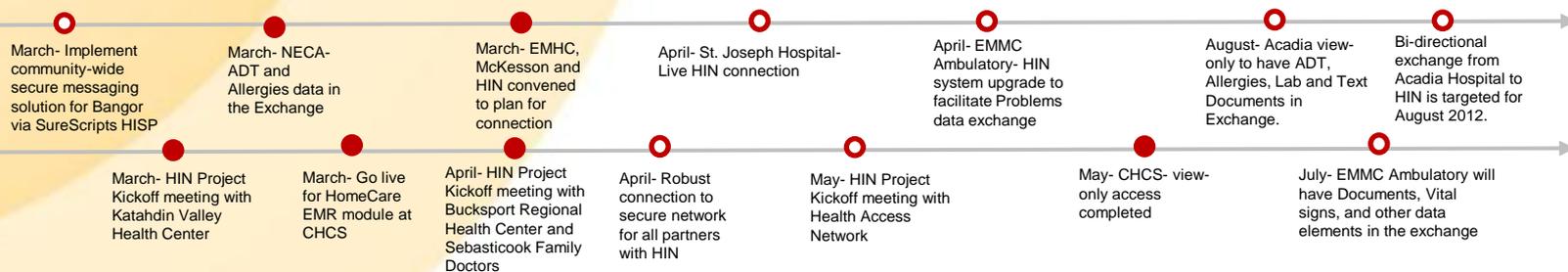
# HIT & Meaningful Use

## Legend

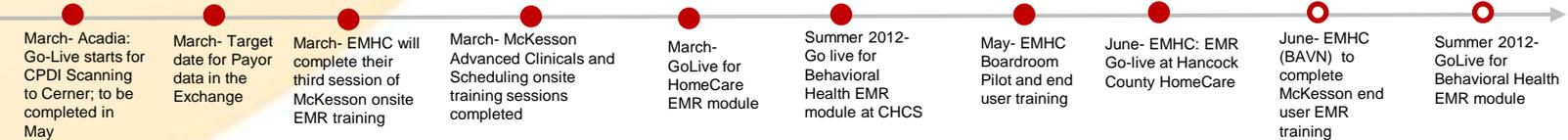
Completed Milestone ●  
Milestone in progress ○

March 2012-March 2013

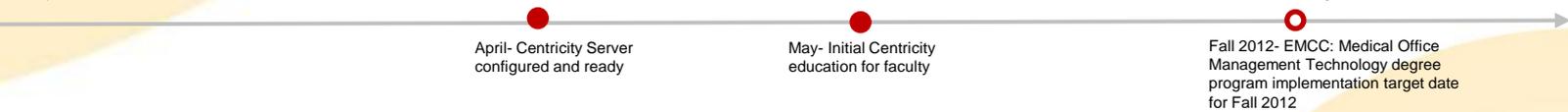
### HIE Connectivity



### EMR



### Workforce Development



### Meaningful Use



Beacon Community Program

Awardee of The Office of the National Coordinator for Health Information Technology



Cathy Bruno-Lead  
Dale Hamilton-Alt

### Program Governance

Cathy Bruno, Bangor Beacon Community executive sponsor, was honored with the 2012 Award for Innovation Leadership from the MIT Sloan CIO Symposium. The award honors chief information officers who lead their organizations to pursue the innovative use of information technology and business processes to deliver business value.

### Patient Advisory Group

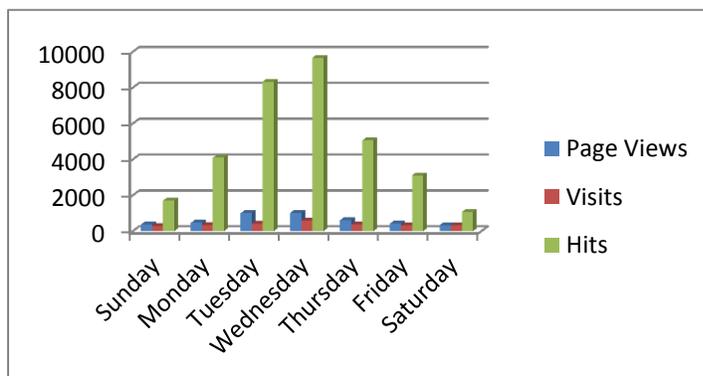
The Beacon Patient Advisory Group held their second meeting the end of May. The willingness of participants to share both insights and perspectives is contributing to the Bangor Beacon Community project by informing our practices. In the most recent meeting we shared some highlights of data we are collecting and how it is going to be used to (re)define our standard of care for patients with chronic conditions and provide care for more people in our community. Participants consistently commented on how much they value being a part of the Bangor Beacon conversation. The only recommendation was to elicit their involvement sooner; however, it is better now than not at all. The next meeting is scheduled for the end of June and the group requested information about the Pioneer Accountable Care Organization.

The next scheduled Statewide Advisory Committee group meeting is July 18, 2012.

### Communications & Outreach Web

During the month of April the [www.bangorbeaconcommunity.org](http://www.bangorbeaconcommunity.org) website received a total of 4,350 page views and 2,747 visits. The website has seen recent increases in the number of visitors, especially viewing our newly added videos.

### Website Data



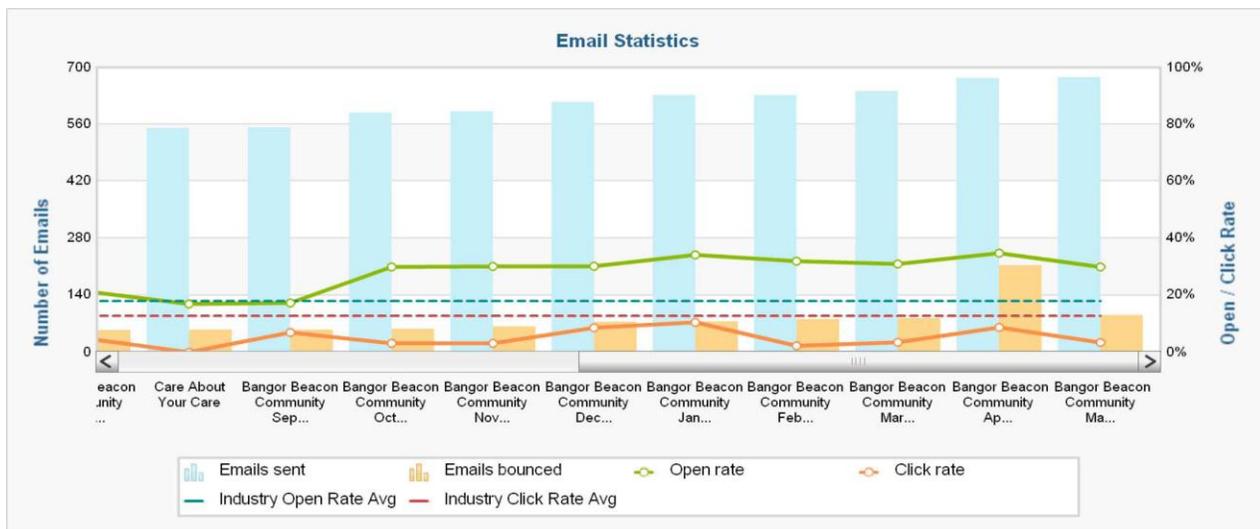
## Social Media

The Bangor Beacon Community actively shares information through social media networks, including Twitter, Facebook, YouTube, and LinkedIn. We track how many people follow, view, and re-post the information we are providing. Bangor Beacon Community is the primary manager of the BeaconNation Facebook page – providing information about what the Beacon communities are doing around the country.

On Twitter as of May 31, 2012, @BangorBeacon has 956 followers, has sent 5,651 Tweets, is following 1,999 users, and is listed 36 times. Bangor Beacon was nominated for a 2012 SMBBRG Award. The awards recognize social media excellence in the greater Bangor area. All nominees and winners are chosen via social media. Awards will be presented on June 7.

## Program Communications

The program sends a monthly eNewsletter to more than 670 people. The newsletters continue to be popular and are consistently opened by more than 30 percent of our mailing list. This is much higher than the industry average of 17 percent. May's issue open rate remained steady at 30%.



# Leadership & Governance

## Legend

Completed Milestone ●  
Milestone in progress ○

March 2012-March 2013

### Program Governance



### Communications & Outreach



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Mike Donahue-Lead  
Donald Krause, MD-Alt

### **Pioneer ACO:**

Pioneer ACO planning continues. EMHS practices from Eastern Maine Medical Center (EMMC), Inland, and The Aroostook Medical Center (TAMC) are actively participating in the program and each practice has hired care managers. EMHS is continuing negotiations with Penobscot Community Health Center (PCHC) to assess the capability of joining the group for patients who have commercial insurance for the first year of the ACO.

### **Care Coordination:**

There is confidence that care coordination will be sustained in its majority beyond the grant as a result of the current payer contracting efforts underway via Beacon Health, and for Medicare patients through the Pioneer ACO. Updated payer mix and cost reports are being generated by an effort to identify and create a crosswalk for currently care managed patients. Further planning regarding other alternatives for sustaining services for those who may fall outside of those contracted via Beacon Health also continues.

### **ONC Sustainability Calls May 2012**

Cathy Bruno and Mike Donahue presented Bangor Beacon Community's plan for sustainability during the CoP call on Friday, May 25 describing the Pioneer ACO and other opportunities for our community to sustain its activities.

### **Finishing Strong May 8 Retreat Update:**

The Bangor Beacon Community conducted a Finishing Strong Retreat on May 8. Carol Beasley from the Institute for Healthcare Improvement facilitated the meeting. The feedback received from project managers and participants was compiled and shared during the retreat and was the foundation for discussions. The group determined some specific items to research or measure within the next few months, including measuring the Pioneer ACO measures in addition to the Beacon measures, a cost analysis and return on investment (ROI) for payers, seeking other funding opportunities to transition from the grant to ACO, and researching the cost, and steps needed to create a higher performing primary care practice. Following the retreat a comprehensive plan for the final year of the Bangor Beacon Community program will be created and sent to all partners in early summer.

### **Issues/ Risks/Barriers:**

- Securing funding to sustain Bangor Beacon Community activities beyond the Pioneer ACO continues to be a barrier.

### **Mitigation:**

- EMMC's Clinical Research Center is currently conducting a review to provide a ROI analysis for the cost to continue Beacon activities following the end of the program.

### **Events planned for the next reporting period:**

- Final provider survey regarding sustainability to be completed.
- BBC Final Year Plan.
- Updated payer mix and cost reports to identify and crosswalk of patients currently provided care management.

# Sustainability

## Legend

Completed Milestone ●  
Milestone in progress ○

March 2012-March 2013

Prepared for sustainability in our community

March- Statewide BBC Sustainability Meeting

May 8th- Final Year Retreat

Summer 2012- Planning and Advanced Team meeting post "Final Year Retreat"

Build clarity about and support for what we should sustain

March- Pre-plan work for the Finishing Strong Retreat began, and a questionnaire was created for Project Managers to target projects which haven't started, barriers preventing success, and what can be done moving forward

April- Send out questionnaire to Project Managers to document current projects, barriers preventing completion of remaining projects and what resources are needed

April- Gather feedback from Beacon participants regarding bright spots, barriers, and what programs will require a transition plan

May- Develop financial model capturing cost and focus on FTE allocation

June- Continued development of financial modeling to ensure sustained services; Care coordination, Performance Improvement, Systems (HIN) Disease Registries/Analytics (Meridios)

Define the model and approach to use for sustainability, especially beyond ACO

March- Claims data file containing aligned lives for the ACO pilot program was received from CMS and is being processed by EMHS IS

March- Pre-planning team create "asks" of our partners to compile three barriers they've encountered and need assistance to move forward

April- Send out Sustainability surveys targeting providers to reach an agreement regarding sustainable priorities, satisfaction with the program to date, and understanding of the program

May- Compile and digest documentation from the Finishing Strong retreat and formulate a final year approach for the Beacon grant

Schedule periodic sustainability meetings with stakeholders, partner decision makers, and project leads to effectively track grant exit operations during the final year

Develop seamless transitions plan to ensure no patient falls through the cracks

March/April- Request sent to Clinical Leaders to define a transition plan to ensure no patient falls through the cracks

April- Data collection and validation calls with partner administrators in prelude to payer mix and cost reports run

April- Align those currently care managed in Beacon with the Pioneer ACO, Patient Centered Medical Home (PCMH), Community Care Teams, and other programs

May- Complete actionable reports which identify the population by coverage (i.e. un-insured, Anthem, Cigna)

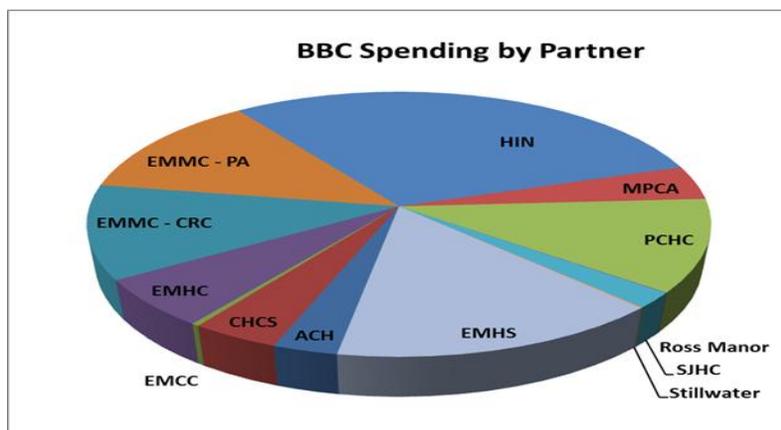
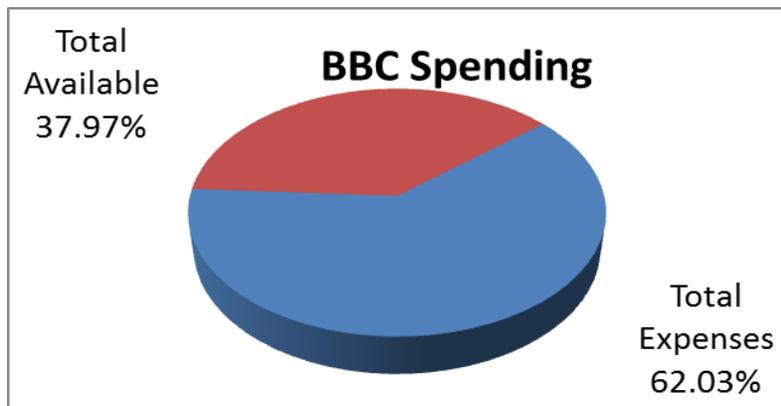
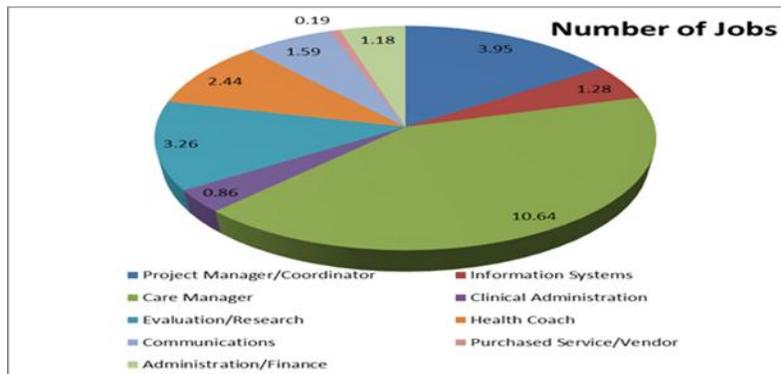
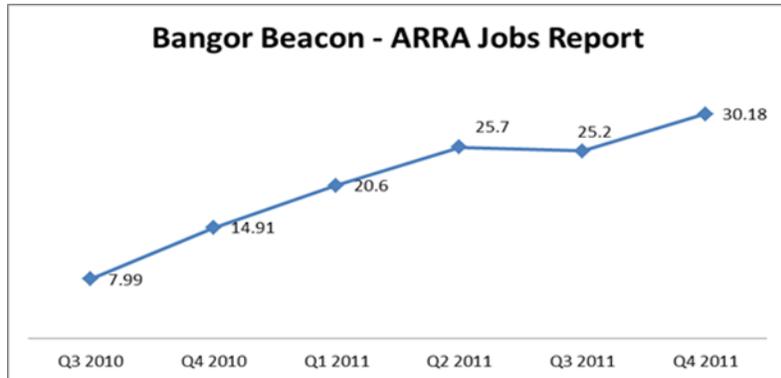
June- Complete payer contracts, and alternate methods of funding report

Nov- Commence conversations with patient regarding options

Beacon Community Program™

Awardee of The Office of the National Coordinator for Health Information Technology

| Direct Charges         | Total                |
|------------------------|----------------------|
| Personnel              | 2,456,199.98         |
| Fringe Benefits        | 918,642.70           |
| Travel                 | 64,830.80            |
| Equipment              | 555,838.51           |
| Supplies               | 625,955.78           |
| Contractual            | 210,819.25           |
| Other                  | 2,654,736.50         |
| <b>Total Charges</b>   | <b>7,909,266.21</b>  |
| <b>Total Available</b> | <b>4,840,473.79</b>  |
| <b>Total Award</b>     | <b>12,749,740.00</b> |



## 4. Administrative Updates

Amy Bates has joined the Clinical Research Center as a Project Coordinator

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## 5. Contact

| <u>Contacts</u>  | <u>Email</u>   | <u>Phone</u> |
|--|--|--------------|
| Andrea Littlefield -Sr. Communications & Outreach Specialist | <a href="mailto:anlittlefield@emh.org">anlittlefield@emh.org</a> | 973-6132     |
| Beth Johnson- Project Coordinator                            | <a href="mailto:eajohnson@emh.org">eajohnson@emh.org</a>         | 973-7528     |
| Lanie Abbott- Sr. Communications & Outreach Specialist       | <a href="mailto:lwabbott@emh.org">lwabbott@emh.org</a>           | 973-9621     |
| Mac Hilton- Program Manager                                  | <a href="mailto:jhilton@emh.org">jhilton@emh.org</a>             | 973-5643     |
| Melanie Pearson- Project Manager                             | <a href="mailto:mpearson@emh.org">mpearson@emh.org</a>           | 973-5095     |
| Samantha Haynes- Administrative Assistant                    | <a href="mailto:shaynes@emh.org">shaynes@emh.org</a>             | 973-5644     |
|  |  |              |
| <u>CoP Report Managers</u>                                   | <u>Email</u>   | <u>Phone</u> |
|  |  |              |
| Mac Hilton- Leadership & Governance                          | <a href="mailto:jhilton@emh.org">jhilton@emh.org</a>             | 973-5643     |
| Andrea Littlefield- Leadership & Governance                  | <a href="mailto:anlittlefield@emh.org">anlittlefield@emh.org</a> | 973-6132     |
| Dr. Barbara Sorondo- Clinical Transformation                 | <a href="mailto:bsorondo@emh.org">bsorondo@emh.org</a>           | 973-4768     |
| Sam Dow- Clinical Transformation                             | <a href="mailto:sddow@emh.org">sddow@emh.org</a>                 | 973-7224     |
| Dr. Barbara Sorondo- Data & Performance Measurement          | <a href="mailto:bsorondo@emh.org">bsorondo@emh.org</a>           | 973-4768     |
| Sam Dow- Data & Performance Measurement                      | <a href="mailto:sddow@emh.org">sddow@emh.org</a>                 | 973-7224     |
| Andrea Littlefield - Sustainability                          | <a href="mailto:anlittlefield@emh.org">anlittlefield@emh.org</a> | 973-6132     |
| Melanie Pearson- HIT & Meaningful Use                        | <a href="mailto:mpearson@emh.org">mpearson@emh.org</a>           | 973-5095     |

## 6. 6-Month Meeting Schedule



| Meetings/Group  | Frequency   | May-12        | Jun-12    | Jul-12          | Aug-12     | Sep-12     | Oct-12      |
|---|---|---------------|-----------|-----------------|------------|------------|-------------|
| Admin Core Team                                       | 1 <sup>st</sup> and 3 <sup>rd</sup> Mondays                 | 5/7, 5/21     | 6/4, 6/18 | 7/2, 7/16, 7/30 | 8/13, 8/27 | 9/10, 9/24 | 10/8, 10/24 |
| Leadership Committee                                  | Quarterly   | 5/29          | 6/28      |                 | TBD        |            | TBD         |
| Statewide Advisory Committee                          | Quarterly   |               |           | 7/18            |            |            |             |
| PM Meeting  | Discontinued  |               |           |                 |            |            |             |
| CEO Meeting   | 3x annually   |               |           |                 |            |            |             |
| CoP Leads Meeting                                     | Ad hoc  | 5/29          |           |                 |            |            |             |
| Communications Advisory Group                         | Ad hoc  |               |           |                 |            |            |             |
| Sustainability (large group)                          | Annual - March  |               |           |                 |            |            |             |
| Sustainability Planning                               | Ad hoc  | 5/8 (Retreat) |           |                 |            |            |             |
| Business Services Task Force Meeting                  | Twice monthly   |               |           |                 |            |            |             |
| Employee Health Plan Task Force (ACO)                 |   |               |           |                 |            |            |             |
| Care Coordination Task Force (ACO)                    |   |               |           |                 |            |            |             |
| HIN/Acadia - Mental Health Data Pilot                 | Dates forthcoming   |               |           |                 |            |            |             |
| HIT & Meaningful Use Committee                        | Every 6 weeks   | 5/31          |           | 7/12            | 8/23       |            | 10/4        |
| Evaluation Core                                       | Every other Wednesday                                       | 5/23          | 6/27      | 7/25            | 8/22       | 9/26       | 10/24       |
| Mental Health Task Force                              | Every 6 weeks   | 5/9           |           |                 | 8/8        |            |             |
| Clinical Leadership                                   | Monthly – 4 <sup>th</sup> Wednesday 7-8:30                  | 5/23          |           |                 |            |            |             |
| Performance Improvement                               | Monthly – 3 <sup>rd</sup> Tues 5-6:30                       |               |           |                 |            |            |             |
| Immunizations Committee                               | 3 <sup>rd</sup> Wednesdays monthly                          | 5/16          | 6/20      | 7/18            | 8/15       | 9/19       | 10/17       |
| Immunizations Core Task Force                         | Every Wednesday except 3 <sup>rd</sup> when Committee meets |               |           |                 |            |            |             |
| Home Care (telemed.)                                  | Monthly   |               |           |                 |            |            |             |
| Care Management Forum                                 | Monthly   |               | 6/21      |                 |            |            |             |
| Care Management Planning Committee                    | Monthly   |               |           |                 |            |            |             |
| ONC Leadership & Stewardship Affinity Group           | Every 8 weeks   |               |           |                 |            |            |             |
| ONC PM Affinity Group                                 | Monthly 3 <sup>rd</sup> Thurs @ 4                           |               |           |                 |            |            |             |
| ONC Vision Calls                                      | Quarterly   |               |           |                 |            |            |             |
| ONC Communications Affinity Group                     | Monthly 4th Thurs @ 3                                       |               |           |                 |            |            |             |
| ONC Primary Care Transformation Affinity Group        | 2X monthly call   |               |           |                 |            |            |             |
| ONC Care Transitions Affinity Group                   | 2X monthly call   |               |           |                 |            |            |             |
| ONC Pharmacy Intervention Affinity Group              | Every 8 weeks   |               |           |                 |            |            |             |
| ONC Research & Evaluators Affinity Group              | Monthly   |               |           |                 |            |            |             |
| ONC Performance Measurement Affinity Group            | Monthly   |               |           |                 |            |            |             |
| ONC Utilization Affinity Group                        | Monthly   |               |           |                 |            |            |             |
| ONC Security & Privacy Affinity Group                 | Every Friday  |               |           |                 |            |            |             |
| ONC Data Layer Affinity Group                         | Monthly   |               |           |                 |            |            |             |
| ONC Sustainability Affinity Group                     | Various   |               |           |                 |            |            |             |
| ONC EHR Integ. Project Affinity Group                 | Monthly   |               |           |                 |            |            |             |
| ONC Health IT & MU CoP                                | 2X monthly call   |               |           |                 |            |            |             |
| ONC LTPAC/HIE   | Every 8 weeks   |               |           |                 |            |            |             |
| HITRC - Health Information Technology Resource Center |   |               |           |                 |            |            |             |

