

**Maine Quality Forum
Advisory Council**

**Friday, September 8, 2006
Summative Minutes of Meeting**

Members present: Dr. Robert Keller, Frank Johnson, Becky Martins, Dr. Paul Tisher, David White, and Dr. Janice Wnek. Maureen Booth and Taryn Bowe of the Muskie School of Public Service, Brenda McCormick of MaineCare, and Dr. Dennis Shubert were also present.

Vice-Chair Dr. Robert Keller called the meeting to order at 9:15am.

Minutes

The Council postponed the approval of July's meeting minutes since a quorum was not present.

Advisory Council Reappointments/Appointments

Dr. Shubert stated that the Health and Human Services Committee would be meeting on October 10 to discuss Council reappointments for those Members with three-year terms and Council appointments to fill the three vacant seats.

Dirigo Update

Ms. Karynlee Harrington updated the Council on DirigoChoice activity and enrollment. She stated that the Dirigo Health Agency (DHA) Board of Directors authorized her to extend the (12-month) contract with Anthem for 2007 and negotiate rates. Ms. Harrington noted that a recent Anthem rate filing (which increases individual rates by approximately 20 percent) does not affect DirigoChoice individuals.

Ms. Harrington reported that the Blue Ribbon Commission held a second meeting, where Dr. Elizabeth Kilbreth and Ms. Kim Fox of the Muskie School of Public Service presented information about other states' initiatives. Overall, most states fund health care initiatives in a similar way to DHA. Ms. Harrington added that six more Blue Ribbon Commission meetings are scheduled before the Commission provides the Governor with its recommendation for alternate DHA funding. Ms. Harrington agreed to add Council Members to the list of interest parties so they will receive updates about the Commission.

Ms. Harrington reported that current enrollment (as of August 2006) is approximately 11,100, which exceeds the Agency goal of having 11,000 members by the end of the year. DHA launched an eight-week television ad campaign featuring member testimonials as a way to attract more small businesses to DirigoChoice. Ms. Harrington also stated that a toll-free hotline number has been established as part of a pilot project funded by Anthem.

Old Business

Remote Physiologic Monitoring

Ms. Taryn Bowe of the Muskie School of Public Service provided an overview of a report she created for MQF about remote physiological monitoring (RPM), computerized technology that monitors patients' vital signs and health via telemedicine or without face-to-face contact between patients and clinicians. Ms. Bowe noted that RPM is used most often in home health care, in conjunction with chronic disease management, and in hospitals. The technology is frequently utilized for patients with congestive heart failure (CHF). The benefits of RPM include: improved quality of care, improved patient self-management, easier access to care in underserved areas, and the reduction of medical errors. Challenges to implementing RPM include: the lack of data demonstrating its cost effectiveness, physician resistance, and restrictive licensing laws. Ms. Bowe provided a brief review of the RPM literature, which suggests that RPM reduces hospital utilization and improves clinical outcomes among patients with CHF or diabetes. In summary, it is clear that RPM improves patient care, what is not clear is whether or not it is cost effective. Large studies are in process that are likely to answer the cost effectiveness question. Most states and third-party payers plan to follow Medicare's lead on RPM.

Dr. Shubert noted that RPM was originally brought to the Council's attention within the context of Maine's relatively poor home health care quality, and the potential for RPM to decrease home health care readmission. Council Members discussed potential next steps for promoting RPM in Maine. Lisa Harvey-McPherson of Eastern Maine Healthcare Systems suggested MQF contact the technology workgroup of the Homecare Alliance to determine the status of RPM use in Maine.

In a Heartbeat Update

Dr. Shubert reminded the Council that an In a Heartbeat kick-off event was held in April and reported that another stakeholder meeting is scheduled for November 9 to disseminate project findings and recommendations. He further reported that funding from the Maine Health Access Foundation and the Bingham Program will enable MQF to set up remote meeting sites, which will help ensure statewide representation at the event.

Dr. Shubert added that the In a Heartbeat AMI (acute myocardial infarction) Community Engagement (ACE) Workgroup is working on ways to increase heart attack symptom recognition and promote calling 9-1-1 among the public. He noted that MaineHealth had established a work plan to address these same objectives. While that plan is now on hold, MaineHealth has agreed to contribute to the funding for the ACE Workgroup activity provided that the effort has financial support and agreement on goals with other hospital systems and hospitals.

Additions to Chapter 270/Health Care Quality Data Sets

Dr. Shubert discussed three different types of metrics MQF proposed to add to Chapter 270: venous thromboembolism (VTE) prophylaxis in surgical patients (two measures); the care transitions measure (CTM 3); and three Surgical Care Improvement Project (SCIP) infection measures (cardiac surgery patients with controlled 6am postoperative serum glucose; surgery patients with appropriate hair removal; and colorectal surgery patients with immediate postoperative normothermia). Dr. Shubert noted that the National Quality Forum endorsed both the VTE metrics and CTM 3. He added that the CTM measures were also part of MQF's attempt to help improve the quality of home health care by reducing the readmission rate. He explained that the SCIP metrics were selected because they will be part of a CMS chart extraction tool and the means to measure them already exist in the marketplace.

The Council unanimously agreed that the VTE, CTM 3, and SCIP measures should be added to Chapter 270. Ms. Nancy Morris of the Maine Health Alliance informed the Council that hospitals lack instruction with regard to the SCIP measures and experience a lot of confusion about what to collect because IHI and CMS have different expectations. Ms. Morris agreed to share with MQF a report given to her by the QIO outlining these concerns.

New Business

Data Website Update

Dr. Shubert reported on the progress of contracting for modifications of the AHRQ data website. Work is expected to start very soon with the site available publicly in the fall.

PSI/IQIs

Dr. Shubert provided an analysis of AHRQ provider-level patient safety indicators (PSIs) and inpatient quality indicators (IQIs). He noted that MQF is working to improve the administrative database, and one approach is improving coding by reducing coding errors. He pointed out that MQF is not telling people how to code. MQF is pointing out to providers where there is variation that might suggest unique coding issues to that provider. It is up to the provider to research and understand the variation. He also discussed the concept of volume as proxy for quality, along with the value of mortality rates, which require risk adjustment. Dr. Shubert explained that mortality rates are more useful in reference to high-risk procedures because rates are meaningful and can be compared. (For example, heart surgery mortality rates are much more useful than hysterectomy mortality rates).

Dr. Shubert reviewed a series of charts outlining various PSIs (including decubitus ulcer, birth trauma, and accidental puncture), and IQIs (such as cardiac surgery mortality rates) for Maine in 2005. He noted that MQF shared the 2005 data with hospitals to enable them to check its accuracy and provide feedback.

Dr. Shubert then went over MQF's general recommendations for continuing use of the AHRQ indicators:

- Continue the present process of indicator generation and provider feedback to serve the purposes of :
 - Improvement in coding practices
 - Provide overview information about provider performance consistent with AHRQ policy
 - Maintain public awareness of the concept of variation in quality and the need to improve laggards and raise all boats
- Present the 2005 data analysis (the second cycle of provider level indicators), after provider feedback, in a manner consistent with the goal of informing providers, regulators and policy makers.
- Clearly separate these AHRQ provider level quality indicators from those indicators that MQF supports for general public understanding by using clearly different presentation methodology for the different categories of information

Council Members unanimously supported Dr. Shubert's recommendation that the following IQIs be discontinued from collection: craniotomy mortality and bilateral cardiac catheterization rate.

The Council expressed its support for "big picture" objectives or themes with regard to sharing the AHRQ data with the public. Members expressed concern that detailed charts only confuse people who do not have a working knowledge of statistics. Members encouraged MQF to develop simple messages to the public about variation or volume to help patients determine what they should be asking their providers and thinking about when they interact with the health care system.

Safety Star Clarifications

Ms. Carrie Hanlon outlined minor changes to two Safety Star standards proposed by MQF as a response to feedback from hospitals. She explained that the proposed language would clarify the verbal order verification standard by noting that verbal order recipients not physicians must confirm immediate read back of verbal orders. Proposed language for the prevention of person-to-person transmission of infection standard would clarify that the "Partners in Your Care Program" is an acceptable method of observational study and measurement to promote hand washing. Council Members unanimously agreed with the changes. Dr. Shubert noted that two hospitals have expressed their intent to apply for the Safety Star, and that the Validation Team would be meeting soon to prepare for possible applications.

Announcements

Dr. Shubert noted that Quality Counts! Part 4 is scheduled for December 6.

Dr. Shubert reviewed the publications in the binder reference section selected for council members' home review. Two articles addressed the issue of provider volumes and outcomes. One article demonstrated that hospitals that had excellent outcomes on one surgical procedure tended to have excellent outcomes on other surgical procedures. The second article demonstrated a reduction in introventricular hemorrhage in premature infants related to NICU volume and staffing. This is a startling finding given the previously unknown causes of IVH. Another article was pessimistic about EMR reducing healthcare costs. The final article was very pessimistic about the future availability of primary care given the shrunken training pipeline for family practice and the large preference of internal medicine program graduates for specialty training.

Public Comments

There were no public comments.

The meeting adjourned at 12:00pm.