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PRESIDENT'S LETTER

“Transparency” is a word we are hearing more and more these days. As the health care world is increasingly being flooded with measurements for processes, outcomes, costs, and efficiency, the reports of these measures are no longer just in the aggregate. It's not just the average total cost for a CABG in Portland is \$Xs, but that Dr Jones costs are \$Zs and Dr. Smith's costs are \$Ys. Twelve percent of Dr. Brown's diabetes patients have HbA1c levels above 9; while only eight percent of Dr. White's patients have levels above 9. While we still see reporting in the aggregate or with blinded data – doctors identified with codes that only the doctor knows his own – transparency is coming; in fact it is already here. We haven't seen the detail suggested above, but people can go to several different web sites and see how his/her physician compares to his/her peers.

Today, in Maine, people can go to the Pathways to Excellence web site of the Maine Health Management Coalition and see how their physician is doing. Does he have one, two, three, or no blue ribbons? Hannaford Associates can go to their web site to see if their physician is among the Physicians of Distinction for PTE measures and efficiency (appropriate use of resources: the right test at the right time for the right cost and for the right reasons). The Aetna, Cigna, and Anthem web sites show who is in their preferred networks. These are all examples of transparency that exist today, and this is just the beginning.

These are measurement tools to differentiate physicians in the market place. They lack two important components of how transparency can be used positively. First, these measurements, with the exception of Pathways to Excellence, come out of a “black box” – the measurement tools are not transparent. How were the measures derived? What was used to differentiate a preferred doctor from one who is not? What can a doctor do to change his status? This is about working to get a grade, versus learning how to improve the value of the care provided. This is the second component that is needed for transparency to have value: it should be a tool for improvement.

While the transparency of physician process and outcomes measures are well on their way, it should be

recognized that in Maine we have a head start on approaching these tools in a collaborative way through Pathways to Excellence which consists of representatives from physician groups, hospitals, PHOs, employers, and insurers. With the PCPs, PTE has demonstrated how such a group can achieve acceptable measures through consensus. One approach is with efficiency measures through use of the ProfSoft software which provides a transparent look at the tools to measure efficiency and process quality (compliance with best practice guidelines). The members of PTE are committed to finding tools that will support quality improvement, while still giving the employers the tools they feel they need for their benefit programs.

While providers and employers may not be in the same place around the use of transparent measures today, in Maine there is a mutual commitment to get to a common place that can result in improved value which reflects optimal quality with the right use of resources (efficiency). This is when transparent data really achieves its potential: service value improvement, not just measurement.

Barbara Crowley, MD
President

PAYOR UPDATES

National Provider Identifier (NPI)

Get it, Use it, Share it. The Final Rule adopting the HIPAA standard unique health identifier for health care providers was published in the Federal Register on January 23, 2004. Health care providers have been able to apply for an NPI since May 23, 2005. Although CMS is delaying their implementation of the NPI some of the commercial payers will only accept NPI numbers from May 23, 2007 forward. It is still important for you to obtain your NPI number and share it with payers and other providers. CMS currently accepts legacy numbers and will require a legacy number to be provided in conjunction with the NPI.

If you need to obtain your NPI, you may apply on-line using the web-based application available at <https://nppes.cms.hhs.gov>. A paper application may be submitted to the entity that assigns the NPI (the Enumerator). A copy of the application and the Enumerator's mailing address is available at: <https://nppes.cms.hhs.gov>.

Aetna

Aetna will be updating its 2007 Provider Directory beginning March 2007. This would be a good time to go on the Aetna Provider Website <https://www.aetna.com/provider/> and make sure that your information is accurate. You can make corrections on this website if necessary.

Effective May 1, 2007, MedSolutions will assume responsibility for precertification for all high-tech outpatient diagnostic imaging procedures for all additional health benefits plans except indemnity Tradition Choice® plans. MedSolutions will now manage precertification for high-tech radiology for your Aetna patients with all commercial and Medicare plans.

Harvard Pilgrim Health Care

Effective January 1, 2007 HPHC offered a new Medicare private-fee-for-service (PFFS) product for members in MA and NH. The product is called First Seniority Freedom. PPO products with effective dates beginning January 1, 2007 are *Harvard Pilgrim Choice Plus* or *Options* plans for member residing in MA, ME and NH and *UnitedHealthcare Choice Plus* or *UnitedHealthcare Options* plans for members residing in all other states. It is important to identify members by looking at their identification cards. The claims submission addresses will be found on the back of the cards.

Anthem

Beginning on April 1, 2007, please use only the following number to contact Anthem Provider Service: (800) 832-6011. This is the same toll-free number currently in use for provider inquiries about local Anthem member eligibility, benefits, and claims status. Beginning on April 1, 2007, the telephone number 207-822-6181 will no longer be in service for provider inquiries.

PHYSICIAN QUALITY REPORTING INITIATIVE

On December 20, 2006 the President of the United States signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by the Centers for Medicare and Medicaid Services (CMS). CMS has titled the statutory program the Physician Quality Reporting Initiative (PQRI). This program will replace the Physician Voluntary Reporting Program (PVRP) that was in place for 2006. Unlike PVRP, this new PQRI program establishes a financial incentive for eligible professionals to participate. Eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for

covered Medicare physician fee schedule services. To access a complete listing of the quality measures specified in the statute, visit the following CMS web page: <http://www.cms.hhs.gov/PQRI/Downloads/PQRI MeasuresList.pdf>. Final specifications for these measures will be published at the CMS website no later than July 1, 2007.

Eligible professionals can participate by reporting the appropriate quality measure data using G-code and Current Procedural Terminology Category II codes on your claim submissions to your Medicare claims processing contractor. While reporting for the 2007 PQRI doesn't begin until July 1, 2007, you should become familiar with the measures before the reporting period begins and should set up office work flows to meet the requirements of this program. Your practice management system will need to be able to accept the new codes- G codes and/or CPT II codes- and there will likely be some additional brief chart review at the time of the visit to select the correct code.

This voluntary phase is an opportune time for you to familiarize yourself with the quality reporting initiative and take advantage of both the financial incentives and feedback from CMS prior to their expected transition over to a pay for performance reimbursement system. As we get closer to the start of the reporting period, more information from CMS will be available on their website. We will also be providing you with updates as they become available.

WELCOME TO THE MAINEHEALTH LEARNING COMMUNITY

MaineHealth and the Maine PHO recently launched the **MaineHealth Learning Community (MHLC)** as a way to provide assistance to Primary Care Practices (PCPs) to improve care across chronic conditions. The MaineHealth Learning Community offers a menu of options to busy healthcare providers seeking to improve care and outcomes.

The goal of the MHLC is to offer practices the resources necessary to expand upon and strengthen existing clinical improvement efforts within their practice. Available resources include

- **Access to chronic illness tools, information, and links to community resources**
- **We will provide you with access to the latest resources via e-newsletters, website, etc.**
- **Practice Improvement Series Meetings—PRISM (day-long sessions offered throughout the year)**

Over 150 people attended our first PRISM on January 18th. Here's what attendees had to say:

“The interactive portions were very stimulating. It really got our team ‘in motion’. It is always so invigorating to attend these programs. It definitely gets all parties involved moving, thinking, and brainstorming!!! What a great motivator! Thank you!!”

“Everything was great—just keep doing it!”

“The sessions were terrific and inspiring!”

“Great resources and chances to network.”

Whether you attended the first PRISM or not, you are invited to our next one, which will be held on May 3rd at the Harraseeket Inn in Freeport. This is not a repeat of the first! Please join us for new information and inspiration to help you achieve your improvement goals!

- **Regional Improvement meetings**

If you can't make it to a day-long Practice Improvement Series Meeting (PRISM), then a Regional Improvement Meeting might be the thing for you!

Regional Improvement Meetings are educational sessions that we will help to arrange in your local area. You request the topic and we will arrange the speakers, including specialist physicians and/or educators. These sessions are tailored to your own improvement interests and needs.

- **Practice coaching and feedback**

If your practice is ready to take on quality improvement work but don't know where or how to begin, coaching may be for you. The purpose of coaching is to support a primary care practice that is working on one or more improvement/redesign efforts. PHO and MaineHealth staff trained in practice improvement will provide coaching services to help practices meet their improvement goals. Activities will be tailored to the needs of the practice.

If you have any **questions or comments**, please contact Cassie Cote at 541-7558 or [visit us online](http://www.mpho.org/clinical_improvement/mainehhealth_learning_community/) at http://www.mpho.org/clinical_improvement/mainehhealth_learning_community/

THE CARE TRANSITIONS INTERVENTION

Background

Older patients often require care from different practitioners in multiple settings. For example, in a given month, the same person may receive care from his or her primary care physician or a specialist in the ambulatory care setting, a hospitalist physician and nursing team during an inpatient admission, a different physician and nursing team during a brief stay in a skilled nursing facility (SNF), and finally, from a visiting nurse in the home. Yet during times when they are most vulnerable and their informal caregivers are often overwhelmed, systems of care fail patients by not ensuring that: (1) the

critical elements of the care plan developed in one setting are transferred to the next; and (2) the essential steps that need to take place before and after transfer are executed. Because patients and their caregivers are often the only common thread moving across settings, together they comprise an appropriate target for an intervention designed to improve the quality of transitional care.

The Intervention

The Care Transitions Intervention (CTI) is a patient-centered intervention designed to improve quality and contain costs for patients with complex care needs as they transition across settings.

How does CTI work?

A Transition Coach, who is a registered nurse, encourages self-management and direct communication between the patient/caregiver and primary care provider rather than to function as another health care provider, per se. The coach meets with the patient and family caregiver in the hospital, makes a home visit and provides three follow-up phone calls during the 4-week Care Transitions Intervention. The coach also maintains contact if a patient is transferred to a skilled nursing facility before going home. The Care Transitions Intervention focuses on four areas: medication self-management, use of a dynamic patient-centered record (Personal Health Record), primary care and specialist follow-up and knowledge of “Red Flags”- indications that their condition is worsening and how to respond.

Intervention Outcomes

The Care Transitions Intervention is an evidence-based program developed by Eric Coleman, MD, MPH, and his team at the University of Colorado Health Sciences Center with funding provided by The John A. Hartford Foundation. The overriding goal of the CTI is to improve care transitions by providing patients with the support and tools that promote knowledge and self-management of their condition. Patients who have received this intervention experienced improved self-management knowledge and skills, primarily in the areas of medication management, condition/disease management, and greater confidence about what was required of them during the transition and beyond. Greater knowledge and confidence in self-care skills translated into patients (and family caregivers) enhanced ability to ensure that a greater proportion of their needs were being met during this vulnerable time. Encouraging patients and their caregivers to assert this more active role in their care transitions also resulted in reduced re-hospitalization rates.

The Care Transitions Intervention is currently being piloted at MMC by MaineHealth Elder Care Services. The MMC PHO will soon begin a pilot offering the Care Transitions Intervention to Greater Portland Medical

Group patients and their caregivers. This intervention does not attempt to change the delivery of healthcare, but rather it is designed to make sure that the excellent care provided in the hospital is preserved after older patients leave the hospital. More information about Care Transitions can be found at: www.caretransitions.org

Payer Satisfaction Surveys

Our annual survey for 2006 has been completed. We sent surveys to each practice with the Maine PHO and 71 practice sites (representing 245 physicians) completed and returned the surveys. 21% of practices responded. We asked practices to rate each payer on a scale of 1-5 (1-Poor; 5-Very Good). The results are as follows:

	Aetna	Anthem	CIGNA	Harvard	CBA	First Health / Health Care Value	Great West/One Health Plan	Martin's Point (USFHP)	Private Health Care Systems
Overall Satisfaction with Plan	3.3	4.0	3.3	3.4	3.6	3.6	3.6	3.6	3.5
Responsiveness of Provider Rep	3.2	3.8	3.2	3.4	3.4	3.5	3.5	3.7	3.5
Timely Notification of Policy Changes	3.6	4.0	3.5	3.5	3.4	3.4	3.4	3.5	3.3
Claims Processing	3.3	3.9	3.4	3.5	3.5	3.5	3.6	3.6	3.5
Satisfaction with Referral Process	2.9	4.0	3.5	3.2	3.4	3.5	3.4	3.5	3.5

Thanks to all who took the time to complete the survey. If you would like more detail on the survey results, please contact Angela Best at besta@mmc.org or 771-2004.