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PRESIDENT'S LETTER

My predecessors and I have used this column over the years to write about quality, measurements, efficiency, electronic medical records and other electronic systems. There have been a lot of words about process and the need for measurable outcomes. We have written about chronic illnesses and evidence based best practices. But where are we (you and the PHOs) going with all of this? How do we know when we get there? Is "there" a target? Who defines it?

First of all, there really is no final "there." Health care, like many other industries, is evolving and dynamic. What our forefathers thought was the ultimate in medical care 50 (even 10 or 20) years ago, we would consider almost primitive. While our technology is the most highly evolved in the world, we'll need to couple that with care that has been known for millenniums, continually searching for the right balance of high tech and high touch.

For the PHO, we try to polish up our crystal ball and figure out what we need to do to help our members be ready for the future. We are seeing three areas of focus that are all linked together: demonstrable measurement of quality performance/improvement, measurable efficiency (for both PCPs and Specialists), and the implementation of electronic systems (EMRs/EHRs; registries; e-prescribing, etc.). The ability to meet the demand for measurable and reportable performance requires the use of electronic systems, particularly EMRs with registry type reporting capabilities. These activities then become the basis for pay-for-performance programs that pay bonuses or enhanced fee schedules for meeting target quality and efficiency performance levels.

What all of this adds up to is a changing reimbursement system that pays for quality and efficiency and will differentiate between how well physicians meet standards. We are already seeing the beginning of this with Anthem, CIGNA, and Aetna offering "preferred" networks of Specialists based on efficiency and/or costs. While no reimbursement is attached to these programs yet, can we doubt that there will be in the future?

We see the role of the PHOs to provide support to optimize our care and our reimbursement. We are fortunate in Maine that the major employers and even the payers are willing to work with the provider community to develop measurements that we can access and work with, not the black boxes that come from away. We can shape the direction care and reimbursement are going. If the result of these efforts is the recognition (financial) of providing quality care efficiently and thus making health care more accessible and patients healthier, isn't that why we are in medicine?

Barbara Crowley, MD
President

PAYOR UPDATES
Martin's Point Health Care

Point Partners: Martin's Point employees will be covered under the Maine PHO Agreement for their Point Partners product effective January 1, 2007.

Generations Advantage: The enrollment period for Martin's Point's Medicare HMO product commenced on November 15th. They are expecting enrollment of about 1,000 members for the January 1, 2007 effective date.

Martin's Point will be mailing provider manuals for these two new products to provider offices in December.

UPDATES ON ASTHMA MEDICATIONS AND DEVICES

As many of you have noticed, MDI's are transitioning to hydrofluoroalkane 'HFA's". Albuterol used to be in a propellant form called a chlorofluorocarbon 'CFC'. The United States and Canada have collaborated and created the Montreal Protocol. Essentially this is an agreement between the two countries to attempt to save the ozone. CFC propellants are destroying the ozone. The new, more expensive preparation is called HFA and is not 'eating' our ozone.

These HFA medications, (Flovent, Ventolin, ProAir, Xopenex) to name a few are made of very negatively charged particles. There is concern that most of the spacing (chambers) currently on the market are made of plastic and are **very** positively charged. All of this static electricity is causing medication to adhere to the walls of the chamber when it is first used and some patients may

or may not get adequate amounts of medication delivered to the lungs.

Though there are very few studies looking at the actual deposition and penetration of medications to the lungs with various devices, we encourage each of you to closely monitor your patient's 'asthma control' or change of control with the devices and inhalant preparations they are using. Maine Medical Center is using a non-plastic chamber for all MDI medication delivery. Currently Monaghan makes two non-plastic chambers called Z-Stat and Aerochamber Max. Vortex makes a chamber with very little plastic as well. The chamber device may not be an issue for your patients. It is our intent to inform you of industry changes.

MaineCare has contracted with the makers of Xopenex HFA, Sepracor as the preferred medication for MDI prepared quick relief. Albuterol in aqueous solution (nebulized) is still preferred for MaineCare recipients. If you have any questions do not hesitate to call Rhonda Vosmus at 662-4515 or vosmur@mmc.org .

TREATMENT OF DEPRESSION WITH MEDICATION

The second depression eLearn module, entitled 'Treatment of Depression with Medication', is now available. We created this module in response to multiple requests from primary care providers for a review of anti-depressant medication in adults. It addresses several classes of medications; their benefits, side effects and use in combination. We've also created and posted a two-page decision support document designed to guide dosing and augmentation.

Follow the steps below to complete the second depression eLearn module:

1. Go to the website http://elearn.mmc.org/depression (note: do not use www)
2. At the login page, use your MMC or SCM ID as BOTH your user name and password. If you don't have an MMC or SCM ID, use 'welcome' (lower case, no apostrophes) as BOTH your user name and password. (e.g., user name: welcome; password: welcome)
3. Follow the links to the module.
4. Read through the presentation.
5. Follow the link to the test.
6. Before you start the test, print out a copy of the PCP Decision Support – Medications for Depression document to use as a reference.
7. The first self-test question asks you for your name. Please enter it in the box provided. Documentation of the test results will be recorded automatically when you click 'submit' at the end of the test. If you have used the 'welcome' login, documentation of completion will be based on your name entered as question 1.

We suggest that you keep a copy of the decision support tool to use when you are seeing patients in your office. It is our intention to publish a paper version of the second eLearn module in the near future as another option for learning about anti-depressant medications. We will include a laminated version of the decision support tool with the paper version.
This eLearn module follows Module 1: 'Use of the PHQ-9 for Diagnosis and Management of Depression'. The first module remains on the eLearn website. A paper version of module 1 is available by contacting Gina Marquis, administrative assistant for MaineHealth's Caring for ME program at 662-4613 or marqug@mmc.org.

For more information, contact: Cynthia Cartwright, Program Manager, or Neil Korsen, MD, Medical Director, MaineHealth Caring for ME. 662-4613

ST. MARY'S CHF PROGRAM IS A SUCCESS!

The number one reason for medical admissions at St. Mary's Regional Medical Center is Congestive Heart Failure. Reducing these admissions and re-admissions remains one of the goals of the "Healing Hearts" Heart Failure Program. This initiative, which began in 2001, is a Chronic Disease Management Program that offers the potential to improve the care of the heart failure patient.
Patients are identified as appropriate candidates for the "Healing Hearts" program while they are in the hospital. Following guidelines that are consistent with the American Heart Association and the American College of Cardiology, the patient is given specific discharge instructions written for their diagnosis. After discharge, the patient is provided educational and emotional support via telephonic monitoring by experienced registered nurses (care managers). Assisting the patient in complying with recommended guidelines, the care manager reviews instructions and the care plan, encouraging self-management of their illness. Telephone contact is made at least monthly, more often if needed. The patient is kept in the program for a minimum of one year. After a year, the care manager and the patient decide if they could benefit from ongoing telephonic monitoring.
The support patients receive from regular telephone follow-ups has drastically impacted the re-admission rate for Congestive Heart Failure for these patients. ***By 2005, readmission rates for CHF had dropped 50%!***
With the support and education they receive, patients have an improved functional health status. The reduction of both the patient's symptoms and the re-admission rates to St. Mary's demonstrates the success of this

program, benefiting both the patient and the community! For more information on this and other cardiopulmonary programs at St. Mary's, email us at cardiopulm@sochs.com or call 753-3259.

ST. MARY'S REGIONAL MEDICAL CENTER TAKE CHARGE!™ PROGRAM UPDATE

St. Mary's Regional Medical Center (SMRMC) in Lewiston, Maine created the Take Charge!™ Program in 2002. Since that time over 6000 individuals from across Maine and even New Hampshire have been screened for cardiovascular risk. A Take Charge!™ screening can include biometric measures (total cholesterol, HDL, LDL, glucose and triglycerides), blood pressure, body mass index, pulmonary function testing, waist circumference and health education. The programs primary goals are to identify individuals at risk for cardiovascular disease and encourage them to connect with their primary care physician for preventive care and risk factor management.

In the last year, the SMRMC Take Charge!™ Program has been offered at numerous businesses including Goodwill of Northern New England, Tambrands (a Proctor and Gamble Company), the Sun Journal, Allen Edmonds, Seniors Plus, the Sisters of Charity Health System and now, Bath Iron Works (BIW), a General Dynamics Company. By the end of 2006, over 2000 of BIW's employees will have participated in Take Charge!™ screenings! Over ninety-five percent of Take Charge!™ participants elect to have their Take Charge information sent to their PCP for follow-up!

In 2005, the SMRMC Take Charge!™ Program found 70% of participants were not getting enough exercise, 15% had total cholesterol greater than 240 mg/dl, 29% had LDL cholesterol greater than 130 mg/dl and 29% had HDL cholesterol lower than 40 mg/dl. Twelve percent were smokers!

Along with providing each individual with information on their cardiovascular risk and health education on how to reduce their risks, the Take Charge!™ Program provides employers with aggregate reports comparing their employee risk with the overall Take Charge!™ results and State and National comparisons. This information can be used to help employers' design and implement interventions and health benefits to encourage employees to reduce their cardiovascular risk and improve their health.

If you are interested in offering Take Charge!™ for your employees or in the community please contact Leslie Bickford at 207-777-8898, lbickford@sochs.com, of St. Mary's Regional Medical Center's Take Charge!™ Program or Deb Silberstein at 207-541-7520, silbed@mmc.org of the Maine Heart Center Take Charge!™ Program.

LOCAL PROVIDERS ON TARGET FOR IMPROVING DIABETES, OBESITY AND CARDIOVASCULAR CARE AND OUTCOMES!

The DOC Collaborative, sponsored by MaineHealth and supported by the MMC Physician-Hospital Organization, had its final "Summary and Celebration Session" on October 12, 2006. Across all teams, data comparing baseline to measurement at 11 months for the approximately **4070 patients** being tracked demonstrated the following results:

- an increase in patients with an HbA1c < 7 from 53% at baseline to 55% at the end of 1 yr.
- a decrease from 19% to 18% in patients with HbA1c > 8
- a decrease from 10% to 9% in patients reaching HbA1c ≥9
- an increase in patients with a LDL < 100 from 61% at baseline to 62%
- an increase in patients with a Blood Pressure < 130/80 from 42% to 44%

The most dramatic improvements realized were in the CVH outcomes of approximately **1170 patients**.

- BP Control < 140/90 went from 66% at baseline to 71%
- improvement in LDL < 100 from 68% at baseline to 72%
- ASA prescribed increased from 75% at baseline to 89%
- tracking smoking status went from 30% to 84% along with an increase in patients being offered smoking cessation from 9% at baseline to 59% after 1 yr

Teams also demonstrated remarkable improvements in process measures.

- an increase in nephropathy screening from 43% at baseline to 61% at the end of 1 yr
- foot exams increased from 49% to 69%
- BMI measurement increased from 80% to 90%

MaineHealth and MMC Physician-Hospital Organization will continue to partner by integrating the MaineHealth Clinical Integration Programs with the web based Clinical Improvement Registry (CIR) to provide a comprehensive clinical package for practices interested in improving care and outcomes across conditions. The nationally recognized Improving Chronic Illness Care program (ICIC) remarked that the quality and abundance of MaineHealth's clinical tools for multiple chronic illnesses led them to recognize MaineHealth as one of the national leaders in chronic illness care. Their upcoming initiative for 2007 is the MaineHealth

Learning Community (MHLC). The MHLC will strive to offer a range of additional educational opportunities to physicians and practice staff interested in learning more about improving outcomes for their patients with chronic illness.

For more information on the MaineHealth Learning Community please go to http://www.mpho.org/clinical_improvement/mainehealth learning_community/ or contact Elizabeth Lambert (tel. 541-7533, lambee@mmc.org). By: Kris Scrutchfield