

SUMMARY NOTES
Maine Quality Forum Advisory Council
November 14, 2008

Present: Kathy Boulet, DC, Josh Cutler MD, Director; W. Stephen Gefvert DO; Jeff Holstrom MD; Robert Keller MD (Chair); James Leonard, MQF staff; Lisa Miller; Rod Prior MD; Doug Salvador MD, Paul Tisher MD; Al Prysunka; Becky Martins, and Jan Wnek MD. Karynlee Harrington, Executive Director of the Dirigo Health Agency, was also in attendance.

Item	Discussion	Decision/Action	Date Due
September 12, 2008 Minutes	Al Prysunka corrected the minutes to read: UPDATE AHRQ Measures: Using 2006 and 2007 inpatient data to generate the AHRQ Prevention Quality Indicators (PQIs) and Area Pediatric Quality Indicators (PDIIs) data set, the MQF will begin reporting four composite measures and individual measures by hospital and hospital service area.	Minutes approved as amended	
Dirigo Update	<p>Funding. Karynlee Harrington discussed the implications of the voters' defeat of Question 1 which would have supported the Dirigo Agency through taxes on wine, beer and other beverages.</p> <ul style="list-style-type: none"> • The Savings Offset Payment (SOP) will remain in effect. In addition to maintaining the current enrollment cap and cutting expenses by 20 percent, the Agency must resolve the cyclical deficit inherent in the timing of revenues under the SOP (e.g., it takes 27 months to receive 12 months of revenue). • A lawsuit has been filed with the Maine Superior Court appealing the Superintendent's decision on the Year 04 aggregate measurable cost savings (AMCS) level as well as the constitutionality of the SOP itself. Arguments are likely to be scheduled in March-April with strong likelihood that the case could end up in State Supreme Court. • The ongoing legal battles raise questions with the vendor (Harvard Pilgrim) about the long term viability of the program. <p>Product Design. The Agency is working with a consultant to consider options for re-structuring the product to better meet its goals of access</p>	Information only; no action required.	

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	and quality. Opportunities to work with the new administration to capture more federal dollars will also be explored.		
Patient-Centered Medical Home	<p>Josh Cutler introduced Lisa Letourneau MD who is under contract with the MQF to facilitate the design and implementation of a patient-centered medical home pilot in Maine. Dr. Letourneau described the initiative as a model for delivering comprehensive, coordinated, patient centered primary care that also recognizes the need for enhanced payment for primary care. The Maine pilot is a collaborative effort of the MQF, Quality Counts and the Maine Health Management Coalition and is guided by a Primary Care Coalition composed of providers, policymakers, payers, employers and consumers.</p> <p>All four major private insurers (Anthem, Aetna, CIGNA, Harvard Pilgrim) and MaineCare are participating and, while agreeing with the basic goals of payment reform, will negotiate specific payment details with each of the 10-20 participating practices.</p> <p>Practices wishing to participate in the 3-year pilot will need to demonstrate structures and processes consistent with the medical home model and will need to commit to targeted initiatives aimed at improving quality and reducing waste. Practices applying for participation will be asked to sign a Memo of Agreement outlining specific expectations for the Pilot. Application materials will be distributed in early January with final selection expected in March.</p> <p>Members discussed the value of this initiative but urged that the State not lose sight of other pressing problems in primary care such as: PCP recruitment, especially in rural areas; the high overhead of practicing that forces practitioners to bill more but shorter visits; creating a better balance of PCPs and specialists and PCPs and other practitioners; and the inherent advantage of large “corporate” practices over small practices. Dr. Letourneau agreed that the pilot would not itself be able to address all these issues but hoped that lessons from the pilot will inform and advance the provision of primary care in the State.</p>	Information only; no action required	
Hospital	Dr. Cutler reviewed the status of data collection in Maine compared to	Information only; no action	

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Associated Infections (HAI)	<p>recommendations of the Infectious Disease Society of America (IDSA) and Society of HealthCare Epidemiology of America (SHEA) with respect to hospital-associated infections. In most cases, Maine conforms to recommendations that have a strong evidence base with the exception of the urinary tract infections which does not have a major impact on mortality nor costs.</p> <p>Dr. Cutler reported that two collaboratives of infectious disease physicians and nurses have been meeting under the leadership of MaineHealth and Eastern Maine. While working independently, the groups have agreed to share data and to develop protocols for reporting standard measures under the umbrella of a coordinating committee chaired by Erik Steele. The two groups include nearly every hospital in Maine. The entire group is called the Maine Infection Prevention Consortium. It is supported by MQF as well as by the Maine Hospital Association and the Northeast Healthcare Quality Foundation (regional QIO for Medicare). Major focus areas include: measurement of hand hygiene compliance using a common measurement tool, statewide assessment of surveillance practices and resources, and the adoption of the National HealthCare Safety Network (NHSN) prevention modules for multi-drug resistant organisms (MRDO) and methicillin-resistant staphylococcus aureus (MRSA).</p> <p>All hospitals are participating in an Infectious Prevention Collaborative sponsored by the MQF. Major focus areas include: hand hygiene, statewide assessment of surveillance practices and resources, and the adoption of the the National HealthCare Safety Network (NHSN) prevention modules for multi-drug resistant organisms (MRDO) and methicillin-resistant staphylococcus aureus (MRSA).</p>	required	
Electronic Health Records	<p>Jim Leonard reminded members that Maine is one of 12 communities selected by Medicare to participate in a 5-year project to adopt and implement electronic health records (EHR) and health information technology (HIT). The demonstration provides incentive payments to physicians for using certified HER.</p>	Information only; no action required	

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	<p>Mr. Leonard reviewed the proposed framework for recruiting practices, training practices and supporting practices in their adoption of EHR and HIT. The MQF role will focus primarily on motivating and recruiting practices, establishing learning collaboratives, and maintaining a system database that can track and trend adoption patterns. The MQF will develop a competitive process for selecting a contractor to assist in this process. As a condition of the CMS grant, 200 sites must be recruited; 100 to serve as a controls and 100 that agree to fully exploit the functionalities of EHR.</p> <p>Members asked whether there was a role for the MQF in establishing standards that could maximize the inter-operability of systems throughout the State. This is a complex issue given that no single standard exists but rather a suite of standards is evolving around many different program areas (e.g., lab, hematology, chemistry, etc.). Most EHR systems start out as clinical care supports; does not mean that they can do clinical reporting in ways that could benefit data exchange for quality improvement. It was unclear what role HealthInfoNet would/should play in endorsing or proposing criteria for selecting systems with maximum utility.</p>		
Variation Analyses	<p>The all payer database is nearly complete with major public and private paid claims represented in the warehouse maintained by the Maine Health Data Organization (MHDO). The original focus of MQF's contract with Health Dialog was to use this database as a platform for analyzing regional variations. That focus has now changed to focus on services and procedures that account for 80 percent of healthcare expenses. In the coming months, analyses will be conducted of areas of potential problems of waste, overuse of services that have no value, and underuse of effective care can lead to improved outcomes and make affordable healthcare possible for all Maine citizens. A report will be prepared for the legislature in March, 2009 followed by public discussions within the provider community about steps to address report findings.</p>	Information only; no action required	

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Next Meeting	The next meeting is scheduled for January 9, 2009		