

President's Letter, Peter Wood.

No, this letter is not going to be about Health Care Reform and what is happening in Washington, DC. But before I write about something else, one observation: there are two bills in the Senate that have to be reconciled and the House has approved its reconciled bill. Both then need to be approved by their respective members. Then those two bills have to be reconciled and that final version approved by the House and Senate and sent to the White House. So, while it is intriguing to speculate on the final version, it is a ways away.

Buried in several of these bills is a proposal for CMS (Medicare) to support a pilot or demonstration project to look at the feasibility and value of the concept referred to as an Accountable Care Organization or ACO. In very general terms, this is an organized group of providers (usually hospitals, physicians, and other providers, (umm, sounds like a PHO) who have agreed with a payer or payers to provide services that are cost effective and provide demonstrable quality improvement. In fact, the ACO is rewarded on its success at improving or achieving target goals for cost management and quality. In many, but not all, models of an ACO, there is no insurance risk (loss risk), only performance risk which means an opportunity to share in savings. If this sounds familiar, it is what the Maine PHO and its members have been working toward for several years – we just didn't know it had a name. Since we started working on quality improvement with the implementation of registries and with the focus of PTE moving in that direction, we have worked with the payers to include incentives based on quality in our agreements.

Accountable Care Organizations may sound like something else that we had (and in some cases still have) in the not too distant past: capitation. In capitation, the PHOs assumed insurance risk, which means we could lose money if more was spent than budgeted. It also meant being financially at risk for all services the patient received whether from a member provider or not. The physicians and the hospitals in the PHO were obligated to cover the PHO's share of any losses. This model of collective risk taking has fallen out of favor with the payers (insurers) so that a return to capitation would be a big challenge for them since they have trashed most of their systems to track and report on these types of arrangements. On the flip side, we have developed better systems for tracking quality improvement, identifying variations in practices, implementing programs such as Care Transition Coaches and Care Managers that help us better manage the flow of care and support patients in self-management, supporting EMRs/EHRs and other electronic systems for sharing information. We have internal staff to support reporting and data analysis. We are participating in the Patient Centered Medical Home Pilot project and initiating spin-off programs such as care coordination. The bottom-line is that the provider community is better positioned today to participate in an ACO, than the payers – with or without risk sharing.

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There is one overarching point in all of this, as providers we will be expected to be accountable for the services that we provide. We have the opportunity to design the tools and measurements that we will be accountable for; or someone else will. We can expect to see our reimbursement change and be more based on outcomes and value (right care, right time, right place). These goals cannot be achieved in the autonomous tradition that we know, but through a team approach...an Accountable Care Organization.

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Letting Go - Jeff Aalberg, M.D.

We're hearing a lot about teamwork in healthcare these days. I interviewed a candidate for our new Tufts-MMC Medical School last week, and even she brought up the concept. What does it mean when we say that we should be working as a team, and what does a good team look like?

I don't watch much TV sports these days, but I've been on a number of teams in my earlier days. I do remember the success and satisfaction of being part of a winning football team that had no single star but was a group of people functioning together in a synchronous fashion. Of course, the quarterback had the most visible role, but each and every team member had individual skills and important responsibilities. Healthcare is similar, but the problem is that we've produced a culture in which a quarterback is expected to organize the team, decide on the plays, throw the ball, run, be responsible for defense, kick the field goal... well you get the picture. The reality is, even with a great quarterback, others will be better at organizing, blocking, kicking, defense, etc. It is this symphony of skilled performers that will be a winning team. And to be honest, the docs can't remember all there is to do in patient care. The key to quality is reliability built through standardization, redundancy and 'watching each other's back'. So I offer a partial list of things the quarterback (physician) may not have to do:

- Remember when to book PEs or disease follow ups
- Order routine labs, preventive screenings: mammograms, colonoscopy, bone density
- Fill out PAs, PHQ9s, AAPs, ACTs, M1s: many can be started by the patient or staff
- Refill routine Rx's that can be done by staff per protocol
- Remember which shots are due
- Triage routine complaints: if the patient wants to be

seen-see the patient; allow add ons per protocol

- Coordinate care
- Be the only 'provider' for your patients

Health care delivery is a team sport but it requires a bold move: *letting go*. None of the above activities require MD/DO training. Once you learn to *let go*, your staff will have increased passion in their work, and you will be freed up for what you enjoy and are trained to do: *talking to patients, diagnosing and treating*. How to build such a team? Let's go back to the football analogy. Say your football team wants more input into creating and choosing plays. You can call a team meeting, create a playbook and develop a system to share decision making. But team interest and creativity will quickly wane if you always call the plays and run the ball. It's the same with our health care teams.

Some things to ponder for successful team building:

- Invite staff to gather, train all in meeting process and request input into problems and solutions. Let's use the example of designing protocols for refilling Rx's: this seems simple but actually requires a full microsystem analysis of steps in the process: patient-phone-MA-protocol-pharmacy-signature. Let the team go at it.
- Demand that your team members work at the top of their training.
- Support the team process (really, honestly, and continually) and never override the process. Give feedback, constructively and frequently; use huddles.

So that college student, soon to be a medical student, already knows what many of us don't: medicine is too complex and the work too important for docs to feel ownership for the entire process of care. *Let go*, give plenty of hand-offs and enjoy the new culture of the team. The more your team is encouraged to be innovative, accountable and involved, the more quality will be delivered, and your patients will be the beneficiaries.

What Does ARRA Mean? - A. Jan Berlin, M.D.

The American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law on February 17, 2009 by President Obama. Its multiple provisions have already and will continue to affect citizens of the United States in numerous ways. For instance, many of you have heard of the first-time homebuyer credit provision, the "Clunkers for Cash" or money back for new vehicle purchases program, and increased unemployment benefits tax free for 2009 to name a few.

The Act officially establishes the Office of the National Coordinator for Health Information Technology (ONCHIT) with Health and Human Services (HHS) to promote the development of a nationwide interoperable Health IT infrastructure to improve

care delivery. This is authorized under the Health Information Technology for Economic and Clinical Health (HITECH) part of ARRA. Financial incentives through Medicare have been made available to encourage physicians and hospitals to adopt and use certified electronic health records (EHR) in a "meaningful" way. The term "meaningful" has been developed by the Health IT Policy Council and a final draft was forwarded to the National Coordinator in August 2009, but will not be formally adopted until December 31, 2009 with a public comment period to follow.

For health care professionals, there are some major provisions that will impact most of us. Financial incentives to adopt an EHR amount *(continued on page four)*

DID YOU KNOW . . .

Harvard Pilgrim's Health Care 2009 Honor Roll

For the second year in a row, MMC PHO was named to the Physician Group Honor Roll in recognition of the physicians commitment to high quality care, and St. Mary's Regional Medical Center was named to the Hospital Honor Role.

Congratulations to each for their continued attention to Quality, Patient Safety and Patient Satisfaction.

Care Coordination A Model for Connecting Physicians and Patients



Care Coordination has been defined as communication in support of patient care between services at separate locations. At a time when our medical community is not yet connected by means of electronic medical record systems, the simple step of referring a patient from a primary care physician to a specialist may result in error and miscommunication.

In an effort to begin to address this problem, the MMC Physician-Hospital Organization began care coordination efforts with pilot teams in three areas; Cardiology, Diabetes and Urology. The output from the work of these three teams resulted in a Master Service Agreement, a Standard Referral Form and Protocol for use of the Standard Referral Form. In addition, the three teams have developed specialty addendums to assist in the referral process and new guides to care and referrals. The pilot program to test these administrative processes began in September. It is our goal to spread this process, both electronically and in paper format throughout the MMC PHO community during 2010.

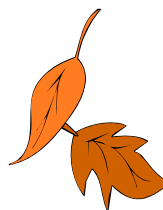
Meet the Care Coordination Pilot Program Physician Teams



We are pleased to introduce our Care Coordination Pilot Program physician teams. We want to thank them and their staff for the many hours of participation, respectful consideration of the practice diversity that exists between them and the hard work that it took to come up with a standardized product. We would also like to recognize the willingness of the physicians that are currently on an Electronic Medical Record (EMR), to pilot the Standard Referral document using a paper form. Once we have completed the pilot phase, we will be working to incorporate these documents into EPIC and Logician.

Team Cardiology:

- John Lualdi, MD – Cardiovascular Consultants of Maine
- Lisa Langburd, MS,BC,FNP Chief Operating Officer
- Gert McCarthy, CPC
- Jay Powers, MD – Maine Cardiology Associates
- Mary Polito, Practice Administrator
- Judi Grassi, Operations
- Sue Seekins, Program Manager, Maine Heart Center
- Louis Hanson, DO – Private Practice
- Margaret Shepp, MD– Martins Point Internal Medicine



Team Diabetes:

- Stephan Babirak, MD – Maine Medical Partners Endocrinology & Diabetes Center
- Audra Buschagen, Practice Manager
- Cindy Young, RN, CDE
- Mark Bouchard, MD – MMC Family Medicine
- John Kazilionis, DO – Private Practice
- Rebecca Hemphill, MD – Maine Medical Partners Internal Medicine
- William (Skip) Schirmer, MD – Martins Point Health Care

Team Urology:

- Brian Jumper, MD – Maine Medical Partners Urology
- Michael Baumann, MD – MMC Emergency Department
- Andrew Candelore, DO – Private Practice
- Steven DiGiovanni, MD – Bayview Pediatrics

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Check out our new Care Coordination tab on the
MMCPHO website!
Go to <http://mmcpHO.org/>



St. Mary's Maine Covenant Goes LIVE with Centricity Interface to the CIR

Over the past year, St. Mary's Maine Covenant (the PHO at St. Mary's) and Maine Medical Center (MMC) have been working to interface St. Mary's Centricity EMR with the MaineHealth Clinical Improvement Registry (CIR).

Earlier this year that interface went live. This interface will provide additional tools to the PCP offices to better manage their patient population, especially in regards to Diabetes and Cardiovascular care. St. Mary's PCP practices that are on Centricity will now be able to utilize the tools available in the CIR to submit for NCQA accreditation electronically.

A Special thanks goes to Laura Brann, Goran Djuranovic, and John Peters at MMC as well as Pamela Beaulé, Linda Nadeau, and Bernie Hall at St. Mary's for making this happen.

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What Does ARRA Mean? (continued from page two)

to up to \$44,000 over a period of five years. For early adopters, Medicare incentive payments of up to \$18,000 would be available for the first payment year. Currently the first payment year is targeted for 2011 or 2012. Payments over successive years would amount to \$12,000, \$8,000, \$4,000 and \$2,000. Although there is some talk in Congress regarding pushing that first year back, no legislation has been adopted yet. Adopters whose first payment year is 2015 would receive no payment for that year or any subsequent year.

Physicians who do not adopt or use a certified Health IT system would face reduction in their Medicare fee schedule of -1% in 2015, -2% in 2016 and -3% in 2017 and beyond. There is also a provision that allows HHS to increase penalties beginning in 2019, but those penalties can not exceed -5%.

All in all, ARRA 2009 will have significant impact on health care delivery. Stay tuned as details unfold.

2009 Payer Satisfaction Survey Results

Our annual survey for 2009 has been completed. Surveys were sent to each practice within the Maine PHO and 50 practice sites (representing 157 physicians) completed and returned the survey. Thanks to all who took the time to complete the survey. If you would like more details on the survey results, please contact Angela Best at besta@mmc.org or 771-2004. We asked practices to rate each payer on a scale of 1-5 (1-poor; 5-Very good) The results are as follows:

Insurance	Overall Satisfaction	Responsiveness	Timely Notification	Claims Processing	Referral Process
Aetna	3.70	3.83	3.88	3.80	3.64
Anthem	4.06	3.86	4.02	4.17	4.28
Cigna	3.68	3.65	3.86	3.76	4.11
Harvard	3.67	3.60	3.81	3.74	3.82
EBPA/CBA	3.89	3.75	3.72	3.70	3.95
Coventry/HealthCare Value Management	3.44	3.53	3.72	3.52	3.89
Great West/One Health Plan	3.55	3.58	3.73	3.56	4.00
Martins Point Healthcare (USFHP)	3.76	3.86	3.74	3.88	4.08
Martins Point Healthcare (Generations Advantage)	3.81	3.94	3.80	3.86	4.02
Multi Plan/Private Health Care Systems	3.56	3.51	3.72	3.74	4.00