

## PRESIDENT'S LETTER

For months we have been talking about and writing about the various incentive programs that have been created in our communities. Pathways-to-Excellence. Anthem's PCP Quality Improvement incentives. Incentive programs created by some of the PHOs. We talk about preferred or select networks of PCPs and Specialists. If a person goes to one of these physicians, he or she pays a lower co-pay or, in some cases, the physician gets paid better. We are measuring quality with process and outcome markers such as HbA1c and LDL levels for diabetics - and we can be rewarded for doing a good job. Inherently, all of this is good stuff, provided we don't lose sight of why we are doing it.

A simple, cliché answer is "because it is the right thing to do." And actually, that is the best answer. Yes, we expect to get paid for the work we do. Yes, doing more can cost more, but is it worth more if it brings added value? Added value for whom? I sometimes fear that is what we may be losing sight of. All of the systems' programs and incentives have been created to help us as physicians serve our patients better. There is a chasm in health care between what we know how to do and what we are doing. The systems are being devised to help us cross that chasm. The incentives are there to lessen the pain of change, perhaps just a little. They are also meant to recognize physicians for the efforts they are making to serve their patients better.

If we do not clearly see that all of this effort is part of an evolution (some may say revolution) in providing better care for our patients, we will look only at the struggle of change and not the value. We must keep our focus on the end game, as they say. What provides greater satisfaction - entering data into a registry or watching Mrs. Jones finally change her diet and get her diabetes under better control. Obviously the latter, but without the tools to track and support you in knowing that Mrs. Jones needs her levels checked, her improvement may not occur. The registries and the incentives are tools to support a more valuable end result. Some of you may see this as an overly simplified example and dismiss it but isn't this really what we are all about?

Like you and your practices, the PHOs are redesigning themselves to be more supportive of their members and to help with this transition. We plan to

help through education, training, and whenever possible, financial support through contracting.

Terrance Sheehan, MD, President

## GREATER PORTLAND ASTHMA COLLABORATIVE MAKING PROGRESS

Last year, MaineHealth received a grant from the Maine Health Access Foundation to support a community-based asthma collaborative.

The two-year project, known as the AH! (Asthma Health) Community Collaborative, or AHCC, works to improve asthma care and outcomes among disparate populations in the Greater Portland area. The Program targets children and adults with asthma, especially low-income individuals, MaineCare enrollees, the uninsured, the underinsured (individuals with catastrophic or high deductible policies), and non-English speaking groups. It has engaged a broad cross-section of the community, including primary care providers, public health, schools, childcare programs, business, and others.

At a recent Learning Session, the teams reported some of their progress so far and it was impressive. The clinical teams are working hard to increase the percentage of patients with documented severity classification and to increase the use of controller medications for patients with persistent asthma among other clinical measures, such as referrals to tobacco treatment. Community teams have goals tailored to their organization; for example, to increase the number of students with a Maine Asthma School Plan, to identify and address cultural barriers to asthma care, to identify and improve indoor air quality issues that impact community members with asthma, and many others.

The Maine Health Access Foundation (MeHAF), created in 2000, is the state's largest health care foundation. MeHAF promotes affordable and timely access to comprehensive, quality health care and seeks to improve the health of every Maine resident. In particular, MeHAF targets projects that serve the medically uninsured and underserved.

For more information about the Community Collaborative, contact Julie Osgood, Collaborative Director at tel. 207-541-7515 or [osgooj1@mmc.org](mailto:osgooj1@mmc.org) or visit us on the web at [http://www.mainehealth.org/mh\\_professional/asthma\\_clinicalpracticecollaborative.htm](http://www.mainehealth.org/mh_professional/asthma_clinicalpracticecollaborative.htm)

## LOCAL PROVIDERS ON TARGET FOR IMPROVING DIABETES CARE AND OUTCOMES!

The TARGET Diabetes Collaborative 2, sponsored by MaineHealth, celebrated its one year mark at a final “Summary and Celebration Session” on May 6, 2005. Fifteen teams committed to making improvements in diabetes care in their practice using a rapid cycle improvement model developed by the Institute for Healthcare Improvement (IHI). During the year, practice teams came together for Learning Sessions, participated in a diabetes listserv and on monthly conference calls with other teams, and reported diabetes outcomes data (HbA1c, LDL, Blood pressure and Patient self-management goals) on a monthly basis, using a diabetes registry. Across all teams, data comparing baseline to measurement at 12 months for the approximately 1350 patients being tracked shows an increased improvement in patients with an HbA1c < 7 from 41% at baseline to 49% at the end of 1 yr.; a decrease from 31% to 24% in patients with HbA1c > 8; a decrease from 13% to 9% in patients reaching HbA1c  $\geq$ 9.5; improvement in LDL < 100 from 49% at baseline to 59% after 1 yr.; improvement in patients with a Blood Pressure < 130/80 from 33% to 36%. The most dramatic improvement realized was in the increase in self-management goal setting with patients with a baseline of 28% to 60% after 1 yr.

Teams also demonstrated remarkable improvements in measures of the process of diabetes care, including improvements in the rates of annual testing for HbA1c, LDL, and blood pressure testing. Improvements were due to a commitment by participating practices to improve their systems of care for patients with diabetes, including the use of a diabetes registry to help track patients due for testing. Process of care improvements included an increase in HbA1c testing from 80% at baseline to 93% at the end of 1 yr; LDL testing increased from 61% to 87%; BP testing increased from 86% to 97%.

“I found the collaborative to be invigorating as it combined real life information and challenges (our patients, our physicians and our systems) with measurements that have been demonstrated to improve outcomes. Also, having time dedicated to examining processes and outcomes was a welcome complement to the usual model of care focusing on one patient at a time,” says Dr. Nicole Cherbuliez, from Scarborough Family Physicians.

MaineHealth is sponsoring a third collaborative beginning in October 2005 that will focus on

improving Dibetes, Obesity, and Cardiovascular outcomes (“DOC” Collaborative), and is currently recruiting new practices interested in participating. Up to 15 new practice teams will be offered an opportunity to participate, and will receive support for developing systems to track and improve outcomes for patients with diabetes. In addition, many of the teams completing the current Collaborative will continue to participate in improvement efforts by enrolling in “DOC” Collaborative as “Phase 2” teams, and will be encouraged to expand their focus to include patients with cardiovascular disease.

MaineHealth and the MMC PHO will be working collaboratively to integrate both the MaineHealth TARGET Diabetes Program with the web based Clinical Improvement Registry (CIR) to provide a comprehensive clinical package for practices interested in improving diabetes care and outcomes. In addition to the upcoming “DOC” Collaborative, the PHO and MaineHealth will also partner to offer a range of additional educational opportunities to physicians and practice staff interested in learning more about improving outcomes for their patients with diabetes.

For more information on the next MaineHealth “DOC” Collaborative, the TARGET Diabetes program, please contact Dr. Lisa Letourneau (tel. 541-7521; [letoul@mmc.org](mailto:letoul@mmc.org)) or Kristina Scrutchfield (tel. 541.7533, [scrutk@mmc.org](mailto:scrutk@mmc.org)).

### The following teams participated in the TARGET Diabetes Collaborative 2

Eleanor Widener Dixon Memorial Clinic – Gouldsboro  
Louis Hanson, DO  
Jett Family Practice  
Richard Kappelman Internal Medicine  
Martin’s Point Family Practice – Portland  
Mercy Primary Care – Westbrook  
Miles Family Medicine – Damariscotta  
Miles Family Medicine – Wiscasset  
MMC Internal Medicine Clinic  
Oxford Hills Family Practice  
Scarborough Family Physicians  
Sheepscot Valley Health Center  
Southern ME VA OP Clinic  
St. Andrew’s Family Care Clinic  
University Health Care – Biddeford

## **IMPROVING DEPRESSION CARE: COLLABORATIVE RESULTS AND NEXT STEPS**

MaineHealth's Improving Depression Care (IDC) program has just completed its second Learning Collaborative. The aim of the IDC program is to assist primary care practices to implement an evidence-based system of care for patients with depression. Over two years, 18 primary care practices and one home health agency have participated in the program. Funding for the program has been provided by MaineHealth, the MacArthur Foundation, and the Robert Wood Johnson Foundation.

The components of the program include the following:

- Use of the MaineHealth Clinical Improvement Registry (CIR) to track key information about people in the practices with depression,
- Use of an outcome measure for depression, the Patient Health Questionnaire (PHQ-9), which has been described as the 'Hemoglobin A-1-C for depression',
- Tools to support patient self-management as a part of depression care,
- Use of care management to support patients in initiating treatment, staying on treatment, and engaging in self-management activities, and
- Access to a psychiatrist for informal consultations when patients are complicated or not responding to treatment.

We were pleased that all participating practices were able to pilot all components of the IDC model and some were able to spread beyond the initial participating clinicians. More than 1000 patients were affected in some way over the last two years by the participation of these practices in the collaborative.

We are moving forward in a couple of ways to extend the work we have been doing on depression in primary care. The one that has the most direct impact on PHO members is that we will be working with the PHO Clinical Improvement team to disseminate the IDC model to all primary care practices that are members of the MMC PHO over the next year or two. The plan is to start by helping people learn to use the PHQ-9 as a tool to assess patients and to track the outcomes of care. Once the PHQ-9 is being used, we will help practices to adopt other components of the model as they are ready and as resources are available. We are working with

the CIR team to enhance the decision support capabilities of the CIR for depression care.

It is clear that the work that we are doing with primary care practices is only part of what is needed to improve care for depression. Another important part of the equation is the ability to access specialty mental health expertise when needed. MaineHealth has just learned that we have received a grant from the Maine Health Access Foundation which will allow us to work on issues of access to and collaboration with specialty mental health providers.

MaineHealth is now recognized as being a national leader in implementing evidence-based approaches to caring for people with depression in primary care. Thanks to the support of the leadership of the organization and the hard work of many primary care clinicians in the system, we will continue to develop new approaches to care that work for patients and for primary care practices.

Neil Korsen, MD

### **PAYER UPDATES – SUMMER 2005**

The following is a brief summary of some payer changes that have recently gone into effect and/or will be going into effect in the near future. If you require more detailed information on any of the information below, please go directly to the payers' website.

#### **CIGNA - [www.cignaforhcp.com](http://www.cignaforhcp.com)**

- Cigna has recently combined provider contracting and provider service teams to improve operational efficiency. Effective May 16, Ron Pelton is the provider service representative for Maine. In addition, Cigna has established teams responsible for provider outreach and education who will help you with their enhanced electronic services. Cigna has expanded their provider website and expects to add new online services later this year. If you do not have access to Cigna's web site, log on to [www.cignaforhcp.com](http://www.cignaforhcp.com) to register.
- Cigna now has one number to call to access information about member eligibility, benefits and claims across all products as well as allow you to speak to a representative who can help you access the resources you need. The number is 1.800.88CIGNA (882.4462).
- OT codes 97003 and 97004 now need precertification after the sixth visit.

**HARVARD PILGRIM HEALTH CARE –  
[www.harvardpilgrim.org/providers](http://www.harvardpilgrim.org/providers)**

- As part of a new initiative, HPHC will send a letter when members begin physical therapy. The letter and informational flyer will detail benefits for these services, including limitations. For questions regarding member's physical therapy benefits, call the Provider Service Center at 800-708-4414.
- Anesthesiologists should report general anesthesia time in minutes; unit counts should not be used. Effective June 1, 2005, claims that are billed incorrectly will result in underpayment.
- Effective with dates of service beginning July 1, 2005, certain classes of drugs that require detailed coding such as chemotherapy drugs, oral anti-emetic drugs, immunosuppressive drugs, hemophilia clotting factors, epoetin alfa and darbepoetin alfa must be billed with revenue codes 634, 635 or 636, and detailed CPT or HCPCS coding. This billing requirement is consistent with UB-92 editor guidelines.

**ANTHEM/MAINE PARTNERS HEALTH PLAN  
– [www.anthem.com](http://www.anthem.com)**

- Beginning with their April 1, 2005 issues, Anthem is replacing their *Working Together*<sup>TM</sup> publication with *Network Update*. *Network Update* will be published six times per year.
- Effective July 1, 2005, Anthem is increasing both the medical and anesthesia conversion factors used to determine their maximum allowance by three percent. Anthem is also implementing a change to the methodology used to reimburse primary care physicians for members enrolled in HMO and POS programs. For services provided on or after July 1, 2005, Anthem will reimburse PCPs on a fee-for-service basis for all covered services provide to these members. They will no longer reimburse these services based upon the capitation methodology.
- Effective July 1, 2005, the RVUs will mirror the 2005 National CMS Resource Based RVUs as published in the November 15, 2004 *Federal Register*. These RVUs will not be adjusted for the geographical practice cost indices.

- Effective July 1, 2005, *In-Office Laboratory Services* will be reimbursed at 100% of the 2005 Medicare Clinical lab Fee Schedule published on November 16, 2004. *Supplies and Durable Medical Equipment* provided in the office setting will be reimbursed at 80% of the Connecticut Durable Medical Equipment Regional Carrier allowances. *Physician In-Office Drug reimbursement*, including oncology, vaccines and toxoids, will mirror Medicare's methodology and will be reimbursed at Medicare's prevailing rates published April 1, 2005, and updated periodically.
- Beginning on July 15, 2005, Anthem will implement Quality Management requirements related to non-emergent, outpatient imaging services. The outpatient imaging Quality Management program will be administered by National Imaging Associate, Inc. (NIA). A Quality Management requirement applies to the following outpatient diagnostic imaging services ordered on or after July 15, 2005: MRI, MRA, PET, CT, and Nuclear Cardiology.

**MARTIN'S POINT HEALTH CARE  
[www.martinspoint.org](http://www.martinspoint.org)**

- The US Family Health Plan at Martin's Point is in the process of issuing new Member ID cards to all US Family Health Plan Members. Members were instructed to begin using their new cards beginning May 2<sup>nd</sup>. If you have any questions regarding this change, you may contact Martin's Point Health Care Provider Inquiry at 1-888-732-7364 (Monday-Friday 8:00-5:00).

**LEGISLATIVE UPDATE**

- Recently enacted LD 416 – "An Act to Amend the Laws regarding the Submission of Health Insurance Carriers" will go into effect October 1, 2005 and will mandate consistent billing practices. Specifically, all claims for professional services must be submitted on the standardized federal form used by noninstitutional providers and suppliers. 24 M.R.S.A. provides that a health care practitioner, as defined in section 2502, must use the standardized claim form approved by the federal Government and practices with >10 providers must submit claims in electronic data format.