The MMC Physician-Hospital Organization (MMC PHO) supports more than 1,200 members from the Community Physicians of Maine (CPM) and MaineHealth Member Hospitals: Maine Medical Center, Lincoln County Healthcare, Pen Bay Healthcare, Southern Maine Health Care, Waldo County Healthcare and Western Maine Healthcare, with the shared goal of delivering value-based, integrated health care to our communities.

Effectively coordinating care for all patients, especially at risk disabled and older adults is a key strategy for success within our health system. We have the advantage of a number of well-established tools, processes and interventions that by themselves, improve the coordinated care for all patients as well as patients at risk. They include: a robust data repository providing predictive modeling, stratification of severity and identification of variations in care; ten years of experience providing RN care management embedded in primary care practices; five years of experience providing Eric Coleman's Care Transitions Intervention ™, two years of experience providing complex care management through multidisciplinary teams and a 'toolkit' of tools and processes built to improve our ability to collaborate across providers.

Following the transformation of the above separate components into an integrated program in 2013, careful integration of the program regionally became a critical success factor for 2014. Because of our presence in 11 out of Maine's 16 counties, variation in patient needs, resources and cultural norms exist. This PCL project aims to advance the integration of our newly transformed interdisciplinary care management program within our expansive and rural state, enabling community teams to identify shared goals and strategies and in partnership with central resources, accomplish those goals with the resources available.

Our two strategies include 1) Care management will be organized into interdisciplinary teams embedded in their unique regions. Each team will have a team lead with responsibility to review their team's data and outcomes, collaboratively study patient gaps and unmet needs, identify training needs and ensure effectiveness of care management interventions. 2) Each region will be supported by regular meetings to review regional data and outcomes, identify barriers to regional success and problem-solve solutions.

Success will be demonstrated by: 1) a 35% increase in risk patients matched with an interdisciplinary care management resource, 2) a 25% improvement in bidirectional, closed-loop communication between care management and regional practices and 3) improved employee engagement as evidenced by 95% active participation in team and regional meetings. It is expected that by mid-year 2014 we will have a clear indication of how our interdisciplinary care management program in in fact changing the trajectory of individual patients' lives and supporting our goal of delivering value-based, integrated health care to our communities.