

**Maine Quality Forum
Advisory Council**

**Friday, May 12, 2006
Summative Minutes of Meeting**

Members present: Dr. Richard Bruns, Rebecca Colwell, Dr. Jeffrey Holmstrom, Frank Johnson, Dr. Robert Keller, Becky Martins, Lisa Miller, Daniel Roet, Dr. Paul Tisher, David White, and Dr. Janice Wnek. Maureen Booth of the Muskie School of Public Service, Brenda McCormick of MaineCare, Al Prysunka of the Maine Health Data Organization, and Dr. Dennis Shubert were also present.

Chair Rebecca Colwell called the meeting to order at 9:10am.

Minutes

The Council approved April's meeting minutes.

Dirigo Update

Karynlee Harrington reported that adjudicatory hearings regarding measurable aggregate DirigoChoice cost-savings for 2007 were held earlier in the week. Interveners such as Anthem and the Maine Association of Health Plans spoke in opposition to the Dirigo Health Agency (DHA) position, while Consumers for Affordable Health Care supported the DHA position. Ms. Harrington stated that the DHA Board of Directors would be holding a public meeting that day to deliberate and make a decision about 2007 measurable cost-savings. That decision will then be reviewed by the Superintendent of Insurance, who will make a final decision. At that point, the DHA Board will decide the actual Savings-Offset Payment (SOP). (

Ms. Harrington also reported that the challenge to last year's SOP finding is currently before the circuit court and may go directly to the State Supreme Court. The court's decision will most likely affect all future SOP calculations.

Ms. Harrington updated the Council on DirigoChoice enrollment. She stated that the program has served over 16,000 members, and current enrollment is just below 10,000. Also, while the enrollment distribution generally remains consistent, more sole proprietors/individuals than small businesses are beginning to be seen. Ms. Harrington noted that Anthem currently has a Request for Proposals out to improve DHA's ability to effectively reach out to small businesses.

Last, Ms. Harrington reported that on May 30 a hearing will be held about implementing an asset test for all applicants. Currently only MaineCare members complete an asset test. The proposed asset test would be a self-declaration process.

Old Business

Paid Claims Update

Chris McCarthy reported that the official warehouse build for the paid claims database has begun; the data in the warehouse will be patient-centric, but actual patient names and possible identifying data are not in the database. Initial findings from the build will be shared at the next Advisory Council meeting. Chris noted that the Maine Health Data Organization (MHDO) has been instrumental to this project's progress.

Al Prysunka shared information about similar projects in other states: New Hampshire adopted the Maine system (with the addition of one more field) and has started collecting data; Vermont is establishing a claims database; and Oregon has inquired about the Maine system.

Quality Metrics Update

Chris reported that the healthcare-associated infection rules passed the legislature. Chris also reported that discussions about specific nursing sensitive indicator definitions (such as pressure ulcers) are ongoing.

Lisa Miller suggested that MQF provide a summer update to the Health and Human Services Committee about its primary role and its activities, with special emphasis on the goal of ensuring better care not blaming providers. Ms. Miller proposed MQF redefine itself for the Committee whenever providing testimony.

Cardiac Project Update

Dr. Shubert informed the Council that participant comments from the coordination of cardiac care project ("In a Heartbeat") kick-off meeting were available for review. He summarized the comments into two categories. One category was request for state wide coordination. The other was for help overcoming the political barriers to coordination. He reminded the Council that Dr. Gus Lambrew is the Medical Director for the project, and Tish Tanski is the Project Director.

Practice Assessment Update

Dr. Shubert reminded the Council that the primary care practice assessment project enables practices that lack resources to have themselves assessed; the project results will be kept private, due to peer-review protection from the Maine Osteopathic Association and the Maine Medical Association. Dr. Shubert noted that practices will be connected with the Quality Counts Learning Network post-assessment to facilitate improvement where needed. Dr. Shubert reported that the project contract has been signed and is with the State Purchasing Department.

Gordon Smith of the Maine Medical Association noted that Dr. Lisa Letourneau has agreed to be a consultant for the project, a committee of physicians has

been established to select project metrics, and nearly thirty practices have volunteered for the project. A part-time project director is needed.

Dr. Bruns stated that this project would be beneficial for the chiropractic community too.

Website Update

Chris stated that a Request for Information has been drawn up regarding the website rebuild.

Safety Star Update

Carrie Hanlon summarized the results of an informal telephone survey she conducted with quality professionals in Maine hospitals to gauge interest in the Safety Star Program and gather feedback about the program. Of the hospitals Carrie spoke to, six reported that they were working towards applying for the Safety Star, seven were unsure/noncommittal, and 10 had decided not to apply. Common concerns and/or reasons for not applying included: being overextended with insufficient time/resources; the fact that other hospitals have not applied; feeling the program is unnecessary or redundant due to participation in the Leapfrog Survey; feeling the program is too stringent; and the fact that the program is voluntary. The two most challenging standards for those working towards applying were reported to be: flu vaccination (because hospitals must wait until the fall to carry out changes) and verbal order verification (because it is a challenge to meet the State of Maine standard for verification within 72 hours, yet the Safety Star requires it within 48 hours). Carrie thanked the hospital quality professionals for taking the time to speak with her.

Dr. Shubert stated that the National Quality Forum (NQF) has reissued the safe practices in a draft form, and that artificial insemination has been added to the NQF list of serious reportable events. The new versions should finish the NQF consensus process with Board approval in October 2006. MQF can then review what changes it will need to make to update Safety Star.

New Business

CMS:

Proposed Rule 1488P

Dr. Shubert provided an overview of proposed rule 1488P, which overhauls the DRG system, quadruples the incentive to hospitals for reporting quality indicators, and starts the process to reduce reimbursement for complications of care such as certain yet to be specified healthcare associated infections.

MQF/CMS Interaction

Dr. Shubert postponed this discussion due to time constraints.

Home Health Metrics/ AHRQ Tools

Ms. Colwell went over the quality of home health care, including metrics used to assess the quality of care. Home health providers complete the Outcome & Assessment Information Set (OASIS) to summarize patient care; the OASIS data system provides quality information that is also used for reimbursement. Forty-one outcome measures are compared with the national rate. Additionally, there is an adverse outcome report. NQF reviewed measures for the public reporting of comparative data last year and endorsed ten for public reporting.

Ms. Colwell explained how the QIO was helping home health agencies improve their internal quality improvement activities and the success of their activities. She pointed out that the QIO efforts were very supportive and successful.

Dr. Shubert noted that home health is the “Achilles heel” of health care quality in Maine, as indicated by the AHRQ state report for Maine which shows many metrics at levels below the national rates. Ms. Colwell explained that poor care transition plays a significant factor in Maine’s performance levels. Ill patients are discharged from critical access hospitals (due perhaps to their regulations) and go into home health care until they can be admitted to a nursing home. Additionally, medication reconciliation at transfer is often inaccurate. Ms. Colwell used her organization’s investment in remote physiologic monitoring for congestive heart failure as an example of investment in quality improvement that home health agencies make that is not recognized with reimbursement by Medicare. Brenda McCormick from MaineCare pointed out that MaineCare is in the early phases of establishing a pilot project for reimbursement of remote physiologic monitoring. She offered to update the AC at its next meeting. Dr. Shubert noted that federal bill S. 1733, which would provide for telehealth demonstration projects, was introduced by Senator John Thune in September 2005.

Dr. Shubert pointed out that the purpose for presenting the information about home health care quality was to evoke from the AC suggestions of what MQF’s and the AC’s role should be in facilitating improve in home health care. The discussion did not come to a specific conclusion other than asking MQF to consider options and return to the AC with alternatives.

Care Transition Measure

Dr. Shubert reported that the three question care transition measure is now in the NQF approval process. Dr. Bruns suggested MQF equip patients with information such as questions to ask and things to ensure providers know with regard to home health. Victoria Kuhn of Blue Cross Blue Shield suggested MQF look to the Institute for Family-Centered Care guidance on ensuring truly patient-centered care.

Members of the AC pointed out that improvement in care transitions and quality of discharges would help improve home health care quality metrics.

Provider Efficiency Measures

Dr. Wnek provided an overview of state and national efficiency measures, noting that efficiency defined as “value” or a combination of quality and cost best meets the goals of providers, payers, and patients. Ideally care is high quality and low cost. Dr. Wnek noted that sharing clinicians’ aggregate quality and efficiency scores (as Regence Blue Cross Blue Shield of Washington does, for example) helps members find higher value providers for general and condition-specific care. This performance data also educates physicians about costly practice patterns that do not add value to care. Care Focused Purchasing Measures Version 1.0 provides claim-based, employer-driven reports about the quality and efficiency of care.

Nationally, the Ambulatory Care Quality Alliance (AQA) has several workgroups devoted to this issue. Doug Libby and Ted Rooney of the Maine Health Management Coalition (MHMC) have been invited to participate in AQA subcommittees. MHMC Pathways to Excellence has a set of metrics on primary care practices. The metrics cover structure, process, and outcomes, and an episode-based cost efficiency analysis showed that the highest rated practices were also more cost efficient.

Vacancies

Ms. Colwell reported that there is a RN faculty member vacancy in the Provider Group since Jane Kirschling has moved out of state. Chairperson Colwell asked for nominations for the RN faculty member slot. Additionally, there are vacancies for a consumer/labor representative and a D.O. provider on the Advisory Council since Jonathan Beal has been appointed to the DHA Board and Steve Shannon has moved out of state. The Maine Osteopathic Association’s nomination for the D.O. slot has been in the hands of the Governor’s office for several months.

Public Comments

There were no public comments.

The meeting adjourned at 12:10 pm.