

SUMMARY NOTES
Maine Quality Forum Advisory Council
May 8, 2009

Present: James Case; Josh Cutler MD, Director; W. Stephen Gefvert DO; Jeff Holmstrom DO; Frank Johnson; Robert Keller MD (Chair); James Leonard, MQF staff; Becky Martins, David White; and Jan Wnek MD.

Item	Discussion	Decision/Action	Date Due
March 13, 2009 Minutes	Minutes of the March 13, 2009 meeting of the Maine Quality Forum were reviewed. Correction was noted to include Jim Case on the list of attendees.	Minutes approved as amended	
Status of Health Dialog Analysis	<p>Josh Cutler referred members to the final report prepared by Health Dialog on behalf of the MQF and the Advisory Council on Health Systems Development. This report, <i>All-Payer Analysis of Variation in Healthcare in Maine</i>, is partial fulfillment of a request by Maine State Legislature to study major cost drivers within the State. Health Dialog’s contract with the Dirigo Health Agency includes additional analyses on quality of care. Members offered several suggestions to focus the scope of the upcoming quality analysis:</p> <ul style="list-style-type: none"> • Target specific chronic conditions and assess appropriateness and adequacy of primary care through analysis of avoidable hospitalizations and evidence based guidelines. • Assess hospital re-admissions, specifically as they relate to mental illness and COPD. • Care for uninsured; use of ER. Members agreed this was a major problem but unrealistic given lack of claims for uninsured,. • Specialty care within limited number of disease categories (eg., diabetes). Members suggested two possible audiences for this work: (1) PCPs who lack access to specialty performance when making referrals; and (2) Consumers and employers through development of practical measures to stimulate more scrutiny of specialty care. • Further drill down on management of specific diseases across physicians, hospital and outpatient settings. • Develop Community Profiles for high versus low performing areas. Members suggested possible Dr. Cutler sought the advice of members in 	Since original cost driver report showed chronic disease as major contributor to cost, makes sense for quality report to focus on these conditions. Report should be meaningful and actionable by wide spectrum of consumer and provider audiences. Need to go beyond variation and assess characteristics of good providers and those that are not.	TBD

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	identifying how best to focus this next phase of analysis.		
Safety Star	Josh Cutler noted that the MQF-sponsored Safety Star was an innovative program when it began in 2006 by recognizing hospitals having exemplary safety standards and performance. To date, no hospitals have sought Safety Star recognition. A telephone survey of hospitals found that facilities are not likely to participate due to the significant burden imposed in the approval process and the fact that the effort is duplicative of other national efforts (e.g., JCAHO, Leapfrog). Hospitals also note that the all or nothing rating did not recognize major progress and lacked any comparative data for assessing a facility's performance against its peer group.	With limited resources and a declining return on investment, it was decided not to proceed with the Safety Star program.	
In a Heart Beat	This MQF-sponsored program was initiated to: (1) standardize the clinical approach to patients with heart attacks; and (2) enhance public awareness of the signs and symptoms of acute MI. The Community Engagement portion of the project provided training to over 18,000 participants with learning evaluated on a pre and post basis. The impact of this effort will be measured in the Behavioral Risk Factor Survey conducted in 2010. During its first years of operation, the MQF sponsored and staffed the Consumer Engagement Committee. The second portion of the project relates to the work of the Heart Committee that developed and promulgated a system for training EMS providers on technologies to shorten the time from presentation in the ER to treatment. Standardized transfer protocols were also developed. The Heart Committee continues to meet. The third component of the project relates to the standardization, collection and analysis of metrics from the point of contact to treatment. This has proven to be the most challenging aspect of the project and is being re-considered based on the availability of core measures from CMS.	The project will continue but without heavy involvement from the MQF. Responsibility for the Consumer Engagement Committee will be transferred to the Cardio Vascular Heart Committee which can better advance the objectives. Josh will continue to participate on the Heart Committee. The MQF will continue to provide periodic reports to the Advisory Council on the status of these efforts	NA
Hospital Associated Infections	Two legislative bills were considered this session and discussed by the HHS Committee. LD 960 requires hospitals to report incidence of MRSA and <i>c. difficile</i> infections. Parties agreed to a resolve that hospitals must perform targeted surveillance in risk areas as defined by MQF. LD 1038 originally would have required hospitals to screen all patients for MRSA, and prescribed a process for isolating MRSA patients, treating them with antibiotics, and flagging their charts. Recommendation was made that hospitals report to the MHDO on (1) its risk surveillance results; (2)	A new workgroup is being established to define "high risk" areas of the hospital and to determine a working definition for "surveillance. Becky Martins volunteered to serve on the workgroup.	

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	adoption of preventive programs and their results; and (3) metrics to be defined by the MQF, Maine Infection Prevention Committee (MIPC) representative of statewide nurses' organization, and consumer representatives. Josh Cutler reported that he was pleased with the outcome and the strong recognition that the statewide MIPC has an influential role to play in this area.		
Shared Decision Making	<p>State legislator Peter Mills introduced legislation requesting that the MQF study the use of shared decision making tools in cases where one treatment option is not better than another and the consumer plays a large part in influencing choice. The Resolve requires that the MQF to:</p> <ul style="list-style-type: none"> • Define preference health care services for use in shared decision making • Examine the availability of approved patient decision tools relating to each of the above health services and effectiveness of the those aids; • Study the payment methods to be used to reimburse providers for the use of shared decision making tools; • Identify incentives to encourage their use • Review evidence based studies that evaluate the effectiveness of tools; • Identify barriers to implementation <p>A preliminary report is due back to the Legislature in January 2010; a final report is due February, 2011.</p>	The MQF will convene a workgroup of representatives from MaineCare, MHDO, state employee health insurance program, health insurance carriers, hospitals, physicians, health care providers and consumers to assist in the preparation of the requested report.	1/2010
Health Technology	LD 257 is a bill to develop a health technology assessment program. Most insurance carriers currently have some elements of a program yet often have conflicting opinions about the efficacy of new technologies.	Work session planned for later in the day; no action at this time	
HITECH Act	Part of the federal Recovery Act includes grants to states for (1) health information exchange planning and development; (2) HIT extension programs to non-profits; and (3) and EMR adoption loan program. Given its history with HealthInfoNet, Maine is well-positioned to apply for these funds. Dev Culver of HealthInfoNet will lead the charge in developing a state strategic	Dev Culver of HealthInfoNet will lead the charge in facilitating a workgroup in developing a strategic plan, a prerequisite for grant eligibility	6/30/2009
Disparities	As part of Aligning Forces for Quality, the MQF was asked to design an analysis of health care disparities in Maine. Working with MaineCare and the Muskie School, claims analyses are being conducted to assess how race,	No action required	9/2009

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	ethnicity and language may contribute to the health care experience.		
Person Centered Medical Home	Josh Cutler reported that 51 primary care practices applied for participation in Maine's medical home pilot project. Twenty-three adult practices were selected in addition to 4 pediatric sites. The stage is now set for payors to work with the practices to negotiate payment. \$500,000 was set aside in the state budget for enhanced payment by MaineCare for members served by pilot sites.	No action required.	
Next Meeting	The next meeting is scheduled for September 18, 2009		