

SUMMARY NOTES
Maine Quality Forum
Advisory Council
December 14, 2007

Present: Kathy Boulet; James Case, Rebecca Colwell, Chair; Josh Cutler MD, Executive Director; W. Stephen Gefvert MD; Jeffrey Holmstrom MD; Maureen Kenney; Robert Keller MD, Co-chair; Rebecca Martins; Brenda McCormick, Chip Morrison, Al Prysunka, Rod Prior MD, Doug Salvador MD, and David White.. Also in attendance were Karynlee Harrington, Executive Director of the Dirigo Health Agency and Maureen Booth of the Muskie School of Public Service.

Rebecca Colwell, Chair, called the meeting to order at 9:05 a.m.

Welcome Jim Leonard

Ms. Colwell welcomed Jim Leonard who was recently hired as the MQF Quality Initiatives Administrator. Jim formerly managed the diabetes program for Maine's Center for Disease Control (CDC) and brings to the job extensive experience in data analysis, behavioral health and public health.

Minutes – November 8, 2007

The minutes were approved as distributed with David White commenting that statistics quoted by Trish Riley regarding US health care expenditures were not accurate.

MQF Project Update

Dr. Cutler reviewed the status of several ongoing MQF projects:

- *In a Heart Beat:* Begun a year ago, this project aims to improve outcomes of acute myocardial infarction through community engagement, emergency care protocols and improved hospital care. Several training sessions on standardized protocols are scheduled in February 2008 at six sites throughout the state. Meanwhile, agreement has been reached on metrics to be used to track performance. The MQF is in discussion with the Maine Health Information Center regarding the potential designation of the MQF as a public health authority to protect data confidentiality during the initial phase of the project.
- *Hospital Acquired Infections.* Under Chapter 270, the MQF collects process measures related to hospital acquired infections. However, variations in case finding make comparisons across hospitals impossible. The MQF has been in discussion with Maine's major hospital systems to establish an Infection Control Collaborative. The Collaborative would provide administrative and technical support to the state's 18 non-affiliated hospitals in their data collection efforts. Questions were raised about the potential role of the Maine Department of Health and Human Services and CDC in the collaborative. There was general support for the concept and more

generally encouraging public/private partnerships as part of the MQF's recommendations for the 2008 State Health Plan.

Dirigo Update

Karynlee Harrington reported that enrollment of individuals (whether subsidized or not) has been stopped given that legislation requires individuals not to exceed 50 percent of total enrollment. The Dirigo Health Agency (DHA) is examining ways to increase the number of sole proprietors/small businesses which would expand enrollment and subsequently lift the cap on individuals. This is challenging given that funds are not available to provide subsidies to small groups and sole proprietors. Dirigo is working with the Governor's Office of Health Policy and Finance (GOHPF) to consider reforms in the individual market that would temper the rate of increase in premiums. One such option is to re-position the age bands used to set rates in the individual market in an effort to attract younger/healthier people.

Meanwhile, Dirigo continues to look at its financing mechanisms and is planning for the fourth Savings Offset Payment. While hoping that there will be legislative change that will avoid the contentious SOP assessment, the Agency is having to prepare for the worse. Early next session, the Insurance and Finance Committee is expected to review possible options.

State Health Plan

The primary purpose of this meeting was to develop recommendations for the 2008 State Health Plan. Dr. Cutler reminded members of guidance given by Trish Riley at last month's meeting to focus on specific actions that can be taken in 3-4 priority areas.

Members identified the broad levers that could be used by the MQF in promoting change. In general, these fell into three major activities.

1. Build on the data already collected. Make data as reliable, consistent and accurate as possible.
2. Conduct rigorous analyses showing variations within the State and with national benchmarks. Select 2-3 priority areas where the science supports the need for change.
3. Apply the role of the MQF and State as purchaser/payor/convenor/collaborator/educator to advance change in these areas. Consider public/private pilots or demonstrations.

There was general support for using this framework for whatever priority areas may be recommended for inclusion in the State Health Plan.

► **Hospital Acquired Infections.** To date, efforts have been placed on the selection of metrics for assessing the scope of the problem and collecting standard data across hospitals. These efforts should be continued while considering expanded efforts in the following areas:

- Better understand variations and underlying causes across hospitals
- Support and expand the HAI Collaborative, with possible inclusion of DHHS and CDC, to work with unaffiliated hospitals in the collection of data and improvement in outcomes.
- Reconsider whether to require the “present on admission” code to improve the collection of data.

► **Improved Primary Care.** Members identified multiple issues which suggest the need for reform in how people access and receive primary care.

- Inappropriate use of emergency rooms
- Recruitment, retention and payment of primary care practitioners
- Voluntary practice assessment conducted through MMA
- Designation of advanced medical homes
- Rise in hospital-owned practices; implications and trends
- Community-based care management and chronic care management; how to develop home grown and sustainable programs
- Intersection of public health and primary care
- Avoidable hospital conditions
- Telehealth
- Medical education
- Self management
- Mental health as a driver of medical care

There are initiatives throughout the state in many of these areas that are not coordinated. The MQF and its partners could work to inform these efforts through data analysis and support the establishment of pilots to demonstrate the successful integration of payment and practice reforms.

► **Health InfoNet.** Substantial investments have been made in this initiative that envisions the creation of electronic health records from data made available through electronic medical records at physician offices, laboratories, pharmacies and hospitals. MQF has contributed financially to the project and remains actively involved in its development. Much remains to be done in building an adequate funding base and developing the network. Inclusion in the State Health Plan would signal the importance of the project to building a technological infrastructure to Maine’s health care delivery system. Parenthetically, the recommendation was made to invite Maine Health InfoNet to a future MQF meeting for a briefing on its progress and status.

► **End of Life Care.** Data presented in the Dartmouth Atlas of Healthcare underscores the major expenditures during end of life care. Data show that integrated health systems, where hospitals and providers are under single control, generally do better in this area. Given Maine's low use of hospice care, this may be an area where the MQF and its partners can promote a better understanding of best practice.

► **Integration of Public Health, Clinical Care and Healthy Communities.** The recent designation of six health districts throughout the State has raised questions about their role and interface with the provision of primary care and the healthy partnerships funded with tobacco funds. This may not be an area where the MQF has authority or expertise to help direct but it could impact the delivery of health care in the State.

► **Health Systems Development.** The MQF has a statutory role in assessing new technologies and advising the State on certificate of need applications. The question was raised as to whether the MQF should be more proactive in assessing the need for new technology in the State and promoting its development in under-served areas.

Members agreed to meet again on January 11, 2008 to review the options discussed at this meeting and to prepare final recommendations for the State Health Plan. There being no further business, the meeting adjourned at 11:30 a.m.