TAMC
MORE THAN A HOSPITAL
EMHS MEMBER

Coordinated Care & Beacon Health Program

By the Numbers...

4 RN care coordinators embedded within TAMC's primary care practices (Family Practice & Internal Medicine and the health centers in Caribou, Mars Hill and Fort Fairfield)

1 Care coordinator at TAMC to serve inpatient transitions of care needs

1 RN health manager to manage patients with educational needs specific to their disease processes, such as diabetes.

302 Patients being care coordinated for complex care.

8,132 ACO Beacon Health Patient Population at TAMC

Breakdown:
888 – GHP (Geisinger Health Plan for EMHS employees & families)
2,887 – ACO Pioneer (CMS – Medicare)
549 – SEHC (State of Maine Employees)
203 – Maine Community Health Options
3,039 – Anthem
566 – Cigna

27,800 Total Pioneer Patients for Beacon Health

Over 100,000 Total Number of covered lives with Beacon Health ACO program

Numbers accurate as of January 27, 2015

*Note: These totals do not include Patient Centered Medical Home (PCMH) model of care, as it is a separate model from Beacon Health. However, the Beacon Health Care Coordination team at TAMC does support the patients in the PCMH and follow those patients for complex care needs. In the PCMH model, the care coordination team does include Community Care Team services, but does not include services provided by Transitional Care Coordination or Health Manager.

What is coordinated care?

Care coordination is a function that fosters information sharing across levels of care to ensure patients' needs and preferences are met. Care coordination engages patients and families in the development of their care plan and links them to health and other services that address the full range of needs and/or concerns related to their healthcare. The purpose is to improve the outcomes and patients' experiences of care by providing patient-centered, evidence-based holistic care.

What are the goals of coordinated care?

- Coordinate care of patients across care settings by providing care coordination through the transitions of care.
- Assist the patient with self-management of their chronic disease.
- Provide patient education so patient can better manage their health with an ultimate goal of fostering independence.

How does care coordination benefit patients?

Patients living with a chronic illness have a nurse who will help coordinate and monitor care between appointments, and many will see an improvement in the quality of their daily life. Patients are encouraged and shown how to be more active participants in their health and healthcare.

What does it mean to providers?

Providers have better, easier access to colleagues, best practices and a nurse care coordinator to help keep their patients as healthy as possible.

How does it work?

A nurse care coordinator is assigned to a patient by the patient's provider, if it is discovered that a coordinator may be a helpful resource for the patient. Together, the patient and coordinator speak regularly, and the coordinator checks in on how the patient is doing with their care plan. Oftentimes, the care coordinator is a front line resource for a patient navigating the complexities of the health system.

What is Beacon Health?

Beacon Health was developed from the success of a three-year pilot project that helped EMHS make upfront investments to enhance electronic medical record connectivity, invest in care coordinators, and work with a selected set of patients with chronic illness to improve their health and stay out of the hospital. TAMC is among the hospitals and primary care practices across Maine participating in the Beacon Health Network, a subsidiary of EMHS.

What is the collaboration between Beacon Health and the State of Maine?

An agreement between Beacon Health and the State of Maine provides an innovative health delivery model to more than 5,000 State of Maine employees and their dependents, who will have access to more than 600 primary care providers in nearly 100 practices statewide, including TAMC. The relationship allows Beacon Health to expand its innovative health delivery model to more people in Maine, which has documented success among both EMHS employees and Medicare patients.

140 Academy Street • Presque Isle, ME 04769 • 207.768.4000 • www.tamc.org

A Patient Story

Patient: Bobby Saucier

Care team:
Mary Walton & Bev Joy ~ *Care Coordination*
Ralph McPherson & Lori Buckingham ~ *Community Care Team*
Christine O'Meara ~ *Diabetes Educator*
Dr. Mirdula Sood & Jessica Gagnon, FNP ~ *Primary Care Providers*
Dr. Jared Kolbacher ~ *Diabetic Foot Care*

Bobby Saucier of Caribou has had his ups and downs with his health over the years, but as he reached 400 pounds, his Type II insulin-dependent diabetes began to slowly shut down his body.

"One morning, I tried to get out of bed and I could barely move," said Bobby. "I was mad at myself – at everyone. How did it come to this?"

Bobby had reached a point where he felt that no primary care provider was actively trying to help him. He was on 28 pills a day, many of which were not covered by his insurance. He was in and out of the hospital annually. He was also dealing with diabetic neuropathy in his feet. Bobby knew something needed to change, but he didn't know where to start. He had no idea how to impact change in his life and still effectively treat his diabetes.

Due to many emergency room visits for his soaring blood sugars, Bobby was referred to the Care Coordination team for follow-up. When contacted, Bobby agreed that he needed help managing his diabetes and began to work with the primary care providers at TAMC's Caribou Health Center as well as the Community Care Team.

"Even though I was in constant contact with my provider, my blood sugar was still out of control," remembers Bobby. "I ended up in the emergency room again and this time they strongly encouraged me to work with TAMC's Diabetes Educator, Christine O'Meara, RN."

O'Meara works with patients to provide consistent education and examples that they can make work in their day-to-day life. Bobby did not have transportation, so getting to classes in Presque Isle was nearly impossible. His team arranged to begin one-on-one classes with him at his next primary care visit in Caribou. They worked with him to help him understand the food choices he should make, monitoring his blood sugar, knowing what his blood sugar numbers mean in terms of management, weight loss, and the importance of connecting regularly with his care team.

"Getting my insulin at the right amounts and understanding it more clearly really helped turn the tides," said Bobby. "Jessica told me my sugars were so high that I would continue to see more health issues until I got them down. She then patiently helped guide me to that point. I understood what I needed to do, what I needed to watch."

Since Bobby began his journey a year ago he has lost over one hundred pounds and his blood sugar consistently tests in the normal range. When asked about what he needs to do to take care of his diabetes, he not only lists off a litany of important facts, he also explains how they pertain to how he can manage his health. He feels that his understanding of his disease is very good, but he feels that his connection to his care team is better.

"I feel a big difference in myself. I feel like I have help with the resources I need. I have people I can contact, or they contact me, and we can get to the bottom of what I need to take the best care of myself," said Bobby. "I hope one day I won't have to take insulin – that's my goal. But for now, I'm just thrilled to have the support of people who care and who celebrate my success with me."