

Summary Notes
Maine Quality Forum
Advisory Council
December 10, 2004

MQF Advisory Council members present: Jonathan Beal, Rick Bruns, Rebecca Colwell Jeffrey Holmstrom, Frank Johnson, James McGregor, Chip Morrison, Dan Roet, Steve Shannon, and Janice Wnek. Dennis Shubert, Maine Quality Forum, Karynlee Harrington, Dirigo Health Agency and Maureen Booth, Muskie School of Public Service were also in attendance.

The minutes of the November 12, 2004 meeting were approved as distributed.

Dirigo Health Reform Update

Trish Riley, Director of the Governor's Office of Health Policy and Finance, thanked members for their hard work over the past year. As originally envisioned, the MQF was seen as an umbrella organization to help make the translation for those who don't live in the day-to-day world of quality. The MQF and its Advisory Council were seen as a place where diverse perspectives could come together to form consensus on how to define and measure quality; where policymakers and consumers could go to get information and advice; and where work being done across the State to improve quality could be linked and synergies created.

Trish described three major health reform initiatives:

- **Dirigo Choices:** Presently 140 businesses have signed up, for a total of 2143 members, with an effective start date of January 1, 2005. Major marketing campaigns are currently underway to enhance awareness.
- **Study Commission on Hospitals:** The Commission has been meeting weekly to develop recommendations on containing hospital costs. Three public hearings will be held across the State to further vet these recommendations before being submitted to the Legislature.
- **The State Health Plan:** The goal is to adopt a State Health Plan that is reflective of local needs. A Data Book is being prepared for each of Maine's 3 hospital regions that will provide a profile of health status and resources in each region. A day-long town meeting is being planned for March 12, 2005 that will allow for citizen input via video hook-ups and electronic voting. In advance of this meeting, surveys will be sent to citizens asking of their interest to participate in the town hall meeting. One thousand citizens will be selected based on demographics and geography. The intent of the town hall meetings is to develop a state health planning process, not just a plan, that conveys citizen priorities and acceptable trade-offs.

Questions were raised about the sustainability of the Dirigo Choice Plan should the anticipated enrollment not be reached or if the program primarily attracted only the previously insured. Trish noted that, while reducing charity care was an important goal for the program, other cost-saving strategies were also being implemented.

In response to a question on the role of the M

QF in the State Health Plan, Trish noted that assessing new and emerging technologies and advising the certificate of need process and capital investment fund on such matters was critical. The work of the MQF would also be instrumental in identifying major priorities for quality improvement and statewide initiatives. Every effort should also be made to apply quality improvement approaches to Dirigo Choice (e.g., introduction of a standardized health risk assessment, disease management). The Governor's Office will look to the MQF to help in establishing performance goals and benchmarks that should be achieved within defined timeframes.

Trish acknowledged the stress that has been placed on the MQF to respond to ambitious schedules and deadlines. Bob McArtor expressed concern that such deadlines weaken the ability to fully benefit from the expertise of the Advisory Council. Whenever possible, deadlines will be anticipated.

Performance Measurement Subcommittee

Dennis reported that the Provider Group was consulted to clarify their recommendation on the nurse-sensitive conditions. Final list of recommended measures will be included in the MQF report on LD 616; others will be included in work plan for further development/refinement.

LD 616

Jonathan Beal referred members to revisions made to the legislative report based on input from the last Advisory Council meeting:

- On page 5, replace “disturbing” with “concern”.
- Correct the recommendations of the Provider Group regarding nurse-sensitive conditions.
- Clarify the matter in which input was received directly from nurses

Members unanimously recommended approval of the report for submission to the Legislature. Dennis noted that the MQF was working to include the collection of nurse-sensitive conditions into rules along with other indicators that had been previously agreed to by the Maine Health Management Coalition, the Maine Hospital Association, and the MQF. It was also noted that the MQF will need to develop means for educating hospitals on the data collection specifications required for the collection of the indicators. Thinking through how best to do this was delegated to the Performance Measurement Subcommittee.

Elections

Current terms for the Chair and Vice Chair of the MQF Advisory Council are scheduled to end in January 2005. Discussion followed on whether there should be an annual rotation of leadership or if successive terms should be permitted. It was generally agreed that there was value to continuity given that this first year has been largely devoted to developing critical organizational relationships and operational protocols. Members approved a two year terms for the Chair and Vice Chair but left undecided whether there

should be a Chair elect. Votes were taken and approved to re-elect Bob McArtor to the position of Chair and Becky Colwell to the position of Vice-Chair for an additional year.

2005 Work Plan

Members of the Advisory Council and the audience were asked to participate in a process to both reflect on the past year's efforts and to help plan priorities for the coming year. Findings from this exercise would be used to develop a work plan. Participants were asked to identify:

- Accomplishments for the MQF and its Advisory Council for 2004
- Missed opportunities in 2004
- Priorities for 2005

Attached is a summary of the responses.

Next Meeting

The next meeting is scheduled for January 14, 2005.

Major Accomplishment for MQF and Advisory Council – 2004

Advisory Council Comments

1. Effectively brought together folks from a variety of health care disciplines to begin the “quality agenda”.
2. We stayed together
3. Establishment, staffing, and institutionalization of MQF Advisory Council
4. Establishing framework in the MQF to move forward with quality measures.
5. Bringing stakeholders together: conversation and collaboration towards a goal of quality care.
6. Established a working relationship and links to other organizations leading to the hospital measurement consensus group with the MHMC and MHA.
7. Establishing a functional council that has systems to evaluate quality and implement change.
8. Website initiative
9. Nursing staffing survey study
10. Excellent work process and result on responding to request for input on LD 616
11. Establish a functioning council and forum
12. Indicator reporting and formatting MHINT
13. Organization into a body with considerable potential to make a contribution.
14. Establishment of a process to actually require quality indicator data to be uniformly gathered and reported.
15. Successful Technology Assessment Committee report to the Legislature
16. Report to the Legislature on LD 616
17. Developed a collaborative, dedicated Advisory Council
18. Website launch
19. Activated and utilized a Provider Advisory Committee
20. Website developed and launched
21. Creation of website with a commitment to maximizing transparency for future reporting of quality information.
22. Website – public information portal for quality in health care
23. Establishing Provider Group
24. MQF Website
25. Establishing MQF infrastructure and collaborative trust within the Advisory Group.
26. MHINT project development initiation
27. Joining the National Quality Forum and Quality Counts
28. Established group as active, viable, significant source of healthcare information (to public, legislature, providers, etc.)
29. Getting up to speed on our charge and working together as a group
30. Staying interested and viable in a challenging environment

Public Comments

31. Identified specific safety indicators
32. Website is up!
33. Drafting initial rules for submission of quality/performance data sets
34. Website
35. Establishment of broad partnerships that will mature and help us move toward the goals established in the work plan
36. Great job in diving into problems and articulating the complexity

37. Clearly identified “connectivity” (EMR and clinical info sharing) as a major priority in improving patient safety and quality.
 - Funded feasibility study
 - Laid groundwork for securing support and funding for implementing statewide coordinated electronic clinical info sharing system
38. Just getting Council members on the same page – growing the common knowledge base.
39. Development/implementation of MQF website
40. MQF website up and running.
41. Played leadership role in pulling together a single, coordinated effort (with MHA and Coalition) to publicly report on hospital performance.
42. Nurse measures
43. Council members meshed/developed relationships
44. Identified provider group
45. Including members of oral health community on provider subgroup
46. Good collaboration (linkages with other Dirigo committees)
47. Great to seek and be open to public comments

Missed Opportunities in 2004

Advisory Council Comments

1. Involvement in the State Health Plan
2. To “weigh in” on formative stage of State Health Plan
3. Educate the public about quality and its importance in developing a health care system and Dirigo product (and patients’ and community’s role in quality).
4. Explaining to the public and to the professions the value of the Dirigo Plan.
5. Being a part of Dirigo first year development; disjointed effort
6. Consumer education
7. Occasionally lost focus of need to strive for comparative indicators to measure provider performance.
8. Could have better built on work of existing groups and agencies.
9. Better educate ourselves on the NQF – what they have already developed and how this relates to the Maine Health Plan as foundational information
10. Educate ourselves on what quality activities are on-going in the various segments of the health care system.
11. More input about quality into both the Maine Health Plan and more importantly the Dirigo Health Plan.
12. Consumer education
13. Inventory of quality activities in state and possibility of establishing a leadership role for the MQF
14. Addressing public health (consumer) education

Public Comments

15. Did not name a dental hygienist or dental assistant to provider subgroup.

16. Bring in additional experts inn health care system to talk with us about quality or lack thereof (consumers, brokers, school personnel, Healthy Maine Partnerships and other coalitions like HMPs)
17. Excluding experts who may be aware of Maine quality and/or healthcare system environment but may live in another New England state.
18. Nurse indicators should be compared to patient outcomes along with staffing levels.
19. Failure to harness the power of health disparities collaboratives
20. Inaction on EHR campaign
21. Provider Group was too narrowly engaged
22. Establish MQF AC as highly visible and respected liaison between MQF and provider community.
23. Decrease the amount of time it typically takes for evidence-based treatment protocols to become standard practice throughout the state.
24. Distractions like LD 616 report have prevented Council from doing more outreach and communication to both providers and consumers. Perhaps a quarterly newsletter discussing MQF activities sent to all providers.
25. Focusing on 1-2 high priorities to give group focus.
26. Engage deeply with individual providers (e.g., patient and provider interaction)
27. Technology assessment – single focus on electronic medical records. No examination of medical technologies.
28. Chronic disease management.
29. Opportunity to research and educate council on consumer attitudes, needs and understanding of health care quality information and issues.
30. Clear dissemination of info on programs of MQF t public/medical community.
31. Securing grantsmanship expertise and get applications submitted for funding.
32. Standardize staffing plans.
33. DHHS document staffing levels – transparent to the public.

Priorities for 2005

Advisory Council Comments

1. Patient safety – including public education as part of curriculum
2. Be a significant partner in developing the State Health Plan
3. Consumer Education
4. More closely align MQF goals and activities with overall Dirigo goals
5. Input into State Health Plan
6. Focus on chronic care indicators, especially diabetes
7. More aggressive means (outside web) of communicating our work and its value to the public
8. Identify and push 3 initiatives for quality improvement
9. Establish standard process and measures of quality across the healthcare spectrum

10. Engage the provider community in our efforts in a positive way
11. Implementation of performance indicators statewide
12. Proactive CON process
13. Indicators and implementation of quality performance for 3 chronic diseases (cancer, heart disease, diabetes)
14. Seek grant funding to support local initiatives (collaborative efforts) designed to communicate quality issues to consumers – tool development.
15. Identify and standby standards to implement MHINT program (described by John Field 10/8).
16. Make scan of technology (emerging and present) working from pending CONs and inventory in State Health Plan.
17. Proactively identify quality issues for focus of our efforts
18. Use HRA information to validate Dirigo program value to member, employer, provider, state and payors.
19. Advance the concept of EMR/MHINT
20. Inventory statewide quality activities with a goal of helping to decrease duplication, advancing successful projects, maximizing resources, and possibly providing some leadership/coordination function.
21. Continue unique projects: nursing indicators, variation reports
22. Identify and pursue funding opportunities for MQF AC activities.
23. Define a transparent, reliable work process for interface with Governor’s office, MQF AC and back the other way.
24. Prospectively develop a work plan for our focus rather than be reactive only to opportunities coming from the outside.
25. Examine chronic illness care opportunities for focus.
26. Research and implement effective ways to reach employers and individuals so they make informed health care decisions.
27. Address chronic illness care
28. EMR
29. Explore pharmaceutical “counter-retailing” to begin informing provider of drug options, and overall gain/savings to system.

Public Comments

30. Make website more user friendly so people of all educational levels - don’t assume that all movers and shakers are highly educated.
31. Document nurse indicators overtime, including additional hours worked per assigned and what the nurse was hired for.

32. Establish a coordinated statewide effort to build health care literacy among consumers.
33. Move beyond hospital report cards to: education/communication; support quality improvement on report card measures; and include other health care settings and providers.
34. Consumer health education projects
35. Roadmap for how Maine should optimally engage the national campaign to establish an EMR for every patient by 2014. This includes the requisite interface: interoperability with CMS' effort to roll out "Vista-Lite" beginning with its California project.
36. Construct a statewide effort to underwrite infrastructure improvements that support data interchange and the emerging CCR (see Dr. Brailer's plan). This should include bond-funded projects to improve bandwidth in medically underserved areas.
37. Gain provider buy-in to the larger mission of the MQF; there is a wealth of intelligence that is both fragmented and ripe for harvesting among primary care practitioners.
38. Nurse staffing study showed that a higher proportion of more highly educated nurses can reduce the 30 day mortality rate and the odds of failure to rescue.
39. Communicate mission to providers. Only a small percent of physicians and other providers know of the Forum's activities. It is a difficult group to reach so we need to reach out to them in multiple forums and a variety of modes – ie. Medical staffs, specialty societies, professional associations, group practices.
40. Support implementation of a coordinated statewide electronic clinical information sharing system aimed at improving patient safety and quality.
41. Establish a data partnership with one or more technical organizations to ensure forum has ready access to quality related data.
42. Patient safety: metrics, hospital awareness, consumer education
43. Additional quality and performance measures
44. Work with provider organizations to disseminate evidence-based treatment protocols.
45. Provide to consumers meaningful comparisons between facilities, providers.
46. Work to improve consumer health literacy
47. Activating citizens to act on health care quality information
48. Chronic disease management (health risk assessments are probably an integral part)
49. Further development/enhancement/expansion of website
50. Establish palliative and hospice care to begin at the time the patient is diagnosed with a terminal illness.

51. Coordinate MQF quality measurement and reporting with myriad of national efforts to prevent re-inventing the wheel.
52. Each hospital reports the number of acquired infections and medical error incidents annually.
53. Create process to reject an issue/project turfed to MQF by legislature and other agencies in order to concentrate on core mission.
54. Further develop public/private/academic partnership to fund and implement citizen education, engagement and activation regarding health literacy and healthy behavior.
55. Use nurse indicators that are more sensitive to nurse staffing. Three studies found that pneumonia rates are particularly sensitive to nurse staffing levels.
56. Need to identify more patient safety indicators to keep patients free of infections, unnecessary procedures, under/over utilization.
57. Focus on healthcare literacy – making it real for Mainers (applicability)
58. Review MQF website for readability – engaging average citizens so folks can read/understand/make decisions about their healthcare needs.
59. Focus on specific technologies and how these technologies will/may affect our healthcare system – cost, quality, access.
60. Connect with CON, hospital commission, etc to develop process for identifying evidence-based technologies.
61. Engage with non-traditional provider systems – e.g. FQHC, rural health clinics, etc. to learn of their population needs and then compare to other groups (privately insured, Medicare, Medicaid, etc) to identify quality disparities.
62. DHHS Division of Licensing /Certification to document the direct care RN to patient ratios including the number of patients that non-RNs are assigned to and/or the RN responsibility.

Note: This Document is incomplete without accompanying discussion

