



# Maine's

2008-2009

# State Health Plan

Issued by  
The Governor's Office  
of Health Policy and Finance  
With  
The Advisory Council  
On Health Systems Development

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## Executive Summary

The State Health Plan is a roadmap to guide and reflect the action underway and the next steps required to make Maine the healthiest state with an efficient and effective, high-performing health system. Maine's Dirigo Health reform law requires the Governor to develop and issue the plan with guidance from the 19-member Advisory Council on Health Systems Development (ACHSD). That Council is appointed by the Governor, after review by the Legislature's Joint Committee on Health and Human Services, to oversee the development and dissemination of the biennial State Health Plan.

The State Health Plan recognizes the collaborative efforts of the many public and private groups involved in health system reform throughout the State: consumers, healthcare providers, public health officials, employers, payors, researchers and many others continually come together to tackle the difficult issues of healthcare reform. The ACHSD believes that it is the unique willingness of Maine people to work together collaboratively that will enable Maine to achieve the goals established by the State Health Plan to become the healthiest state for all, with an efficient, effective and high-performing health delivery system.

Yet, while these are important goals, they will not be easily achieved. Collaboration needs to be supported by consensus building and the leadership to make tough decisions. They require all of us to change the way we think and act about health and healthcare, to acknowledge that the health and healthcare systems are complicated, intricately interwoven systems without quick fixes, and to be willing to move beyond individual self interest to what's good for the whole health system.

And Maine's goals cannot be achieved by government alone. We encourage the continued and expanded involvement of all stakeholders both public and private working in partnership to achieve what no one interest group could achieve alone.

The strategies and actions outlined in the 2008-09 State Health Plan continue to move us along the road for achieving Maine's goals. And although we do not expect to fully reach the goals of healthiest state with an efficient, effective and high-performing health delivery system by 2009, we do expect significant measurable progress – progress that the citizens of Maine need and deserve. The ACHSD expects that the tasks identified in this plan will be completed in the biennium and will provide information on the impact of these actions on achieving Maine goals and needed next steps.

To acknowledge the difficulty of the road ahead and still move courageously forward, the ACHSD has set in motion a process whereby each biennium it identifies meaningful actions towards the goals, learns from the results of those actions, and identifies new and/or continued actions that will enhance Maine's capacity for achieving its goals. The executive summary is structured to reflect this process: accomplishments to date, what we learned, and next steps.

## **Accomplishments**

The 2008-09 State Health Plan supports the work we need to do by defining and coordinating actions that will build on the strong foundation that has been laid during the past two years. The work at times has been grueling with many stakeholders involved, much information to be processed, and many ideas to be explored. Yet, within this environment of complexity and frustration, great things have begun to happen. There is much to celebrate and many people to thank for their hard work and commitment. The following accomplishments represent just a few of the successes achieved:

- The Public Health Group completed the design of a consolidated and efficient public health infrastructure that will bring public health information and support to local and regional groups engaged in creating healthy communities.
- The Maine Center for Disease Control (CDC/DHHS) supported the new infrastructure by streamlining and consolidating 150 grants into 28 to create a more effective Healthy Maine Partnership System.
- MaineCare launched a pilot to improve the health status of its highest cost users by assuring they get the appropriate care and follow-up.
- The Maine Quality Forum's (MQF) In-A-Heartbeat initiative is improving care of heart attacks statewide through a treatment map that uses evidence based medicine. Additionally, MQF trained people around the State in recognizing and responding appropriately and quickly to people experiencing heart attack symptoms. Both the effects of the training and education as well as the quality of care for heart attack patients will be monitored through Maine CDC/DHHS.
- Dirigo Health has covered 28,300 people, and the Bureau of Insurance has found that Dirigo Health Reforms generated \$111 million in savings over the first three years since Dirigo's passage.
- As a result of Dirigo Health Reform's rate regulation in the small employer group market, insurers refunded \$6.6 million to small businesses.
- The Governor's Office on Health Policy and Finance (GOHPF) led a work group that developed a worksite wellness toolkit and provided trainings to small businesses enrolled in Dirigo.
- HealthInfoNet has made significant progress towards becoming one of the first statewide health information exchanges in the country by securing initial



financing and service contracts with the four large health systems and Maine CDC that will bring the process of building efficiency and improved quality to the healthcare delivery process through shared information.

- In both 2006 and 2007 Maine received "A"s across the board from the American Lung Association in tobacco prevention, smoke free air, restricting youth access and excise tax.
- Maine was successful in reducing deaths due to cancer, coronary disease, stroke, and chronic lung disease.
- Average annual costs from hospital capital projects approved under the Certificate of Need program were 17% lower than the average in the eight years prior to the Capital Investment Fund (CIF), resulting in projected reduced costs of \$22 million from 2006-2009.

### **What We Learned**

In June 2007 the Maine Legislature increased the responsibility of the ACHSD with a requirement to analyze healthcare cost drivers and make recommendations that will lower the increase in the cost of healthcare in Maine to the increase in the cost of living. During the past year, the Council has focused much of its time on identifying specific elements of Maine's healthcare system that are driving healthcare costs and in October 2007 issued a report, "ACHSD Data Book: Investigating Maine's Health Care Cost Drivers" ([www.maine.gov/governor/baldacci/cabinet/health\\_policy.html](http://www.maine.gov/governor/baldacci/cabinet/health_policy.html)). In keeping with Legislative intent, many of the recommended actions for this biennium are based on this report, as well as on input received from the public during district health forums around the state in Fall 2007 and from expert panels that advised the Council.

The Council learned that, while the U.S. spends twice what peer nations do on healthcare, we do not have better health or better quality, and Americans get the right care only half of the time. Additionally, 47 million Americans lack access to healthcare coverage. Like other states, Maine's healthcare costs are driven primarily by utilization and inefficiency. However, Maine data shows that we spend more on healthcare and have lower health outcomes when compared with most national data. The following findings are of particular interest when we consider the challenges to making Maine the healthiest state with an efficient, effective and high-performing health system:

- New England's health care spending is higher than the national average, and Maine's per capita healthcare spending is the second highest in the nation.
- Maine is above the national average in the available supply of healthcare services:
  - Maine has 1.5 times the number of hospital-based MRIs as the U.S. average;

- Maine uses more out-patient & Emergency Room services than most other New England states;
- Compared to other New England states Maine has among the highest number of staffed hospital beds per 1000 population and among the lowest occupancy rate; and
- Maine has more physicians, nurses and rural clinics per 100,000 population than the US average, although there are areas of significant shortages and an aging workforce that portends future problems.
- The cost for treating the same patient for the same illness in different Maine hospitals varies by as much as 20-60%.
- Nearly 37% or \$1.2 billion of Maine's increase in health spending from 1998 to 2005 is attributable to the leading chronic illnesses, which are often preventable: cardiovascular disease, cancer, chronic lung disease and diabetes.
- Despite recent improvements, Maine has a higher average rate of deaths per 100,000 in cancer, diabetes, and chronic lung disease than the US average.

So while we have accomplished much in the first biennium, there remains a significant gap between where we are as a state and where we want to be. The 2008-09 State Health Plan focuses the next steps on specific cost drivers identified in the available data as a way of moving Maine more effectively toward its goals. The work ahead requires us to benchmark the results of these tasks against the goals we have identified and to continually report on the measurable progress that we are making.

### **Next Steps: Responding to the Cost Drivers**

To become the healthiest state with an efficient, effective high-performing health delivery system, we need to start with each of us – what we need to do as individuals, families and communities to maximize our health. It will require will and better information, and it will also mean having a health system that works for all of us and with all of us, by: investing in prevention; providing the right care at the right time throughout the State; eliminating costly redundancy and variation; assuring high quality; paying for the buildings, technology and equipment we need but not more than we need; and putting the patient at the center of the healthcare system.

Further, the ACHSD understands that Maine's health status depends on the health of the environment and looks forward to receiving reports from groups working to promote better air and water quality, reduce dependency on chemicals containing toxins (e.g.. the Maine Medical Association's Public Affairs Committee working on toxins in the environment) and provide healthy neighborhoods and communities.

The council also recognizes the broad and complex nature of health systems reform and believes the State Health Plan must focus its resources and attention to those actions accomplishable within the biennium, so that the next steps we take will bring substantive gains in developing the health and healthcare system we need in Maine.

The 2008-09 State Health Plan's next steps are organized in three major categories representing the change we want to see: (1) Improving Health, building a system that supports every person getting and staying healthy; (2) Assuring Best Practices/Less Variation in Care Delivery, making sure that every healthcare consumer receives the right care at the right time; and (3) Efficiency and Effectiveness, eliminating redundant or ineffective systems and treatments so that every consumer gets the quality and services needed at the lowest possible cost. Because these steps are based on the cost drivers identified by the ACHSD's study, they will have a substantial impact on Maine's movement towards its goals.

### **I. Improving Health**

- Implement a streamlined and coordinated statewide public health infrastructure with a Local Health Officer in every municipality.
- Provide Healthy Maine Communities with information on the health status of their communities so they can design solutions targeted to their specific demographics and needs.
- Identify ways to sustain and increase coverage for the uninsured and underinsured population.
- Identify inhibitors and reforms needed to increase affordable products in the small group market.
- Continue MaineCare's High Cost User Care Management Benefit.
- Implement a pilot in one district to improve coordination of public health and behavioral health systems.
- Implement a public-private multi-payor pilot that pays for integrated patient centered care (the Advanced Medical Home model).
- Create partnerships between higher education and healthcare providers to assure a supply of healthcare workers to rural areas.
- Develop recommendations for assuring all Maine people have access to critical oral health services.
- Work to achieve an appropriately-developed, utilized and reimbursed telemedicine infrastructure that serves the best interest of patients.
- Develop an evidenced based tool kit for employers to use in implementing worksite wellness programs.

### **II. Assuring Best Practices/Less Variation in Care Delivery**

- Convene a group of stakeholders to study the over-utilization of emergency departments for non-emergent care and to identify potential cost savings and

strategies for developing new models of 24/7 care for non-emergency conditions.

- Decrease unwarranted variation in health care practice and utilization by intensifying the analysis and publication of data identifying the extent and nature of variation.
- Promote the utilization among Maine practitioners of practice standards that have achieved national consensus.
- Continue to educate and promote the treatment protocol for heart attacks defined in the "In a Heartbeat" initiative to reduce deaths by heart attack.
- Understand the needs of older adults, people with disabilities, and others who face health disparities to assure the availability of quality, cost-efficient care delivery systems.

### **III. Efficiency and Effectiveness**

- Increase the flow of Medicare dollars to Maine through advocacy for a wage index adjustment.
- Increase utilization of the Medicare hospice benefit by eliminating barriers to hospice use.
- Support patient service integration, quality improvement, and enhanced patient safety by supporting and advocating for utilization of interoperable electronic health information systems and a statewide health information exchange system.
- Refine and improve the State Health Plan's Certificate of Need (CON) criteria to: encourage efficient and coordinated use of healthcare and health services in the CON applicant's area; and guide DHHS in prioritizing CON approved projects within the Capital Investment Fund (CIF) limit.
- Evaluate the CIF to assure that the process and amount supports cost effective long term planning
- Complete a report that analyzes State claims data and identifies and quantifies specific cost drivers, to inform actions at the State, District and local levels.
- Identify strategies for improving, increasing, and coordinating Maine's health data analysis capacity to enable deeper cost and utilization analysis, and to improving abilities to address health disparities.
- Collaborate with Maine hospitals to monitor and publish Healthcare-Acquired Infections and promote infection prevention standards and practices.

It is unrealistic to hope these steps will result in Maine's fully achieving its goals in the next biennium. Meaningful and sustainable change takes time, energy, thoughtfulness, and commitment. What has been accomplished is worth celebrating. What will be accomplished is worth working for. Hope grounded in accomplishment will continue to fuel the work that lies ahead.

## Introduction

Dirigo Health Reform, enacted in 2003, provides a comprehensive approach to reduce costs, improve health, increase access to health coverage, and improve the quality of care we receive. It established as a priority the creation of a biannual plan (the State Health Plan) to improve the health of our state, and to make quality health coverage more affordable and accessible to all Maine citizens. The Dirigo reform set out a three part strategy – the most significant and least understood being a commitment to a more efficient, effective health system which will help make universal coverage possible in large measure by addressing affordability. Dirigo intends to make coverage more affordable by improving health and the quality of care of all Maine people; healthier people require less costly healthcare services.

Each biennium, the State Health Plan identifies initiatives that define how Maine will fulfill the intent of the Dirigo Health Reform.

The health of the people of Maine is inextricably integrated with the State's economic success, its environment and its quality of life. The 2006-07 State Health Plan set as its goal "to make Maine the healthiest state." Being the healthiest state requires everyone in Maine to have access to quality, affordable healthcare, information about health and health care, and a clean and healthy environment. The health of the population requires systems that work efficiently and effectively, systems that effectively address health disparities, and systems that support health and remediate illness and disease while providing the financing that properly incentivizes disease prevention and health maintenance.

In 2007 the Maine Legislature expanded the role of the Advisory Council on Health Systems Development (ACHSD) to conduct a cost driver study to help target the primary contributors to the increased cost of healthcare. As a result, the 2008-09 State Health Plan includes the goal "to have a cost-effective, efficient and high-performing health system." While many issues influence Maine's ability to achieve healthiest state status – environmental quality, economic opportunity, education, for example – the ACSHD in keeping with its legislative mandate has focused on the issues identified in the cost driver study. The ACHSD believes that the two goals – healthiest state and cost-efficient, effective, and high-performing health system – can be achieved by supporting initiatives that promote health, enhance appropriate utilization of healthcare, and reduce system inefficiencies. The State Health Plan supports these goals by:

- Providing a comprehensive look at the many efforts in progress around the State to improve Maine's health and healthcare delivery system.
- Assuring health and healthcare initiatives that are value added and not duplicative.
- Enhancing shared information and analysis.

- Identifying the key barriers to improved health and healthcare delivery.
- Maximizing resources.
- Holding those responsible for improving Maine’s health status accountable for results.
- Informing the Governor, Legislature, and the public of the status of Maine’s health system and any actions needed to move Maine toward the goal of healthiest state.
- Assuring that there is public input into the State Health Plan.
- Focusing on elimination of health disparities.

The goals are lofty, and the challenge is great. As indicated in the chart below Maine has socio-economic factors that present difficult, though not insurmountable challenges.

**Socioeconomic and Demographic Factors: Maine vs US**

	people per square mile	Median Household Income (2004)	% <HS Education (2000)	% families In poverty (2004)	% Adults With a Disability (2006)	Age >65 (2006)
Maine	41.3 (2006)	\$41,287	14.6	11.3	23.8	14.6
U.S.	79.6 (2000)	\$ 44,334	9.4	11.5	15.1	12.4

\*See appendix II for demographic and health status information by Maine public health districts

However, it is because of Maine’s socio-economic challenges that it is especially important that healthcare be made more affordable. Maine must reduce the financial burden of healthcare costs on consumers, tax payers, and employers. The Cost Driver study released in October 2007 reports on the extent that Maine’s per capita healthcare costs exceed those of the US and other New England states. Maine is therefore particularly challenged to meet the healthcare needs of its population while not burdening it with an unaffordable healthcare bill. Access to healthcare is primarily a factor of costs. If costs prevent consumers from getting the health and healthcare services they need, Maine’s goal of healthiest state will remain unachievable.

As ACHSD, supported by the Governor’s Office on Health Policy and Finance (GOHPF), has gathered and analyzed data over the past two years, it has become clear that Maine has efficiencies to be gained in its healthcare delivery system that will enhance quality and access by shifting from disease treatment to disease prevention and health maintenance. These goals will be pursued with the full participation of the public and the many groups currently involved in improving our health and healthcare delivery systems. Health is ultimately less costly than disease. Being the healthiest state is our goal; doing it within our resources is our challenge. We will ask all stakeholders private and public to continue their hard work and to remain thoughtful, innovative and willing to step beyond their particular interests to assume responsibility for the health of the whole system.

## **Connecting the Consumer With Health & Healthcare Information**

The 2008-09 State Health Plan recognizes that health and healthcare is inherently a personal matter -- it starts with the active engagement of individuals, families and communities in partnership with health and healthcare providers. We individually make decisions that influence our health status – what we eat, what we do for activity, how we relate to our environment – and how we work with our healthcare providers to make decisions that effect our health. Consumers' behavior and access to affordable healthcare strongly influences our ability to get healthy and stay healthy, and consumers' making the right health and health care choices is essential to creating a healthy state.

Consumers are vital stakeholders in the deliberations to reform health delivery systems. They are ultimately the payors of healthcare, whether through insurance premiums, personal payment, lower wages, taxes, or the price of goods and services that they buy. The State Health Plan encourages all groups engaged in collaborative health reform efforts to assure that they include meaningful participation of consumers.

To participate effectively in our own health and healthcare, consumers need information. Health literacy is a key to a healthy population, and without good, open information we cannot expect consumers to partner effectively in their health and healthcare. We don't expect consumers to have a home built without knowing the cost of materials and labor, the qualifications of the builders and what the house will look like. We should not expect them to buy healthcare or prevention services without knowing the quality, costs and predicted outcomes.

And while the ACSHD believes that informed Maine consumers will be healthier and wiser purchasers of healthcare services, it also recognizes that consumers must not be expected to navigate health care alone – providers, payers and government have critical roles in protecting and informing consumers. Because health literacy is so important and involves the efforts of so many, over the next biennium the ASCHSD will begin cataloguing health literacy efforts currently being undertaken by different groups around the state, with the possibility of developing measures of health literacy, so that we can assess progress in increasing health literacy over time.

The 2008-09 State Health Plan includes this consumer section to encourage the role and responsibility of individuals in making Maine the healthiest state by identifying the information available to support our ability to make wise health and healthcare decisions. Several Maine groups and organizations have made efforts to reach out to the public with information that will help us to become better health consumers. Below are some of the web sites that consumers can

access directly to answer questions about the quality and costs of healthcare in Maine. The ACHSD encourages consumers to use these web sites and give feedback to the sponsoring organizations on how they meet or do not meet information needs and to suggest additional information that would be helpful.

Making Informed Health and Healthcare Decisions: Where to find what you want to know:

**Maine Health Management Coalition [www.mhmc.info](http://www.mhmc.info)**

- How do I know if the provider I want to go to gives quality care?
- How can I make a good choice in my primary care physician?
- How will I know if I'm getting the best care?

**Consumers for Affordable Health Care  
([www.maineahc.org/healthcare/default.htm](http://www.maineahc.org/healthcare/default.htm))**

- What are my options for health coverage?
- How can I get access to the health care services or prescriptions I need?
- What programs might I qualify for to help pay for health care or health coverage?
- What are my rights and how do I navigate through private health insurance or public health care assistance programs?
- How do I resolve a dispute with my private health insurance company or a public health care assistance program?
- Who do I call for other questions related to health coverage or health care?

**Maine Health Data Organization ([www.mhdo.maine.gov/imhdo](http://www.mhdo.maine.gov/imhdo))**

- How much will I likely need to pay for different services at different providers (available fall 2008)

**Maine Quality Forum – Dirigo Health Agency  
([www.mainequalityforum.gov](http://www.mainequalityforum.gov))**

- Where do I get information about my health? What are my health risk factors? How do I manage my chronic illness?
- How do I make a choice about what doctor or hospital I will use?
- How do I stay safe when I'm a patient in a hospital?
- What difference in treatment can I expect from healthcare providers based on where I live in Maine?

**Maine Department of Health and Human Services  
([www.maine.gov/dhhs](http://www.maine.gov/dhhs))**

- What services or programs are available to help my teenager? Elder parent? Child?



**Maine Center for Disease Control and Prevention (Maine CDC/DHHS)  
([www.mainepublichealth.org](http://www.mainepublichealth.org))**

- What is available in Maine to help me manage my chronic illness?
- Is there an influenza outbreak in Maine?
- How do I get information on my specific condition/illness?
- How do I get my drinking water tested and other environmental public health information?

**Maine Bureau of Insurance  
([www.maine.gov/pfr/insurance/index.shtml](http://www.maine.gov/pfr/insurance/index.shtml))**

- How can I find out which companies sell health insurance to Mainers? How can I choose among those companies?
- How do I find out about Medicare supplement (or Medigap) policies?
- What can I do if I lose the insurance I've had through my employer?
- How do I get help if I'm having a problem with my health insurance company?
- How can I get financial information about insurance companies doing business in Maine (e.g., total premium collected annually, amount of premiums going towards claims, administration, profit)?



## Chapter I – What is driving Maine’s health care costs? What We’ve Learned

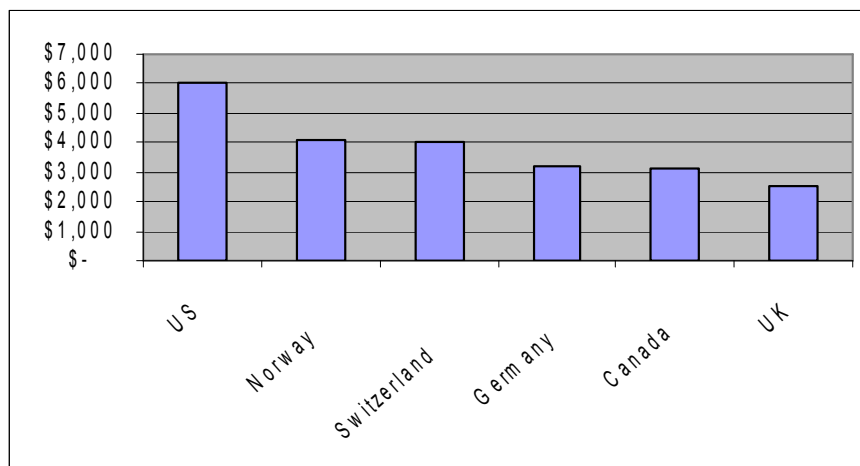
The ACHSD conducted an extensive review of available data, compiled in the “ACHSD Data Book: Investigating Maine’s Health Care Cost Drivers,” available at [www.maine.gov/governor/baldacci/cabinet/health\\_policy.html](http://www.maine.gov/governor/baldacci/cabinet/health_policy.html)

The Data Book summarizes existing, available information and has been reviewed in public forums, by expert panels representing providers, consumers, businesses, other payers and represents a summary of the best available data. However, it is clear that while this data shows a pathway to address costs, many questions remain unanswered and require further analysis. The discussion below summarizes key findings to date.

### Findings

Maine’s health care cost crisis reflects national and regional trends and must be understood within that context. Today, the United States spends almost twice as much on health care as other industrialized nations.<sup>1</sup> Despite higher costs, the United States does not deliver objectively better quality and access for US citizens as a whole relative to peer countries.<sup>2</sup> In addition, we leave 47 million people – 18% of the US’s under-65 population – uninsured. According to a recent report by the McKinsey Global Inc., “Accounting for the Cost of Health Care in the United States” (2007), the United States could save \$477 billion a year in health care spending if we embrace some of the efficiency from other peer nations.

### 2004 Spending by Other Nations (Per Capita)



<sup>1</sup> Thorpe in Health Affairs 10/2/07 citing OECD data.

<sup>2</sup> McKinsey Global Institute “Accounting for the Cost of Health Care in the United States”2007

In comparing the United States with other developed nations McKinsey concludes that in the United States there is:

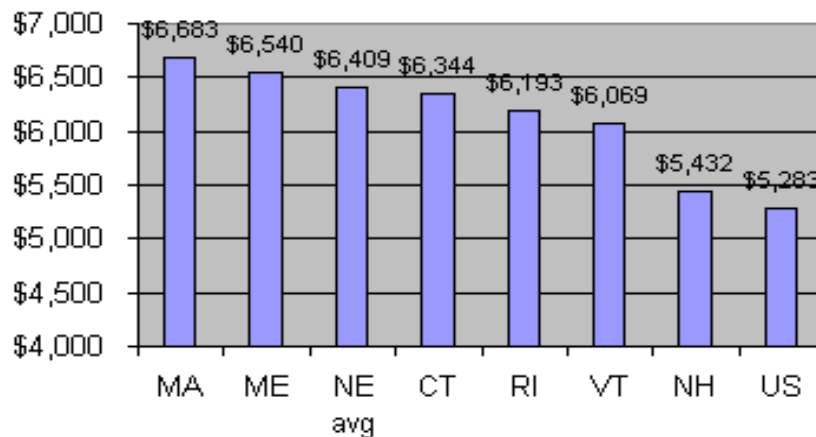
- Excess capacity – for example, we use fewer in-patient beds but the cost for each bed day is 4X peer nations;
- More surgery but with no better outcomes; and
- Over-supply of technology – 3 to 6 times more scanners and 30-40% of imaging is inappropriate or non-contributory.

In addition, McKinsey points out the United States:

- Has administrative costs that are higher, reflecting our market based system and desire for choice;
- Pays physicians higher;
- Uses nurses differently; and
- Uses 20% fewer prescription drugs but pays 60% more for them largely because we neither set nor negotiate prices.

While the United States spends twice what peer nations spend and fails to cover all our citizens, or achieve better health and quality for the investment, New England states spend even more than the U.S. average. Only a small portion of Maine's higher spending is attributable to having an older population. Specifically, Maine's per capita spending of \$6,540 is 24% higher than the US spending of \$5,283, but only 9% of that difference is attributable to Maine's being older.<sup>3</sup> Further, Maine's per capita spending is higher than the national average even when states' Medicaid enrollment is excluded.<sup>4</sup>

### 2004 Per Capita Health Care Spending



Source: US Centers for Medicare and Medicaid Services

<sup>3</sup> See appendix VI.

<sup>4</sup> See page 14 of the ACHSD Data Book.

Health – and therefore health care spending – is influenced by economic status. As seen in the below Mainers’ income is lower and health status poorer than national rates. Among New England states Maine has the lowest median household income, and fewer of our citizens report excellent or very good health than in all other New England states.

**Socioeconomic and Demographic Factors: Maine vs US**

	Median Household Income (2004)	% Adults With a Disability (2006)
<b>Maine</b>	\$41,287	23.8
<b>U.S.</b>	\$ 44,334	15.1

\*See appendix II for detailed demographic and health status information by Maine public health districts

As is true across the country, chronic illness is a cost driver. Researchers have shown that 15 of the most common clinical conditions accounted for 56% of the increase in health care spending in the United States between 1987 and 2000. This research also provides a method to determine the components of that spending – how much is due to: more underlying disease in the population; our growing ability to diagnose and treat disease; the growing cost of treatment; and growth in the population.<sup>5</sup>

Applying this same methodology to Maine’s growth in health care spending from 1998 to 2005, and adjusting for the fact that Maine’s population has grown more slowly than that of the nation as a whole, it follows that nearly 37% or \$1.2 billion of Maine’s increase in health spending from 1998 to 2005 is attributable to leading chronic illnesses that are often preventable: cardiovascular disease, cancer, chronic lung disease and diabetes (see table).

increase in Maine health care spending 1998-2005, by driving factor (bil)	portion of total increase attributable to this condition		portion of this increase attributable to:					
			increases in the cost of treatment		increases in the diagnosis and treatment of the condition		increased population	
<b>heart disease</b>	8.1%	\$0.26	83%	\$0.22	1%	\$0.004	16%	\$0.04
<b>pulmonary conditions</b>	5.6%	\$0.18	42%	\$0.08	47%	\$0.09	11%	\$0.02
<b>mental disorders</b>	7.4%	\$0.24	24%	\$0.06	66%	\$0.16	10%	\$0.02
<b>cancer</b>	5.4%	\$0.18	51%	\$0.09	33%	\$0.06	16%	\$0.03
<b>hypertension</b>	4.2%	\$0.14	67%	\$0.09	21%	\$0.03	11%	\$0.02
<b>cerebrovascular disease</b>	3.5%	\$0.12	23%	\$0.03	67%	\$0.08	10%	\$0.01
<b>diabetes</b>	2.4%	\$0.08	28%	\$0.02	58%	\$0.04	14%	\$0.01
<b>total</b>	36.6%	\$1.201	49%	\$0.585	38%	\$0.462	13%	\$0.154

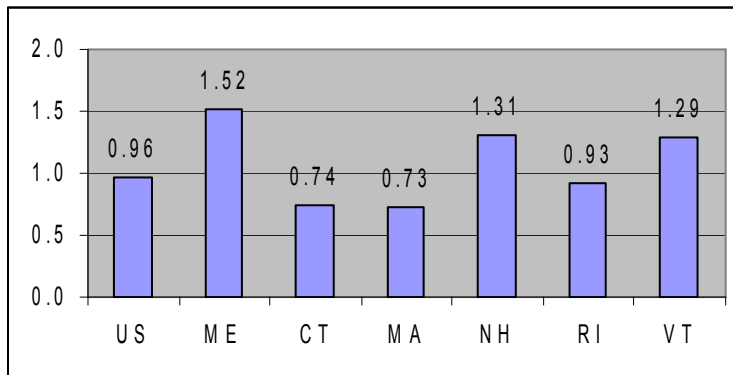
<sup>5</sup>Thorpe (“Which Medical Conditions Account For the Rise in Health Care Spending?” Health Affairs Web Exclusive. August 25, 2004. [www.healthaffairs.org](http://www.healthaffairs.org)).

Appendix II shows that there is considerable room for improvement in Maine's rate of these and other health conditions, and thus room for considerable cost reductions.

### ***How is Maine different from the U.S. and New England?***

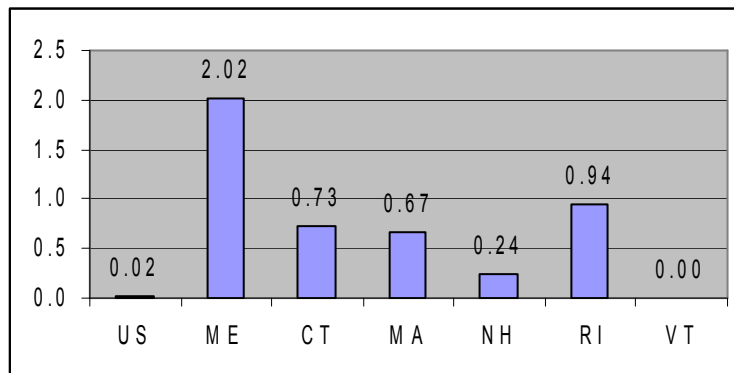
**Supply of technology** - Per population, Maine has more hospital-based MRIs than other New England states. However, there are also free-standing MRIs, but recent data on how Maine compares to other states is not available. The most recent publicly available data on non-hospital MRIs (from 2001) showed that Maine had significantly more freestanding MRIs than the nation and the rest of New England.

2005 Minimum Hospital-Based MRIs per 100,000



**Source:** 2005 minimum hospital-based MRIs per 100,000 computed by dividing the number of hospitals that responded to the AHA annual survey that they had at least one hospital-based MRI by state population. We say "minimum" because actual number could be higher because some hospitals might have more than one MRI, but this is not captured in the survey.

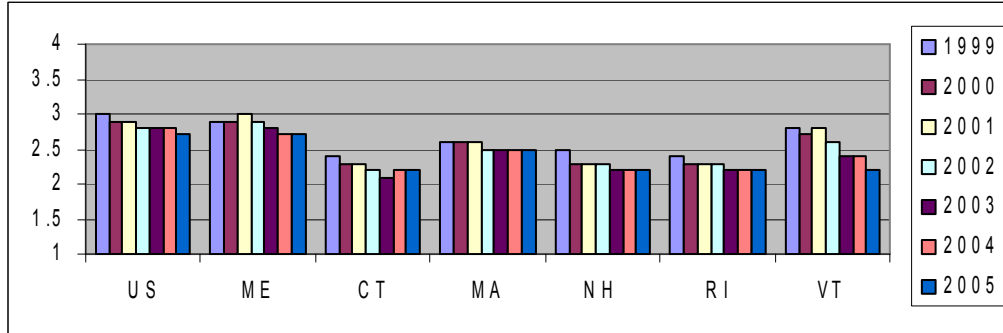
2001 Freestanding MRIs per 100,000



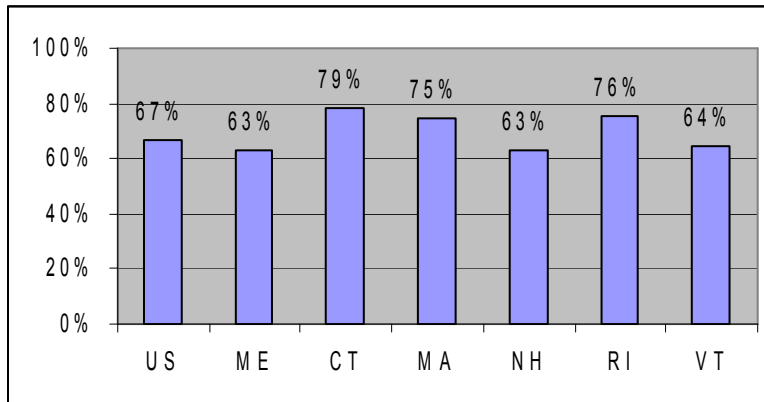
**Source:** 2001 data from [www. content.healthaffairs.org/cgi/reprint/hlthaff.w3.537v1.pdf](http://www.content.healthaffairs.org/cgi/reprint/hlthaff.w3.537v1.pdf).

**Hospital bed supply<sup>6</sup>** - Maine has more beds per capita than the other New England states even during a period of conversion to critical access hospitals, and our occupancy rates – along with Vermont’s and New Hampshire – are lower than the southern New England states.

Staffed Beds per 1,000 Population, 1999-2005



Average Daily Occupancy, 2004



Occupancy rates computed using statewide annual average daily census divided by staffed beds, both as reported by hospitals on American Hospital Association annual survey and therefore does not reflect seasonal fluctuations.

**Physician and Other provider Supply<sup>7</sup>** - New England exceeds U.S. averages on available physicians, but Maine has fewer specialty physicians and primary care physicians than every New England state except New Hampshire. The issue of physician shortages is a national discussion from which Maine is not immune. In Maine, the Maine Medical Association reports significant recruiting challenges and distribution issues that result in underserved rural areas and notes the changing expectations and employment patterns of physicians creates more need for additional workforce. For some specialties, the issue is more

<sup>6</sup> [www.statehealthfacts.kff.org](http://www.statehealthfacts.kff.org)

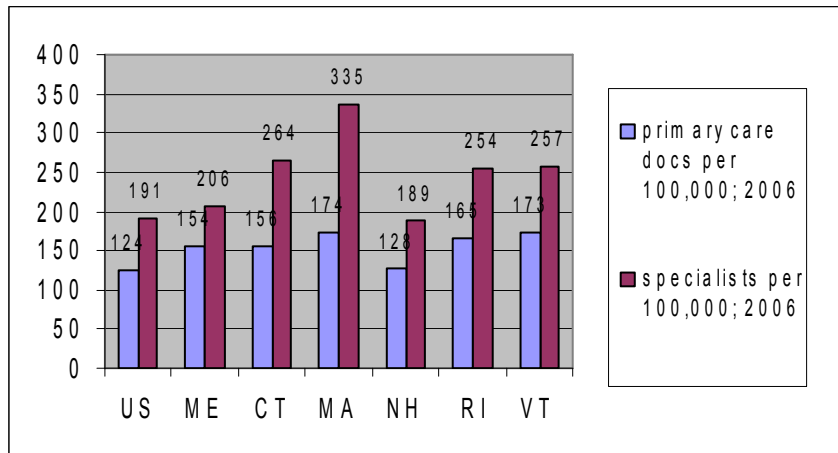
<sup>7</sup> Unless otherwise noted, all data from [www.statehealthfacts.kff.org](http://www.statehealthfacts.kff.org).

exacerbated. Notably, one in three surgeons in Maine is over the age of 60, according to the Maine Department of Labor's 2006 Healthcare Occupations Report.

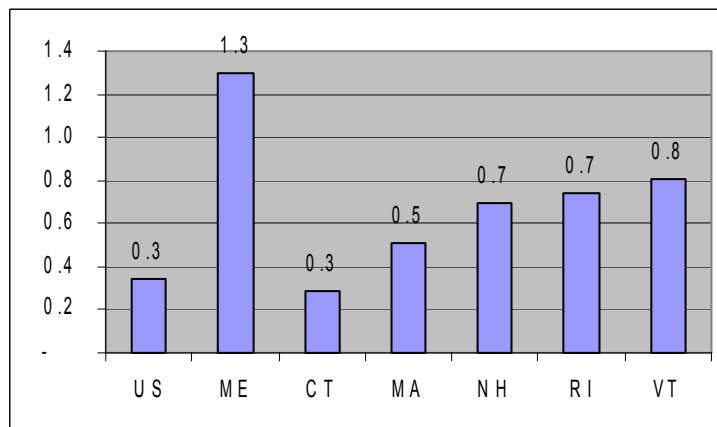
That same report notes that demand for physician services may be tempered by patients relying more on providers such as nurse practitioners and physician assistants and that new technology will increase physician productivity.

Maine has more federally qualified health centers and rural health centers than other New England states, and ranks 2<sup>nd</sup> and 1<sup>st</sup> in New England in the penetration of nurses and physicians assistants, respectively, only one state has fewer nurse practitioners than Maine.

Physicians per 100,000; 2006



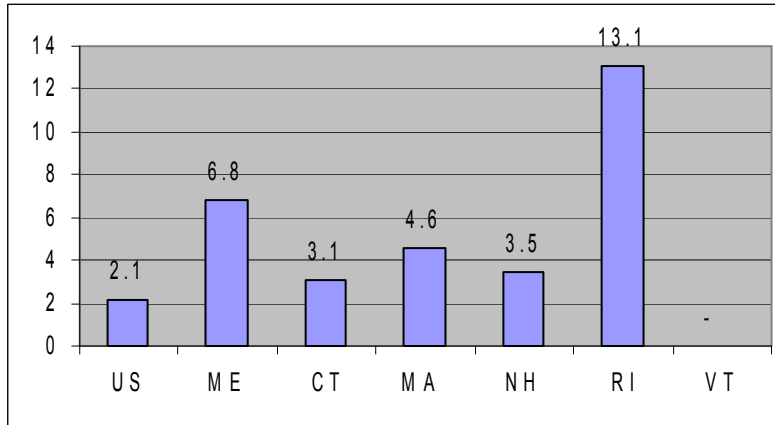
Number of Federally-Funded Federally Qualified Health Centers<sup>8</sup> per 100,000, 2006



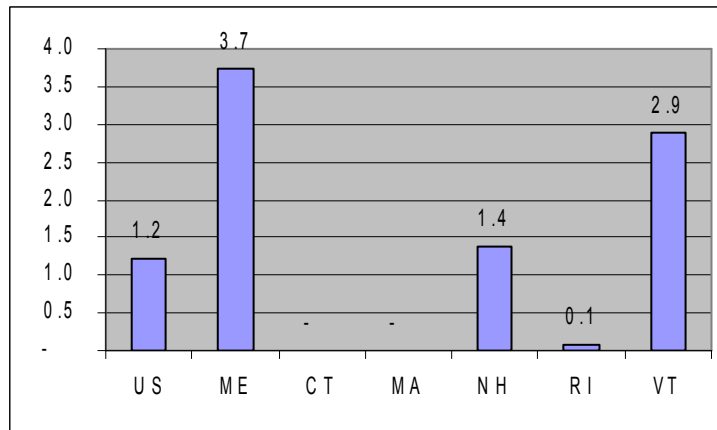
<sup>8</sup> See glossary



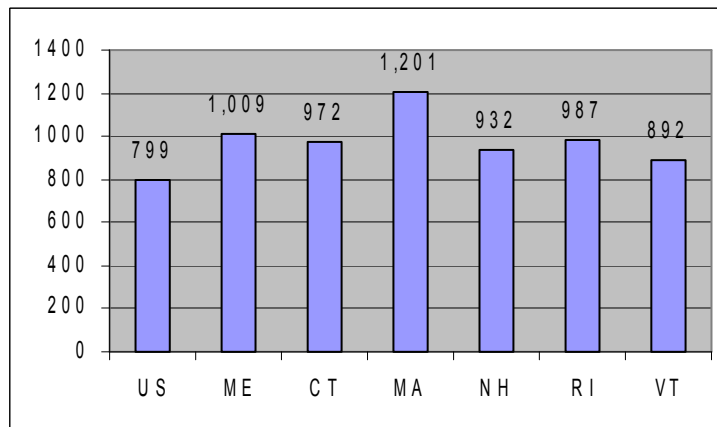
Service Delivery Sites per 100,000 Operated by Federally-Funded FQHCs, 2006



Rural Health Clinics<sup>9</sup> per 100,000, 2004

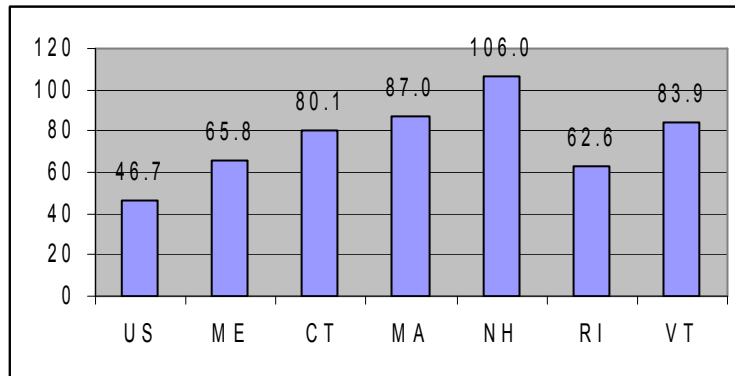


Registered Nurses per 100,000, May 2005

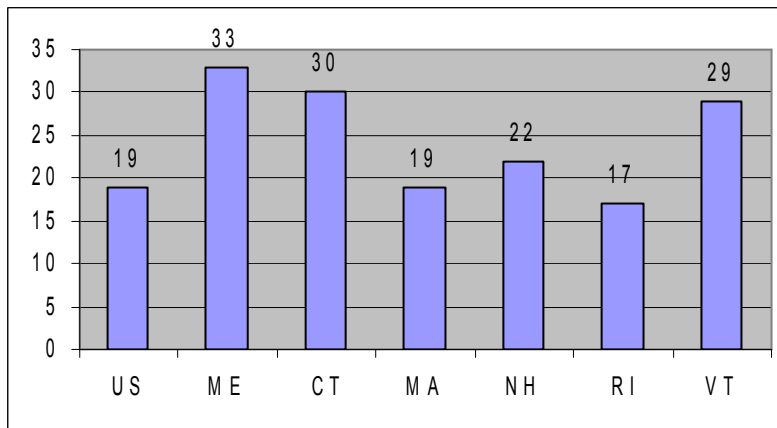


<sup>9</sup> See glossary.

Nurses Practitioners per 100,000, 2007<sup>10</sup>

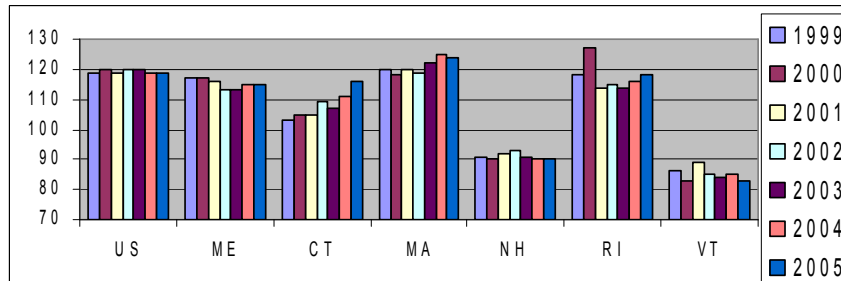


Projected Physicians Assistants per 100,000 in Clinical Practice, Jan 1, 2005



**Utilization<sup>11</sup>** - Maine's inpatient utilization is slightly lower than the national average but considerably higher than New Hampshire's and Vermont's. Maine's rates of out-patient visits and emergency room use are considerably higher than both national and New England-wide rates.

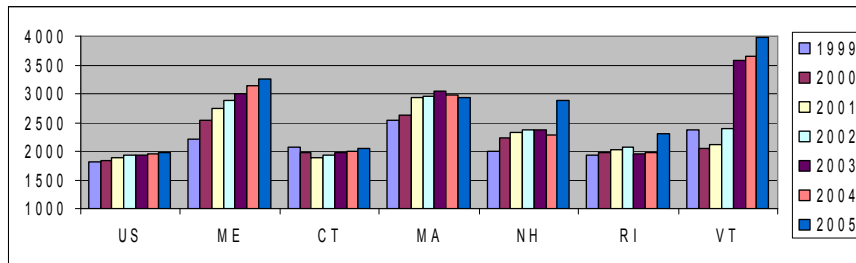
Inpatient Visits per 1,000 Population, 1999-2005



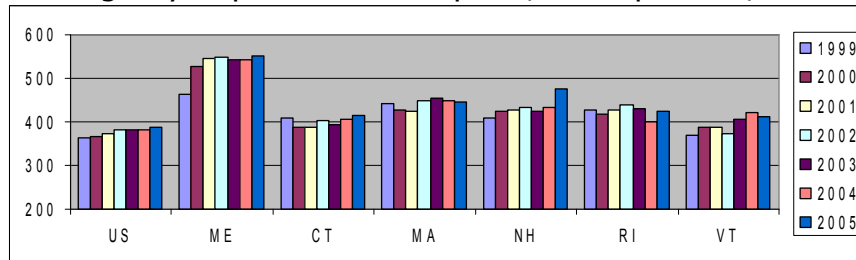
<sup>10</sup> Pearson MSN, DNSc, APRN, BC, FAANP, Linda J, "The Pearson Report" The American Journal For Nurse Practitioners, Vol. 12, No.2, February 2008.

<sup>11</sup> [www.statehealthfacts.kff.org](http://www.statehealthfacts.kff.org)

## Outpatient Visits per 1,000 Population, 1999-2005<sup>12</sup>



## Emergency Department Visits per 1,000 Population, 1999-2005



### ***Variation in how care is delivered***

Not getting the right care at the right place at the right time.

Nationally, we only get the right care half of the time.<sup>13</sup> We under-use effective, inexpensive preventive care and over-use ineffective and expensive care. As McKinsey noted, the United States does far more surgery but with the same outcomes as those nations that use less surgery.

There is considerable variation in how care is delivered. Medicine is practiced differently across the State. Even when there is significant evidence to support “best practice” it may not be practiced in every physician’s office in our State.

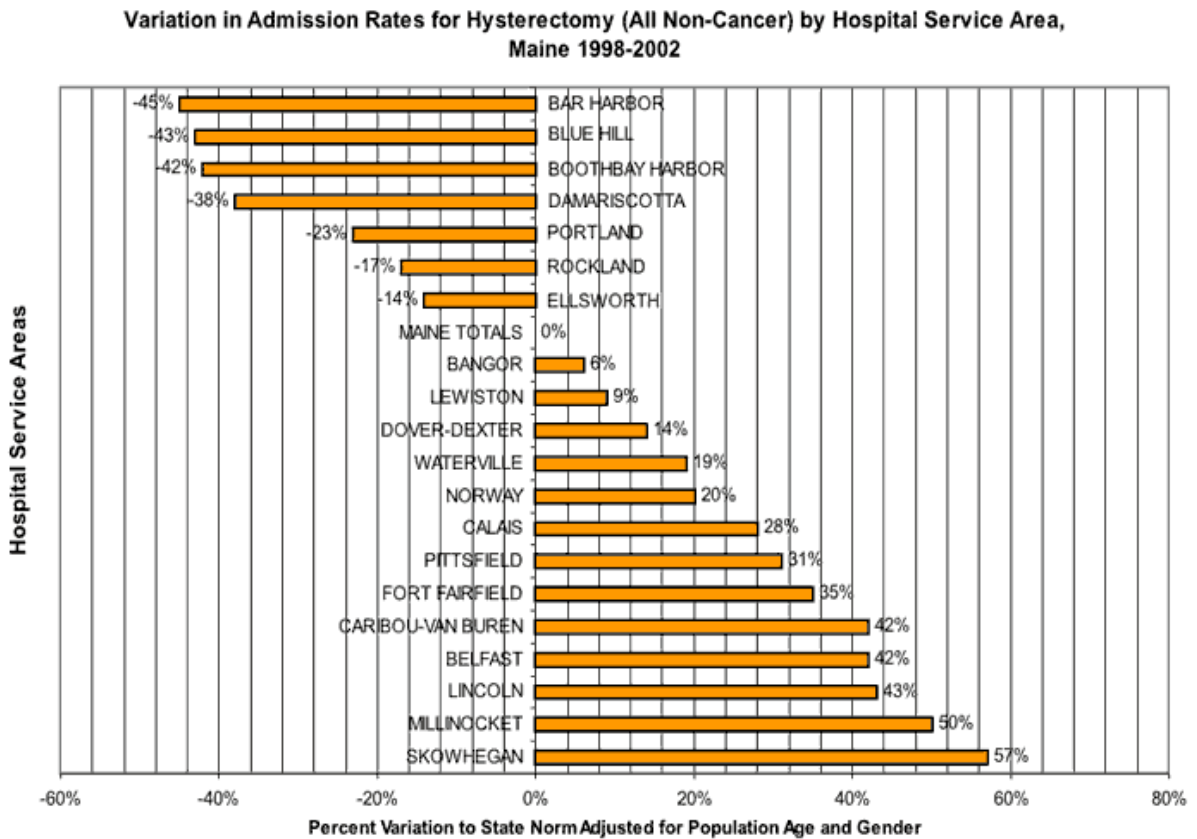
Data available at the Maine Quality Forum website ([www.mainequalityforum.gov](http://www.mainequalityforum.gov)) shows how significant the problem of variation is in Maine.

<sup>12</sup> We have inquired with the Vermont Association of Hospitals and Health Systems regarding possible causes for Vermont’s jump from 2002-2003. VAHHS speculated that there might be an error in the data or some a definitional change in what Vermont hospitals were reporting, since there were no infrastructure or other changes that would have caused such a marked increase. Given that Vermont’s inpatient and emergency department utilization rates are comparable to the rest of New England, VAHHS believes it is likely that Vermont’s outpatient utilization during the 2003-2005 period is considerably lower than shown in the chart.

<sup>13</sup> 2004 RAND study (McGlynn): only about half the care we receive is care we should receive based on accepted best practices (the exact percentage depends on the health condition).

The chart below identifies regions of the state where people live and shows what happens to people when they need care. Note: the communities identified are regions where people live; it is not necessarily so that the care provided is in those communities.

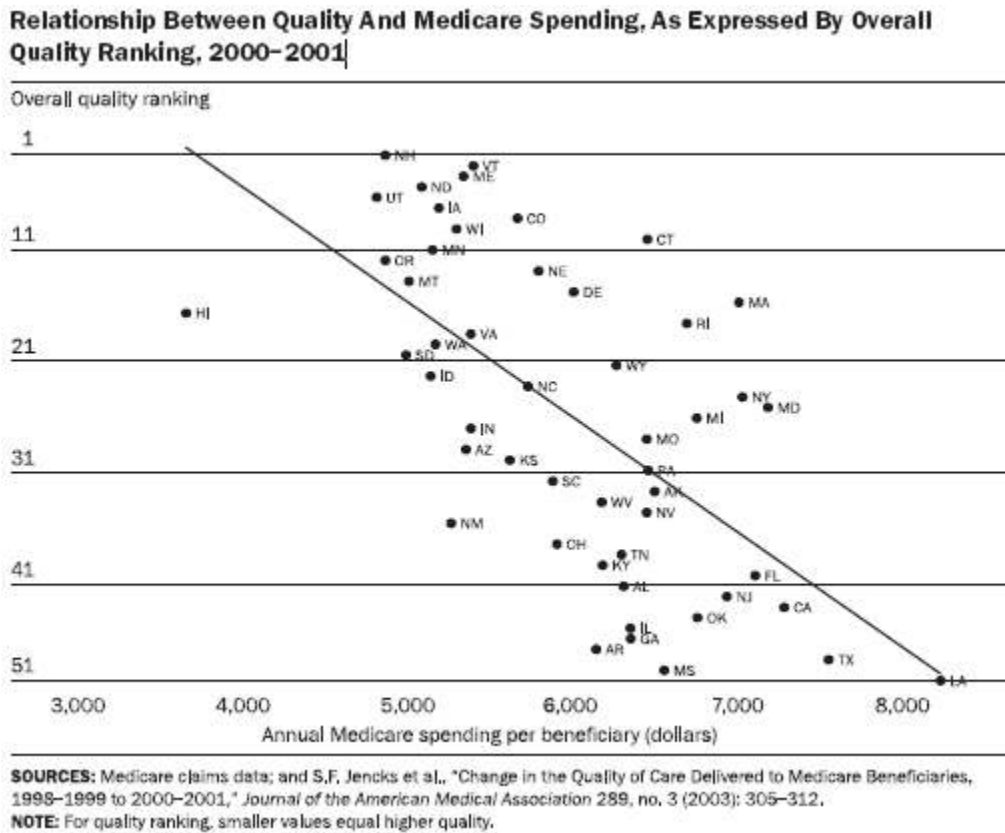
In this example, the data has been adjusted so that we are following the same woman with the same symptoms and see that she is treated differently depending on where she lives. Again, this is not necessarily the hospital in her community but where she resides. In the communities on the left side of that chart she is treated medically; on the right side she has a hysterectomy – a 3-fold difference in how care is delivered to the same person with the same symptoms.



That kind of variation is found throughout the State for a range of specialty services. Frequently, standards of best practice can identify what is appropriate practice.

More spending and utilization does not result in either higher quality or better health. The chart below, for example, shows that higher spending (and thus higher utilization) states rank lower on quality (bottom right of chart), while lower spending (and thus lower utilization) states rank higher on quality (upper

right of chart).<sup>14</sup> Importantly, severity of illness does not drive the differences in the chart. That means that costs could be reduced without any decrease in outcomes.



### ***Variation in cost of care (Inefficiency)***

Even if we succeed in assuring that all inappropriate variation in practice is eliminated, those people who do require hospital care will see significant variation in what care costs. (Limits in available data and transparency make it hard to identify costs in all health sectors. Hospital data does allow comparisons of hospital efficiency.)

The chart below shows the cost of treating the average, identical patient at each Maine hospital. The 'cost per adjusted discharge' shown in the chart is calculated by dividing the hospital's total operating budget by the number of patients it sees in a year. It includes adjustments to show the cost of treating the same person with the same illness at each of Maine's hospitals. The chart shows actual costs of care and does not reflect difference in payment.

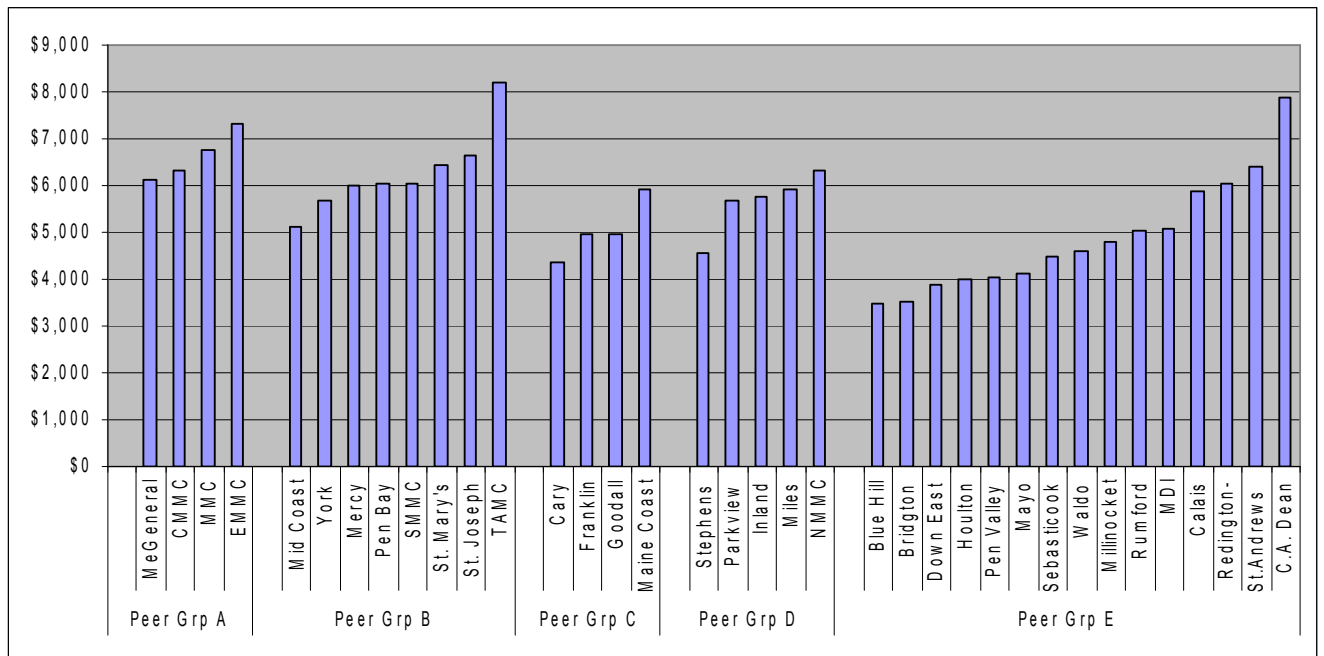
<sup>14</sup> <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.184v1.pdf>

In the chart, hospitals are grouped by peer groups, identified by the Maine Hospital Association, to reflect similar hospitals. Peer Group E, for example, includes all the critical access hospitals which are short stay, limited service facilities.

The charts show that – even when hospitals are grouped by similarity – costs vary significantly for the same person with the same illness and the same treatment. Importantly, there is no correlation between quality and cost here – higher quality hospitals (using the State Employee Health Plan’s preferred hospital list, which was created using Maine Health Management Coalition’s quality measures) are found among the most and least efficient facilities.

To illustrate the effect of such variation on health care spending, if each hospital that was above its peer group's median cost per discharge had lowered its budget so that its cost per discharge were equal to the peer median, statewide operating expenses in 2006 would have been \$102 million (5%) less than they actually were.

### Variation in Maine Hospital Efficiency, 2006



2006 Cost Per Case-Mix- and Outpatient-Volume Adjusted Discharge calculated by Schramm-Raleigh using Hospitals' Medicare Cost Report Data, Following Maine Hospital Assoc. Methodology

## ***Cost versus price***

What it costs – that is, what the provider spends when caring for patients as identified in the chart above – isn't what you'll pay. There are two primary reasons why:

- Providers need reserves and operating margins -- for example to fund future needs;
- Cost-shifting – when someone doesn't pay or pays less, others pay more;
  - Bad debt and free care; and
  - Medicaid and Medicare payments.

## ***Cost shifting***

Much has been made of cost-shifting as the reason for high private premium growth. As the preceding charts show, health care costs are driven more by medical claims and the underlying cost of health care. But the issue of cost-shifting is real. Specifically, cost shifting in Maine exacerbates our cost problem by shifting the burden of the cost of high utilization of health services to a smaller base. When those without resources need and receive care they cannot afford or when government pays less than private payors for their share of the costs, these costs are added to the price paid by those with private insurance. This drives premiums even higher.

### Bad Debt and Free Care

When an uninsured or underinsured individual needs care and is unable to pay, the cost of that care is shifted in higher costs to those who pay premiums.

- Bad debt and free care decreased from 5% of charges in 1999 to 3.5% in 2004 but there has been an increase in the last two years to 3.9% in 2006 (Source: Hospital audited financial statements).
- Free care eligibility limits have changed from an average of 130% of poverty (\$11,674) in 2003 to 188% of poverty in March 2007 (\$19,195).
- Increasing bad debt may reflect growing out-of-pocket costs (e.g.; high deductibles) to families and individuals who have private coverage.

## Public Payors

Hospitals rely on public payors for much of their revenue.

### Hospital payor mix (charges, 2005)

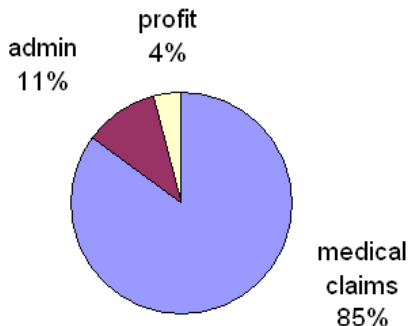
Medicare	Medicaid	Self-Pay	Other – (private & other federal)
43%	15%	5%	37%

Medicare's per enrollee health spending in Maine is lowest in New England (\$6,015 ME vs \$7,592 NE).<sup>15</sup> Some of that is due to payment and some is due to utilization:

- Utilization: even though Maine's Medicare enrollees' health status is similar to the nations, Maine's Medicare enrollees use less in-patient and out-patient care than national averages.<sup>16</sup>
- Payment: According to the Maine Hospital Association, Medicare pays Maine hospitals only 89¢ on the dollar.<sup>17</sup> Medicare underpayment is due in part, according to the Maine Hospital Association (MHA), to Medicare's failure to properly adjust its payments to Maine hospitals to reflect wages paid in Maine. By law, Medicaid cannot exceed Medicare rates.

## ***What's the best way to make health care more affordable?***

The chart below shows how your premium dollar is spent. Of the \$1.423 billion in premium collected by the largest insurers in Maine in 2006, 4% (\$53 million) went towards insurers' profit, 11% (\$158 million) went towards administrative costs, and 85% (\$1.212 bil) went to pay claims. Therefore, the most effective way to bring down the high rate of growth in premiums is to reduce medical claims.



Source: Insurance companies' 2006 945 filings with BOI

<sup>15</sup> CMS Office of Actuary

<sup>16</sup> [www.dartmouthatlas.org](http://www.dartmouthatlas.org)

<sup>17</sup> DataGen Medicare Margins Analysis forwarded by MHA to GOHPF, 3/26/2008.



Medical claims can be reduced by:

- Better health through improved prevention, early detection, effective treatment, and rehabilitation of chronic health conditions. For example, the CDC's, "An Ounce of Prevention....What are the Returns Report" outlines 19 strategies and demonstrates how spending money to prevent disease and injury and promote healthy lifestyles makes good economic sense. According to the CDC, some childhood vaccines, for example, save up to \$29 in direct medical costs for each dollar spent.<sup>18</sup> And a recent review of health promotion and disease management programs found a significant return on investment for these programs, with returns ranging from \$1.49 to \$4.91 for each dollar spent.<sup>19</sup>
- Assuring best practice and less variation in how care is delivered.
- Assuring that our health care system is as efficient and effective as it can be so costs are as low as they can be.

This State Health Plan is a two year plan focused on these and other key cost drivers and is designed to highlight certain actionable activities where progress can be made and measured. It is, therefore, limited and focused, but it also supports all the other excellent work underway in Maine to meet the Plan's broad goals to make Maine the healthiest state with an efficient and effective delivery system. The 2008-2009 Plan proposes several key strategies to address the cost drivers identified through our work. They are:

### **Improving Health**

- Streamlining Public Health Infrastructure
- Patient Centered Care
  - Patient Centered Medical Home
  - Coordination of Public & Behavioral Health
  - Other Maine-based Integration Initiatives
- Worksite Wellness
- Access to Coverage for the Un & Underinsured
- Oral Health – Prevention & Access
- Rural Health and Telemedicine – Healthcare access in rural areas
- Possible Role for FQHCs in Providing Veterans' Care

### **Assuring Best Practices/ Less Variation in Care Delivery**

- Emergency Department Over-Utilization
- Reducing Variation in Medical Practice

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<sup>18</sup> US Centers for Disease Control and Prevention "An Ounce of Prevention....What are the Returns," October 1999.

<sup>19</sup> US DHHS, "Prevention Makes Common "Cents," September 2003 citing info on employee wellness programs obtained from [www.healthproject.stanford.edu/koop](http://www.healthproject.stanford.edu/koop).

- Prototypes for Evidence Based Medicine – In-A-Heartbeat and Stroke Systems of Care
- Right Care, Right Place for the Elderly & Disabled

**Efficiency & Effectiveness**

- Medicare Equity Project
  - Hospital Reimbursement
  - Medicare Hospice Benefit
- Electronic Health Information
- Using Data to Enhance Performance
  - Deepening the Analysis of Maine’s Healthcare Cost Drivers
  - Coordinating Maine’s Research & Analysis Capacity
- Patient Safety
  - Healthcare Acquired Infections
  - Sentinel Event Reporting
  - CAH Collaborative
- Certificate of Need and the Capital Investment Fund

## **Chapter II – Responding to the Cost Drivers**

Maine can be proud of the work that has been accomplished by the many stakeholders engaged in finding solutions to the health and healthcare problems in Maine, but it can't be satisfied. Much of the first work of any complex change effort is developing a deep enough understanding of the issues to enable effective and sustainable solutions to be designed and implemented. Although becoming the healthiest state with an efficient, effective and high-performing health delivery system is a long term process, we expect that the framework and understanding developed from the 2006-07 Plan and the 2007 Cost Driver study will begin to deliver measurable results during the 2008-09 biennium.

This chapter outlines the deliverables that the many stakeholders have committed to in the 2008-09 State Health Plan. Their efforts will be focused on the cost drivers that have been identified as having a major influence on the high cost of healthcare in Maine. Some cost drivers require deeper study before specific solutions can be recommended, e.g. variation in provider efficiency. Others -- e.g. the Patient Centered Medical Home -- are being piloted. However, we expect that in this biennium consumers, providers, payers will begin to experience some of the benefits of the improvements in Maine's health and health care delivery system. The ACHSD will continue to hold the many stakeholders accountable for measuring and reporting the outcomes identified in this chapter.

### ***I. Improving Health***

#### **A. Public Health Infrastructure – Build Local Capacity for Change by Bringing Health Information & Support to Maine Communities**

With Maine's health care spending the second highest in the nation fueled in part by high rates of preventable chronic illness, one of the major goals of the 2006-07 State Health Plan was to increase prevention activities to improve health and assure early detection, treatment and rehabilitation of chronic conditions by building an efficient and effective statewide public health infrastructure. Accordingly, the 2008-09 State Health Plan relies upon this new infrastructure to continue the crucial work of prevention, early detection, treatment, and rehabilitation of chronic conditions. The Plan is supportive of the Fund for Healthy Maine as a means to continue efforts in prevention, public health, and access to healthcare, essential to making Maine the healthiest state.

Because improving health status and reducing health disparities requires local action between providers and patients, informing and empowering consumers and supporting healthy behavior options, the Plan created the Public Health Work Group to build a public health infrastructure that will bring information, education and support to the local and regional level through Public Health Districts and Healthy Maine Partnerships including private sector efforts within the public health districts, so that we may build upon Maine's successes in addressing such issues as preventing youth smoking, teen pregnancy, and infant mortality.

As detailed in Appendix I the Public Health Work Group has completed its planning work. The next step is implementation of a public health system that engages and supports local and regional groups in the development and implementation of strategies that will increase the effectiveness of prevention efforts and improve Maine's health status and reduce health disparities.

The new infrastructure is designed to enhance efficiency and operate within existing resources.

Specifically, we plan to have leaders in our public health workforce engaged with other stakeholders at the district and state level to coordinate public health efforts through the District Coordinating Councils (DCC) and the State Coordinating Council (SCC). We plan to revitalize the Local Health Officer (LHO) system, in which every municipality will have a LHO with appropriate training, education, or experience to handle local public health nuisances and provide assistance with other potential public threats to assure these threats do not spread.

Through creation of a linkage between HealthInfoNet and the Maine CDC, automated reporting of mandated disease test results will result in much higher compliance levels and enhanced protection against public health threats.

We plan to continue our efforts to locate some Maine Center for Disease Control and Prevention (CDC/DHHS) positions to district offices and re-align the agency to assure it is able to better meet the needs of the public. We plan on streamlining statewide health assessment and public health planning efforts, which will then assist in streamlining at the district and local levels.

As Maine's consolidated statewide public health infrastructure emerges, it is also important that it does not operate in a silo. Our public health system should work hand in hand with our health care delivery system, including physical and behavioral/mental health delivery systems and the Emergency Medical System. To accomplish this, we plan on some specific activities, including some involving the behavioral/mental health system (see Section B, Subsection 2) and some

involving the health care delivery system. This latter topic has a specific activity focused on childhood and adult immunizations, which have emerged recently as an important public health topic, given the ongoing reductions in federal funding for vaccines relative to their cost as well as increasing numbers of effective vaccines for both children and adults. In spite of these changes in funding, we have set as a goal that 90% of all Maine children and adults will have received recommended immunizations.

**Goal:** Complete the implementation of the streamlined statewide public health infrastructure that is responsive to local and statewide health needs and assure its coordination with the physical and mental health care delivery systems.

## **Tasks**

### Statewide Coordinating Council (SCC)

- Convene and staff the Public Health SCC with defined leadership and action plan to advise on the ongoing implementation of the public health infrastructure and assure efficient and effective public health functions – Maine CDC/DHHS and GOHPF by June, 2008.
- SCC will report annually to the ACHSD on matters related to public health infrastructure – SCC, Maine CDC/DHHS and GOHPF, starting December, 2008.
- Determine the most cost effective approach to having a unified public health plan that meets the criteria of the U.S. DHHS Healthy People decadal initiative (upcoming Healthy People 2020) as well as a periodic statewide health assessment as desired by the OneMaine Collaborative - Maine CDC/DHHS, GOHPF, SCC, ACHSD, and others such as OneMaine Collaborative, by December, 2008.

### District Coordinating Councils (DCCs)

- Public Health DCCs will be designated and functional in each of the eight HHS Districts and serve as district-wide representative bodies for collaborative planning and decision-making for functions that are more efficiently and effectively performed at the district level – Maine CDC/DHHS and SCC by December, 2008.
- Public Health DCCs will have working relationships and participation with the major health care systems in the District, including behavioral/mental health care providers – Maine CDC/DHHS and SCC by December, 2008.
- Public Health DCCs will conduct an assessment of adult and childhood immunization needs in the district, using data from Maine CDC/DHHS, with long term goal that 90% of all Maine children and adults will have received recommended immunizations, by December, 2009.

### Local Health Officer (LHO) System

- Complete the modernization of LHO statutes – Maine CDC/DHHS with the Legislature by June, 2008.
- Complete the rule-making for LHO requirements – Maine CDC/DHHS by June, 2008.
- Implement LHO annual training program in each HHS District – Maine CDC/DHHS by June, 2009.
- Complete the formation of Maine CDC/DHHS Public Health Units with co-located staff and District Public Health Liaisons within each HHS District in DHHS Offices – Maine CDC/DHHS by December, 2009.
- Complete Maine CDC/DHHS organizational realignment to most effectively and efficiently serve the needs of the public and to work hand in hand with the public health infrastructure – Maine CDC/DHHS by December, 2009.

## **B. Integrating Care – A Path to Better Outcomes while Lowering Costs**

The Maine health delivery system, like that of the US in general, is a patchwork of unique systems each targeted to specific health education, prevention, treatment, or support needs of the population. The benefit of this system is that we have developed a supply of health and healthcare specialists who have a deep body of expertise and are excellent at meeting specialized needs.

However, the human body is an integrated system. People seldom experience a health or healthcare need that is not influenced by other aspects of their physical, mental and/or social health. The non-integrated system of health and healthcare results in consumers shuffling from one health care provider or system to another often duplicating or missing the care, information or support that would improve his/her total health status. An integrated healthcare system is the first and most important step to prevention. Additionally, a non-integrated health and healthcare system not only compromises the effectiveness of the health and healthcare system in achieving Maine's healthiest state status, it is also inefficient and costly.

The 2008-09 State Health Plan supports the continued and enhanced analysis, design and implementation of integrated health models, particularly with a patient-centered focus. The Maine CDC/DHHS, Maine Quality Forum, and MaineCare have been collecting and analyzing data that measure the extent to which non-integrated care negatively influences the health status of Maine citizens and increases healthcare costs. Statewide, regional, and local provider groups are piloting care models to better understand how to make integrated care the standard of care in Maine. A great deal of information on integrated care has been collected and studied, and the results of these efforts have

informed current pilots and will guide future efforts. The State Health Plan initiates additional efforts to improve care and enhance integration.

The two major strategies recommended in this biennium's Plan to enhance the development of integrated care models are: (1) the design and implementation of a Patient Centered Medical Home (PCMH) pilot; and (2) the continuation of the work of the Maine Center for Disease Control (CDC/DHHS) and MaineCare to raise awareness and inspire action on addressing the relationship between depression and the prevention and treatment of chronic diseases. As a third strategy, we will learn from and build upon the work of other organizations that are integrated care priorities

### **1. Patient Centered Medical Home**

Over the last several years many problems affecting the efficient delivery of health care services have been identified. Prominent among these are the high and growing prevalence of chronic illness in the population and the expected shortage of primary care physicians. The convergence of these two problems has led to the concept of the patient-centered medical home as a model for efficient and effective primary care.

As mentioned earlier, Maine has high incidence of chronic illness, including obstructive lung disease, diabetes, cardiovascular disease, and cancer. Nationwide, 45% of the population has a chronic illness, and half of these people have more than one. The incidence of chronic disease is higher in older people; 83% of Medicare beneficiaries have one or more chronic conditions; 23% have five or more. Complications of chronic disease account for a large portion of hospital admissions and emergency room use. Many of the episodes causing these services are felt to be avoidable; that is, they could have been prevented with more adequate primary care.

However, primary care practices have been hampered by increasing clinical and administrative demands and by declining compensation relative to other specialties. As a result, fewer medical school graduates are entering primary care fields. A reimbursement system that values the essential role of primary care physicians in preventive care is one means of addressing this shortage of primary care physicians.

The concept of the patient-centered medical home (also called the advanced medical home) has been advanced by primary care associations and specialty societies as one that embodies the principles of coordinated, longitudinal, relationship-based care which should be supported by an alternative payment model that recognizes the investment required by practices to embrace this model. Collaborations of providers, purchasers, and payers have formed to

promote the medical home model across the country, and many practices, health systems, purchasers and payers in Maine have expressed interest in a medical home pilot model. The medical home model will embody the principles advanced by the American College of Physicians, the American Academy of Pediatrics, the American Association of Family Practice, and the American Osteopathic Association. These include:

- Every patient has a personal physician.
- Care is provided by a physician-directed team that collectively cares for the patient.
- The team is responsible for providing all of the patient's needs and/or arranging for services to be provided by others.
- Care is coordinated and integrated across all aspects of the healthcare system (e.g., sub-specialty, behavioral/mental health, hospital, home health, and nursing homes care) and the patient's community (e.g., family, public and private community-based services).
- A patient's care is coordinated throughout all stages of life and provides a process that focuses on prevention through screening and early treatment.
- Quality and safety are hallmarks; evidence-based guidelines and tools guide care; and the practice regularly assesses the quality of its care.
- Patients are offered enhanced access to care (e.g., expanded hours, enhanced communication).
- Payment recognizes added value of medical home.

Studies have shown that practices modeled on these principles are associated with better patient outcomes, reduced costs, and reductions in health disparities. Notably, the Primary Care Study Commission of the current legislature included recommendations to change primary care practice in this way.

Dirigo's Maine Quality Forum, Quality Counts (a multi-stakeholder organization whose major mission is the advancement of the planned care model for chronic disease), the Maine Health Management Coalition, MaineCare, and Anthem Blue Cross Blue Shield of Maine have begun preliminary discussions about implementing a medical home pilot project in Maine.

The goals of pilot are to demonstrate that the patient-centered medical home can: improve the health of all patients receiving care from the practice; create a vital and sustainable practice team; reduce costs by controlling inappropriate utilization and unwarranted variations in care; promote an integrated system that supports coordinated care across settings; and be supported by an appropriate payment method that recognizes the infrastructure and systems needed to support this type of primary care.



### Development of a Patient Centered Medical Home Model

**Tasks** to be completed by Oct 2008:

- Formation of a wider steering group to guide the pilot.
- Identification of key principles for a Maine-based model that is both consistent with emerging national models and supports principles that are unique to Maine.
- A structured process for obtaining direct input from patient and consumers about their vision for the medical home.
- Identification of clear goals for the pilot.
- A framework for evaluation of the pilot, including specific performance measures and data sources.
- Maine Quality Forum will evaluate the capability of the paid-claims database and other datasets to measure improvements in unwarranted care variation as a result of adoption of the medical home model.
- Convening of all major private and public payers in Maine to discuss a common framework of reimbursement policies and methods.
- Exploration of the opportunity to participate in Medicare's planned medical home demonstration project.
- Recommendations for benefit design elements needed to support effective implementation of the medical home.

### Implementation of a Patient Centered Medical Home Pilot

**Tasks** to be completed by spring 2009:

- A methodology to identify practices to participate in the pilot.
- A plan and methods to support the practice transformation needed to become a medical home.
- A plan for linking pilot practices with local community resources and the public health infrastructure.
- Funding sources to support the pilot.

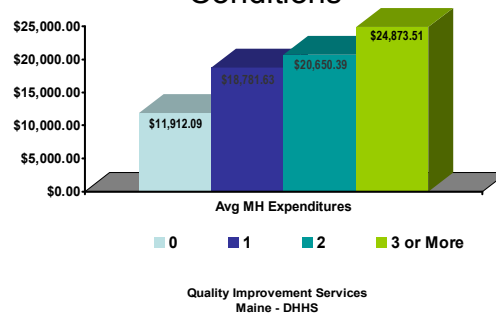
The Maine Quality Forum will report regularly to the Advisory Council for Health Systems Development on the progress of the medical home initiative.

The planning phase of the medical home pilot is anticipated to take six months, with the goal of being able to implement a multi-payor pilot in July 2009. The pilot itself will be a three-year project and will identify problems and solutions on implementation and practice transformation issues, performance measurement methodologies (including structure, process, and outcome), and workable reimbursement models. If successful, the patient-centered medical home model of primary care practice will be ready for adoption throughout the state at the conclusion of the pilot.

## 2. Coordination of Public Health and Behavioral Health Systems

While public health has traditionally worked to address the needs of a variety of populations and a myriad of health issues, public health and behavioral health in the United States have usually been housed in separate organizations with few interactions. Yet, there are many consumers being serviced, though separately, by these systems. For instance, the charts below identify the costs of MaineCare recipients with both chronic and mental illness:

Maine Medicaid Mental Health Expenditures for Persons with Serious Mental Illness and Chronic Health Conditions



Medical Expenses for Maine Medicaid Service Users 2002

MH/SA Behavioral Services	MH/SA Medical Services	General MaineCare Medical Services
\$359 PUPM	\$422 PUPM	\$163 PUPM

PUPM=per utilization per month

Quality Improvement Services  
Maine - DHHS

In recent years organizations in Maine have implemented some joint public health and behavioral health initiatives, including youth suicide prevention efforts, health center behavioral health initiatives, post partum depression screening, and the inclusion of behavioral health in the Partnership for a Tobacco Free Maine's current strategic planning process.

Still, in general, the two systems – public health and behavioral health – involve different statewide infrastructures, different sets of professionals, and different sets of goals and strategies. As a result the efficiency that is gained when two

systems work together towards shared goals and utilizing shared resources is not realized.

We propose a process for this coming biennium to assure that appropriate public health and behavioral health systems, including statewide and local stakeholders, are brought together to form working relationships and to move forward with a common road map. We have and will continue to work with the Maine Health Access Foundation which has studied the barriers to integrated care. We propose at least one pilot of bringing the two systems together in one district. We also propose continuing some behavioral health questions in the ongoing public health telephone survey tool, since these data provide some of the foundation for identifying joint public health and behavioral health issues.

### **Tasks**

- Identify resources to continue the depression and mental health questions on the Maine CDC/DHHS' Behavioral Risk Factor Surveillance System ongoing telephone questionnaire - Maine CDC/DHHS, Office of Quality Improvement and Office of Adult Mental Health, by October, 2008.
- Develop a public health strategic plan using an inclusive stakeholder process, on how to further integrate behavioral health into existing public health work - Maine CDC/DHHS by December, 2009.
- Implement a joint DCC (Public Health District Coordinating Council) - CSN (Mental Health Community Service Network) initiative based on the plan in at least one HHS District as a pilot - Maine CDC/DHHS and Adult Mental Health Services/DHHS by December, 2009.

### **3. Other Maine-based Integration Initiatives**

Many organizations in the state are engaged in promoting integrated, patient-centered care, through projects funded by the Maine Health Access Foundation (MeHAF) and the Chronic Disease Partners.

As mentioned in the last State Health Plan and listed in this Plan's "accomplishments" appendix, in April 2006 MeHAF convened a broad-based Steering Committee including representation from patients, providers, business, insurers, state officials, policy analysts, researchers and others. The steering committee helped define integration, articulate barriers and opportunities to advance integration, and outline benchmarks to assess how Maine's health care system is moving toward improved integration. This group developed a consensus vision for integration that is summarized in "Integrated Health Care in Maine: Vision, Principles and Values, and Goals and Objectives" (available at [www.mehaf.org/pictures/integration\\_vision.pdf](http://www.mehaf.org/pictures/integration_vision.pdf)).

Additionally, MeHAF has contracted with the University of Southern Maine's Muskie School of Public Service to study barriers to the integration of care. This study, scheduled to be completed in summer 2008, will identify barriers at the national, practice, and patient levels and will also investigate regulatory, licensure, and reimbursement issues related to integration. The report will include suggested policy approaches and practical solutions to overcome some of the barriers.

### **Tasks**

- The ACHSD, the MQF Advisory Council, and the Patient Centered Medical Home Steering Committee (see earlier in this chapter) will invite MeHAF to share information and lessons learned from the Integration Initiative grants as information becomes available, starting in 2009.
- The ACHSD, the MQF Advisory Council, and the Patient Centered Medical Home Steering Committee (see earlier in this chapter) will invite MeHAF and the University of Southern Maine to present findings from the study of barriers to integration. The focus will be on those barriers with policy implications relevant for state and ACHSD action and oversight. Summer/Fall 2008.

### **C. Worksite Wellness**

Significant research on worksite wellness programs over the past 30 years has led to three important conclusions. First, employee health risks are directly linked to healthcare and productivity costs. Second, worksite wellness programs can reduce employee health risks, leading to lower healthcare costs, decreased workers compensation and disability expenses, and reduced absenteeism. Third, worksite wellness programs produce savings that are many times greater than the costs, from \$3 to \$6 saved for every \$1 invested.

Despite the potential to reduce healthcare-use and improve productivity, a vast majority of Maine employers do not have wellness programs in place. However, numerous Maine-based initiatives have succeeded in helping both small and large employers develop wellness programs. Among these are the Dirigo Wellness Pilot, a small employer grant-funded project of the GOHPF and Dirigo Health Agency, the Wellness Council of Maine's (formerly Bangor Region Wellness Council) Well Region initiative, the Southern Maine Wellness Council's Worksite Wellness Certificate Course, the Maine Health Access Foundation's small business initiative with Somerset Heart Health, and Maine CDC's efforts to improve support for worksite wellness at the local level. In addition, there have been strong efforts by Maine hospitals to support community and worksite health.

The previous State Health Plan called for the development of the Dirigo Wellness Star, a worksite wellness recognition program. Although that program did not come to fruition, the development of evidence-based criteria for measuring the scope, rigor and quality of employer wellness programs is valuable in the development of employer sponsored worksite wellness programs. The criteria developed could be used for numerous efforts, including state and local level recognition models, aiding future efforts by insurance carriers to link employer wellness programs to premium reductions, and in guiding the work of Healthy Maine Partnerships and others who provide worksite wellness assistance to employers. Upon completion of the criteria, the Council will use the criteria to enhance worksite wellness practice through dissemination to all interested Maine parties.

**Task:** The Maine Council for Worksite Wellness will draft a set of evidence-based criteria to be used to guide the development of employer sponsored worksite wellness programs, for adoption by ACHSD. Begin Summer 2008.

#### **D. Supporting Dirigo's Goal of Universal Access During Challenging Economic Times**

Maine ranks as a leader in covering the uninsured. 11% of Mainers under 65 lack health care coverage, making universal coverage within our reach but challenged by harsh economic times. MaineCare and DirigoChoice, the subsidized health coverage for individuals, the self-employed and small businesses with household income below 300% FPL, have played critical roles in assuring health coverage. But in a system like ours, assuring access to health coverage takes more than subsidized programs for lower income people; it takes an affordable insurance market to ensure that employers can continue to offer good, affordable health insurance and that individuals can afford to buy it.

As ominous trends in the national economy ripple across Maine, health security is even more important, but health care costs and insurance affordability are growing impediments to access. The State's budget is challenged to preserve MaineCare eligibility. Employers, squeezed by an economic slowdown and rising health care costs, drop coverage for employees or pass more costs on to them. In these tough economic times, efforts to stem the loss of employer sponsored coverage become more critical in order to avoid adding to the ranks of the uninsured. Without employer coverage, more individuals turn to the costly non-group market where sales of the most widely sold product – a \$15,000 deductible – grew 29% from 2002 to 2006.<sup>20</sup> While plans with such deductibles can be appropriate for families with higher incomes, a \$15,000 deductible

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<sup>20</sup> Maine Bureau of Insurance.

represents 1/3 rd of Maine's median income of about \$45,000 – before premiums are paid. High out of pocket health care costs are leading to a growing number of under-insured Mainers.

That's why the Dirigo Health Reform approach to universal access to coverage embraces three key strategies:

- MaineCare for our lowest income citizens;
- DirigoChoice, a subsidized health coverage plan for those ineligible for MaineCare but unable to pay the full cost of private coverage; and
- System reforms – investments in public health to prevent costly diseases, insurance market reforms and cost containment strategies to shore up the employer-based system to assure that premiums remain affordable there and in the individual market.

Despite challenging economic times, there is promise in Maine. The Legislature will annually examine a report on cost drivers and recommendations to lower health care cost growth presented by the Advisory Council on Health Systems Development. The Legislature recently enacted revisions to the state's budget to respond to declining revenues protected MaineCare eligibility, continuing coverage for childless adults. The Legislature has yet to act, at the time of finalizing this plan, on a bill to reform and make more affordable the individual market and to secure sustainable funding to continue DirigoChoice.

**Goal:** Build efficiencies in current programs to assure the most cost effective and appropriate coverage to maximize enrollment of un- and under-insured populations, and explore ways to maximize matching funds.

### **Tasks**

- Dirigo Health Agency Board of Trustees will examine DirigoChoice to identify efficiencies to reduce program costs, to sustain and, if possible, grow coverage including but not limited to such options and strategies as: establishment of an asset test; restructuring the subsidy structure; incentivizing small employers to take up coverage; targeting enrollees to cover more uninsured; maximizing MaineCare financing as appropriate and investigating innovations in product design. Proposals to reduce cost/create efficiencies to maximize coverage of un and underinsured by October, 2008 - Dirigo Health Agency (DHA) Board of Trustees.
- The GOHPF with the Bureau of Insurance will work with stakeholders to examine current regulations governing the small group market. If reforms are not enacted in 2008 in the individual market, potential strategies to increase the availability of affordable products in that market will be included in the review and report to the ACHSD and the Joint Committee on Insurance and Financial Services. Deliverable "policy option" proposal by October, 2008.

- MaineCare Services will continue its efforts to improve the overall health care status of its members by implementing a system-wide approach to care management. The initiatives include expanding its Primary Care Case Management, followed by the development with stakeholder groups and in participation with the MQF-convened initiative to create a Patient Centered Medical Home model to ensure a comprehensive, optimal cost- and outcome-oriented approach to healthcare for MaineCare members. Policy Development for this model with an implementation date of January, 2009.
- The ACHSD will monitor implementation of this State Health Plan recognizing that the plan includes key strategies to make health care more affordable and accessible in Maine. Quarterly reports from ACHSD on progress in implementing plan goals.
- GOHPF with the ACHSD will work with the National Governors Association and our Congressional Delegation to provide information based on the Dirigo Health Reform experience and track, analyze and advocate for national solutions to achieve universal access to health care.

**Goal:** Track how many uninsured people obtain coverage in the individual and small group market.

**Task:** The ACHSD requests that the Bureau of Insurance, to the extent that resources permit, provide the Council with information gathered from insurance carriers' 945 reports regarding previously uninsured enrollees.

**Goal:** Monitor the efficiency and effectiveness of Maine's insurance carriers.

As noted earlier in the Plan, the most effective way to bring down growth in premiums is to bring down growth in claims; this is a primary focus of the State Health Plan. Nevertheless, this does not eliminate the need to examine spending on administration and profit of insurance companies, recognizing that it accounts in the aggregate (across all markets) for about 15% of premium costs.

**Task:** To assist the Council in evaluating this issue, the Plan: (1) invites BOI to present to the ACHSD information regarding the experience of carriers electing to file small group rates under the optional guaranteed loss ratio provisions of the Insurance Code; and (2) urges BOI, to the extent that resources permit, to review and report on historical changes in insurance carrier profitability.

## **E. Oral Health – Increase Focus on Prevention & Education, and Build Capacity To Deliver Oral Health Services By Enhancing Partnerships & Collaborations**

Without good oral health, a person cannot be fully healthy. We have seen improvements in some aspects of children’s oral health and in the oral health of many adults, as well as an expansion of the public and private non-profit resources available to provide dental care in rural areas and to uninsured, under-insured, and lower income residents, but there is still much that can be done to improve oral health for all the people of Maine.

During the next two years and beyond, state government will work to maximize its role as a partner with the private sector and other interested parties to support further development of programs and initiatives intended to improve oral health and to assure an adequate supply of oral health practitioners. When these efforts are implemented soundly and following evidence-based and best practices, they are a good investment for all concerned and more likely to result in better health outcomes and lower health care costs.

The Maine Oral Health Improvement Plan, developed collaboratively by a broad range of stakeholders, including State government, was released in November 2007. It provides a framework for improving state and local policies for oral health and increasing public awareness of the inseparable connection between oral health and overall health and well-being. That Plan is not a detailed blueprint; rather, it is meant to serve as a flexible, working guide for all those who have roles to play in improving oral health.

([http://mainegov-images.informe.org/dhhs/reports/oral\\_health\\_plan.pdf](http://mainegov-images.informe.org/dhhs/reports/oral_health_plan.pdf) )

The Oral Health Improvement Plan’s four Key Action Areas organize a far-reaching agenda for emphasizing cost-effective prevention in oral health. What emerges clearly is that oral health promotion and dental disease prevention programs need to be encouraged and supported. They are a viable way to reduce the incidence and prevalence of oral and dental diseases, and to contain and reduce costs associated with their treatment. Prevention programs focus on changing personal oral health behaviors as well as community factors and environmental influences. The Plan also suggests that oral health services can be delivered more effectively and with maximum quality by enhancing partnerships and collaborations within the existing oral health infrastructure.

### **Goals**

- Change Perception and Increase Awareness: Define and support state and local policies by increasing public understanding of the value and importance of oral health to overall health and to promote optimal oral health.



- **Expand Access and Increase Prevention:** Increase population-based prevention, early intervention programs and expanded access to high quality, affordable oral health services for Maine people throughout the lifespan.
- **Improve Service Delivery:** Enhance oral health partnerships and infrastructure to improve the knowledge base of all health providers and the delivery of quality services.
- **Expand the Dental Workforce:** Expand the capacity and ability of the dental workforce to provide access to cost-effective, high quality oral health services for all Mainers.

### **Tasks**

- Working with partners, refine the Plan's strategies.
- Develop a timeline that will keep the Plan active and current.
- Identify specific activities, key players and areas of responsibilities.

On September 14, 2007, Governor Baldacci signed an Executive Order to establish a Task Force to identify barriers to access to oral health services and to make recommendations to expand access. Working with public and private partners, the Task Force will develop recommendations to ensure that the opportunity for critical oral health services are available to all Maine residents and report back to the Governor by December 1, 2008. The State Oral Health Improvement Plan has been provided to the Task Force as a tool.

## **F. Rural Health - Building Access to Quality & Affordable Healthcare for Rural Residents**

To meet the health and health care needs of our rural communities, we must consider all varying aspects of the rural health system and how they may be supported to meet the changing needs of our rural communities. As components of the rural health system shift in capacity and focus we must act affirmatively to address the issues that arise, rather than await a crisis.

Based upon recommendations in the 2006-07 State Health Plan, a Rural Health Work Group (RHWG) was established to create a Rural Health Plan for Maine. Over twelve months the fourteen-member RHWG developed a plan premised on the principle that coordination and integration of systems and services across the health care, public health, and behavioral health systems are critical for achieving better access to services and better health outcomes.

The RHWG recognizes that it will be difficult if not impossible to ensure appropriate access to the health system for rural residents without furthering

efforts to expand access to affordable coverage for all Mainers; however, the Work Group believes that important incremental progress can be made.

The RHWG intends the plan to serve as a starting point for a statewide conversation about the future of rural health in Maine. The RHWG identified seven goals that are consistent with improving the health and lives of rural people in Maine:

1. Assure access to a foundational, core level of health services.
2. Functionally integrate physical, behavioral, oral, and public health services.
3. Address current and future health workforce needs.
4. Promote and expand the use of a coordinated, chronic care model throughout rural Maine.
5. Develop rural relevant quality and system performance measures.
6. Promote interoperable information technology and telehealth infrastructure development.
7. Ensure financial access for Maine citizens and overall financial stability of the rural health system.

Additional details about the goals and recommendations can be found in the full text of the draft Rural Health Plan at: [http://mainegov-images.informe.org/dhhs/boh/orhpc/documents/RHP\\_2.21.pdf](http://mainegov-images.informe.org/dhhs/boh/orhpc/documents/RHP_2.21.pdf)

**Tasks** of the Maine Center for Disease Control/DHHS, Office of Rural Health and Primary Care over the next biennium:

- Hold three regional listening sessions to obtain input, comments, and suggestions from the larger rural health community and finalize the Rural Health Plan by July, 2008.
- Develop a plan for Maine's federally funded Rural Hospital Flexibility Program with a two to three year strategic vision consistent with the Rural Health Plan by September, 2008.
- Convene the Healthcare Workforce Forum and foster more effective partnerships between higher education institutions and health care providers by June, 2009.
- Create a work group charged with the development of rural quality and performance relevant indicators by June, 2009.

## **G. Telemedicine**

Telemedicine refers to the use of telecommunications technology – ranging from telephone to real-time video and internet connection – to provide health care services to patients who have physical or geographic difficulties in accessing

services from physicians or other health care providers. It can be particularly useful in a rural state like Maine, where some health care services are distantly located from the community and where workforce challenges frequently limit access to many services and has been used to provide rural patients with improved access to specialty care services, home health and dentistry.

Maine's 2006-07 State Health Plan created a workgroup "to develop strategies to help Maine achieve an appropriately-developed, utilized and reimbursed telemedicine infrastructure that serves the best interest of patients."

The workgroup found that while certain communities have adopted telemedicine, in other communities there is a lack of interest on the part of doctors, patients, and employers.

This lack of interest is in part due to a lack of information about telemedicine, including lack of a well developed evidence-base regarding its costs and benefits – and thus a well-documented "business case" – for various services.

To address this and other issues, the workgroup's core recommendation is the creation of an ongoing forum in which telemedicine providers work together to:

- (a) Increase understanding of telemedicine by (i) creating an evidence-base (which services telemedicine is used for; what the outcomes, costs and benefits are, etc.) to establish the business-case for telemedicine and share this information with insurers, providers, and employers, who do not currently use telemedicine; and (ii) educating patients and providers about telemedicine;
- (b) share best practices with one another;
- (c) discuss new and emerging technology; and
- (d) coordinate with one another on applications for federal and other grants and to focus investment in services with the highest need and the most potential to improve patient health outcomes, so that telemedicine technology and services are deployed in a systematic way.

Importantly, in November 2007, two Maine groups were awarded federal grants that should significantly improve connectivity (i.e., the telecommunications infrastructure over which telemedicine must flow). Specifically, the New England Telehealth Consortium – a group of providers convened by ProInfoNet of Bangor that includes 555 rural healthcare sites in Maine, New Hampshire, and Vermont (with the vast majority of the sites in Maine) – received a three-year \$24.6 million grant from the Federal Communications Commission to lay down the broadband lines necessary to create telemedicine connectivity among the teaching centers, tertiary, secondary, and critical access hospitals, Federally Qualified Health Centers, Rural Health Clinics, and other providers that belong to

the consortium

The FCC also awarded a \$3.6 million grant under the same program to the Rural Western and Central Maine Broadband Initiative, a collaborative proposal involving Franklin Community Health Network, HealthReach Network Community Health Centers, and Central Maine Healthcare.

The forum recommended by the telemedicine workgroup will help build on the excellent work done by these grantees by helping to ensure that the new infrastructure is appropriately used to bring maximum benefit to Maine people.

Recognizing the potential telemedicine offers to rural communities this State Health Plan assigns the DHHS/MeCDC Office of Rural Health and Primary Care (ORHPC) the role of convener of the telemedicine forum. The ORHPC will address the 2006-07 State Health Plan's core recommendation by re-convene the telemedicine workgroup and developing a plan to address the four recommendations outlined in the Telemedicine Workgroup Report.

### **Tasks**

- Identify and invite key leaders in telemedicine to an ongoing forum to begin by October, 2008.
- Work with forum members to develop a strategic plan with timeline of specific action steps and areas of responsibility by April 2009.
- Keep apprised of developments in implementation of FCC grant.
- Annual progress report to ACHSD starting in April 2009.

### **H. Possible Role for Federally Qualified Health Centers (FQHCs) in Providing Veterans' Care**

The US Department of Veterans Affairs (VA) estimates that there were 145,419 veterans in Maine in 2003,<sup>21, 22</sup> ranking Maine the state with the highest percentage of veterans in the nation.<sup>23</sup>

While some veterans have health coverage through an employer or – in the case of those age 65 and over – Medicare, a significant number of veterans<sup>24</sup> receive

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<sup>21</sup> All enrollment data in this chapter was supplied by Togus in 2004 a part of the Task Force On Veterans' Health Services' Report To The 122nd Legislature (First Regular Session)

<sup>22</sup> Population estimates are from the Veterans Administration's Vet Pop 2001 demographics model, which is based on 2000 U.S. Census data and may not include changes due to increased service in Iraq and Afghanistan.

<sup>23</sup> In the 2000 Census, veterans constituted 15.9% of Maine's population age 18 and over, while the average among the 50 states and District of Columbia was 13.5%.

[www.va.gov/vetdata/census2000/index.htm](http://www.va.gov/vetdata/census2000/index.htm).

care through the VA system (Togus and VA clinics). And as the number of soldiers returning from Iraq and Afghanistan increases, the issue of improving local access to care for veterans is highlighted.

In 2004 the VA announced the final details of a multi-year review of the VHA called Capital Asset Realignment for Enhanced Services (CARES). A major focus of CARES was to avoid imbalances in its services in the future, by making sure the size and location of its health care facilities match the needs of veterans. CARES included geographic analysis that included driving distance and waiting time as measures to assess access.

CARES found significant access gaps in Maine. The CARES standard for primary care access is that 70% of veterans in urban and rural communities should be within 30 minutes of care (60 minutes in highly rural areas). The study found that only 59% of Maine's veterans are within those guidelines, and that Maine veterans at the time of the study traveled from 30 to 100 miles to receive VA healthcare. The study made a number of recommendations to reduce this distance to an average maximum of 50-60 miles in Maine and 30 miles nationally.<sup>25</sup>

Implementation of the CARES recommendations will eventually close some – but not all – of the access gaps faced by Maine veterans. Achieving the 70% access standard would still leave about 44,470 of Maine's veterans outside the 60 minute/60 mile travel distance.

While the provision of veterans care is the responsibility of the federal government, the State Health Plan proposes a task that could help close some of these access gaps to assist our veterans in securing the health care services they need and deserve, while at the same time bolstering Maine's rural health care safety net. Specifically, there are 50 FQHC sites in Maine, and they could be well suited to close these gaps.

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<sup>24</sup> The VA estimates that there were 145,419 veterans in Maine in 2003.<sup>24</sup> 44,096 (30%) were enrolled with the VHA, up from 16% in 2000. Togus. Population estimates are from the Veterans Administration's Vet Pop 2001 demographics model, which is based on 2000 U.S. Census data and may not include changes due to increased service in Iraq and Afghanistan.

<sup>25</sup> Goals in Maine included, but were not limited to:

- Closing the Access Gap for Primary Care: (1) Adding several VA clinics in rural areas; (2) Adding a new community based outpatient clinic in Cumberland County to meet the needs of veterans who reside between Saco and Togus.
- Closing the Capacity Gap in Primary care and Outpatient Mental Health Services: (1) Increased capacity through previously cited outpatient clinics; (2) Enhance existing mental health services at Togus; (3) Contract with mental health providers as needed.
- Closing the Capacity Gap for Outpatient Specialty Care: (1) add specialists to the existing staff at Togus; (2) Use contract specialists within the community; (3) Expand construction of Togus by 70,000 square feet.

**Task:** The Governor's Office and the Maine Primary Care Association will investigate the possibility of FQHCs' contracting with the VA Affairs to provide care for Maine veterans. Summer, 2008.

## ***II. Assuring Best Practices/Less Variation in Care Delivery***

### **A. Emergency Department Over-Utilization**

Thirty five of the thirty nine hospitals in Maine have emergency departments, and all emergency departments are open 24 hours and day, 7 days a week. Having quality accessible medical care available when an emergency occurs is important to the quality of life of Maine citizens. However, as was seen on page 26, Maine – at 553 ED visits per 1000 population in 2005 – has the highest rate of emergency department visits in New England and the 4<sup>th</sup> highest in the US (the national rate was 387 visits per 1000).

A recent analysis of ED-use by the Maine Health Data Organization (MHDO) suggests that some emergency department visits are being made by choice for non-emergency conditions. Some of the issues influencing the over-utilization of emergency departments are likely to include:

- Unavailability of primary care doctors after office hours.
- Patients without a primary care doctor.
- Lack of a triage system to help patients assess the need for emergency care.
- Availability of full service care in one stop – imaging, lab, specialists.
- Ease of ED-use – no need to make a doctor's appointment.
- Lack of available services for people suffering from alcoholism, drug addiction, and/or mental health problems.
- Ineffective chronic care management, resulting in complications.

Unfortunately, the cost for emergency care is higher than treatment of non-emergent conditions in a physician's office or clinic. This is partially a result of the cost of keeping a large complex institution like a hospital operating. Additionally, hospitals are required under EMTALA laws to screen all patients who perceive that they need emergency care for a possible emergency condition.<sup>26</sup> The screening often results in tests, observation and examinations that are costly and may be unnecessary to improving the patient's condition. Emergency department care also seldom includes any follow up by the emergency department staff thus resulting in incomplete care and/or repeat visits if the

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<sup>26</sup> The Emergency Medical Treatment and Active Labor Act is a statute which governs when and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when he is in an unstable medical condition.

patient does not assume responsibility for his/her own follow-up. Over-utilization of emergency care also utilizes resources that should be directed solely to those in need of emergency care.

Inappropriate utilization of emergency departments is adding to healthcare costs without improving the long term health status of individuals. But the financial impact of inappropriate ED use is not fully understood. On the one hand, it may be efficient for a hospital with fixed costs to keep its ED full, and the cost of the ED may have nominal impact on premiums; on the other hand, absent a system of electronic medical information exchange, ED-use may be driving inappropriate and costly testing and fueling the demand for new and expanded emergency capacity that may not be needed if inappropriate admissions are reduced or eliminated.

In the longer term, the Patient Centered Medical Home model discussed earlier in the Plan should reduce inappropriate emergency room use but, because the pilot will take several years, we believe there is a need to take action in the short term to better understand this problem, including its impact on costs, and to identify solutions that will reduce identified costs and direct non-emergent care to the most efficient and effective site of care.

**Goal:** Identify costs associated with non-emergent use of emergency rooms, and -- if potential cost savings warrant further work -- of strategies to increase the provision of non emergency care in appropriate setting outside of the hospital emergency rooms.

### **Tasks**

- Convene a group of stakeholders representing emergency department personnel, primary care physicians, Behavioral Health, EMT, MaineCare, large and small hospitals, payors, police, medical specialties, medical clinics. GOHPF - June, 2008.
  - Identify the extent, costs, and characteristics of non-emergent care provided in emergency departments and – to the extent possible – the demographics of patients accessing non-emergent care in emergency department settings. Study should also investigate the extent to which ED-use leads to increased tests and use of imaging, as well as the costs of those services.
  - Analyze the cost and availability of 24/7 non-emergent care in both urban and rural areas.
  - Complete a cost comparison analysis of non-emergent care in hospital emergency departments versus 24/7 non-emergent care venues.
  - Identify potential venues for 24/7 non-emergent care including primary care offices, clinics, hospital based clinics, and FQHCs, and – recognizing that different parts of the state have different infrastructures and face

- different issues – complete a cost analysis of providing 24/7 non-emergent care in these venues.
- Report to ACHSD on cost saving and availability of 24/7 non-emergent care. ACHSD will determine if the cost savings and quality of care improvements justify furthering the study to identify strategies for reducing non-emergent care in emergency departments – November, 2008.
  - Identify incentives, regulations, and/or other strategies to create a supply of 24/7 non-emergent care, where appropriate, and prepare a report for the ACHSD - February, 2009.
  - ACHSD report to the Legislature recommendations for creating 24/7 non-emergent care availability in Maine - March, 2009.

## **B. Reducing Variation in Medical Practice**

As mentioned earlier in the Plan, there is significant variation in how medicine is practiced in different geographic areas, and this can have profound implications in terms of cost, quality, and patient safety. The Dartmouth Atlas Project, for instance, has found a two-fold difference in annual spending per Medicare beneficiary between the highest and lowest regions nationally, with roughly 75% of the variation being attributable to utilization and only 25% attributable to price, with outcomes of care – including measures of quality of life, mortality, or patient satisfaction – not necessarily being any better in areas of higher utilization. Local rates of utilization, in turn, have been shown to be closely correlated with local supply of services.

There are rich sources of variation data in Maine, including hospital discharge data, Maine's unique paid-claims database, and data on specific performance indicators chosen by MQF and its Advisory Council and submitted to MHDO by hospitals, and the Maine Quality Forum has analyzed within-Maine variation for a range of specialty services. For instance, as shown in the chart on page 27, even when the patients are identical, a resident of Skowhegan is almost three times more likely than a resident of Bar Harbor to get a hysterectomy.

And as shown in the chart on page 28, more spending and utilization does not result in either higher quality or better health.

In addition, there is evidence that certain types of care, particularly preventive services and care processes related to surveillance and treatment of chronic illness, are actually provided far less often than indicated. A RAND study in 2003 demonstrated that Americans receive indicated, effective care only about 55% of the time. This can result in unnecessary morbidity and complications, with attendant avoidable hospitalizations and costs.



The question remains, "How can this information be used to improve practice, achieve better patient outcomes, and lower costs?" The answer begins with a process that requires engagement of providers, especially medical practices, in a discussion of practice- and region-specific information in order to involve them in initiatives targeted toward improving performance and diminishing variation. And a positive note that will help move the process forward is that, while early studies of geographic variation could simply note differences in utilization frequency or volume, current studies are informed by newly-developed evidence-based guidelines which define quality of care, by linking processes of care such as treatments or tests to beneficial outcomes such as longer life, higher functional status, or avoided hospitalization.

**Goal:** Reduce unwarranted variations in healthcare in Maine to improve health status and reduce costs, through increasing the use of effective care measures and diminishing the use of discretionary, ineffective care.

**Tasks:** For some areas of specialty care, there are national consensus standards about "what is the right rate" of care, while for other areas, no such consensus standards have yet been developed. The tasks below are divided accordingly.

#### Areas Where There Are National Consensus Standards about "What Is the Right Rate"

- MQF is in the process of analyzing Maine variation in primary care and cardiac care practice -- areas where there are national consensus standards about "what is the right rate" -- through the all payor claims database. The analysis is expected to be done by July 1, 2008.
- Once the analysis is complete, MQF will convene a workgroup consisting of members of the Pathways to Excellence primary care and cardiology providers group and other interested practitioners to develop strategies to promote the right rate of care in all communities. September 30, 2008
- Activities will then be ongoing. Process for measuring progress will be ongoing analysis of the claims database (on a biannual basis).
- As new consensus standards relevant to other medical specialties emerge at the national level, MQF will develop plans to measure and promote the right rate of care in the those specialties as well.

#### Areas Where There Are Not Yet National Consensus Standards

- MQF's 11 "Butterfly charts"<sup>27</sup> developed from discharge data (see page 27)
  - The charts currently use 1999-2003 data. MQF will update all charts data to include 2004-2007 data by the end of 2008.

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<sup>27</sup> Lumbar Fusion Procedures, Lumbar Disc Surgery Without Fusion, Back and Neck Procedures, Total Knee Replacement, Total Hip Replacement, Hysterectomy, Carotid Endarterectomy, Adult Medical Conditions, Cardiology Medicine, General Digestive Medicine, Respiratory Medicine.

- MQF and its advisory council will determine which services are high priority/short term focus areas, based on consideration of gains in both patient safety and costs savings, as well as changes from the 1999-2003 data, by March 31, 2009.
  - MQF will convene appropriate stakeholders to generate discussion about lessening the variation for the designated high priority/short term focus areas by May 31, 2009.
  - Activities will then be ongoing. Process for measuring progress will be ongoing analysis of the claims database (on a biannual basis).
- Data from the District Healthcare Utilization Profiles (see page 66).
    - The ACHSD, MQF and Maine CDC/DHHS will hold forums in each of the 8 HHS Districts with District Coordinating Councils (DCCs) to review District Health Utilization Profiles, to engage stakeholders (e.g., healthy Maine Partnerships, Quality Counts, and others) in addressing district-specific issues, and get input regarding specific actions that ACHSD can recommend in its future recommendations. Spring, 2009.

## **C. Prototypes for Evidence Based Medicine - In a Heart Beat and Stroke Systems of Care**

### **1. In a Heartbeat**

To measure and expand on the success of In a Heartbeat in changing the behavior and treatment of heart attacks and thus save more lives, the MQF together with the Maine CDC/DHHS's Cardiovascular Health Program and the AMI Community Engagement Workgroup will work towards the following:

**Goal:** Because of a widespread community effort at education and a consistent message about the importance of calling 911 at the first symptom, the public will recognize and respond quickly to heart attacks. The public will recognize the signs of heart attack and call 911 quickly by providing a consistent message to high risk populations and their family, friends, and co-workers about importance of calling 911 immediately on recognizing heart attack signs.

#### **Tasks**

- Spokespersons in community organizations will be trained through train-the-trainer model. MQF, CDC/DHHS Cardiovascular Health Program, Active Community Engagement Workgroup - March, 2008.
- Task: Explore and develop outreach strategy for high risk populations and develop a consistent message to be utilized by health systems and health care providers. MQF, CDC/DHHS Cardiovascular Health Program, Active Community Engagement Workgroup - June, 2009.

**Goal/Task:** Evaluate the impact on the public's knowledge and ability to take appropriate action using the Behavioral Risk Factor Surveillance System survey. Maine CDC/DHHS - December, 2009.

The model of In a Heartbeat for community engagement and care standardization in emergency departments and hospitals has great potential and can be applied to the systematic approach to the care of other acute illnesses. Prominent among these is stroke. A statewide stroke program which builds on the lessons learned and the successes of In a Heartbeat is an initiative will be considered for inclusion in the next biennial State Health Plan.

## **2. Stroke Systems of Care**

In 2005, the American Stroke Association (ASA) published "Recommendations for the Establishment of Stroke Systems of Care". This comprehensive document outlines the importance of a multi-dimensional team in providing effective and efficient, evidenced based, stroke care, as well as providing guidance around the roles of team members in the various settings involved.

For the past several years there has been an effort to develop a coordinated stroke system of care. "Stroke Care in Maine" a workgroup of state programs, advocacy organizations, health systems, and hospitals in Maine is actively engaged in promoting the establishment of stroke systems of care to transform what are often a fragmented collection of services, to a coordinated system of care that promotes a full range of activities and services associated with stroke prevention, treatment, and rehabilitation.

**Goal/Task:** Progress toward collective statewide initiatives surrounding stroke systems of care will be compiled and reported by the "Stroke Care in Maine" workgroup yearly with the goal of inclusion in the next biennial State Health Plan.

## **D. Finding the Right Place of Care for the Elderly and Disabled in Need of Assistance**

By the beginning of the 1980s, Maine was one of the first states to enact a state home-based care program in order to reduce institutional care for elderly persons and persons with disabilities. In the mid-1990s, Maine became a leader again by rebalancing its long term care (LTC) system by diverting people from nursing facilities to home and community-based services. However, in more recent years, due in large part to fiscal constraints, Maine's efforts to increase home- and community-based options has lost some momentum.

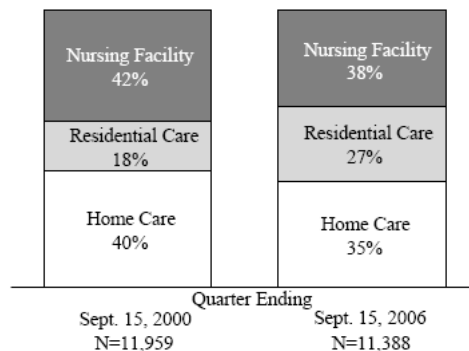
During 2007, the Department of Health and Human Services conducted an assessment of the LTC needs of Maine people and the types and locations of LTC services available. With the help of the Muskie School of Public Service at the University of Southern Maine and the national health and human services consultant, the Lewin Group, we have gathered baseline data and developed a projection model. Data is available by county. The model allows us to project for 2010 and 2015 the number of Mainers who will need services, types of LTC services they will need, and where services will be needed. Importantly, this model will enable the Department to estimate the impact of a change in one program on other programs providing long term care services.

As shown in the figure below, our needs-assessment documents that an increase in the use of residential care served to offset most of the decline in the use of nursing facility care between 2000 and 2006. In 2006, 38% of people using MaineCare or state-funded LTC services were in nursing facilities. This represents a decline from 2000 when 42% of LTC users were in nursing facilities. However, the proportion of MaineCare members in residential care increased from 18% to 27%. In addition, during this period, home care decreased from 40% of LTC users to only 35% of LTC users.

The needs assessment indicates that it is timely to determine the proper balance of home-based and facility-based services in Maine; that is - a balance based on the needs and choices of individuals who seek long term care services and supports.

The Department intends to expand the reach of evidenced-based programs for healthy aging to other community-based and LTC programs. Currently, there are a number of evidence-based programs offered in the community statewide including: A Matter of Balance, Chronic Disease Self Management, Enhance Wellness, Enhance Fitness and Healthy IDEAS. Individuals receiving long term care services can benefit from these programs as well.

Percent of Persons Receiving MaineCare Funded Nursing Facility Care  
Residential Care (Case-Mix Facilities Only)  
or MaineCare and State funded Home Care Services SFY 2007



**Goal:** Determine what services are needed where and that types of care available reflect the needs and choices of the people using those services.

**Task:** Use projection model developed by the Lewin Group, in collaboration with the Muskie School, to project need for and to plan for home care, community residential options, and nursing facility care. DHHS Office of Elder Services - December, 2008.

**Task:** Maine CDC/DHHS will compile a "Maine Elders Health Profile" by December, 2008.

**Goal:** Functional needs assessments for people needing any level of care.

**Task:** Establish/implement functional eligibility criteria for Private Non-Medical Institutions. DHHS Long Term Supports Leadership Team – July, 2009.

**Goal:** Make sure that options are in place that promote maximum choice and independence.

**Task:** Identify/implement strategies to strengthen home care and affordable, homelike living options for Maine's elders. DHHS Office of Elder Services – December, 2008.

**Goal:** Integrated planning, development and service delivery by comparing/contrasting information about long term care experience across all populations.

**Task:** Gather key common data elements across all populations with long term care needs. DHHS Long Term Supports Leadership Team – October, 2009.

**Goal:** Identify/implement strategies to support the direct care work force.

**Task:** Initiatives will be in place to honor and support direct care workers. DHHS Office of Elder Services – October, 2008.

**Goal:** Develop more sites in a variety of settings offering evidence-based programs: A Matter of Balance, Chronic Disease Self-Management, Enhance Wellness, Enhance Fitness and Healthy Ideas.

**Task:** Extend the reach of evidence-based programs throughout the state. DHHS Office of Elder Services – July, 2009.

### **III. Efficiency and Effectiveness**

#### **A. Medicare Equity Project**

##### **1. Hospital Reimbursement**

Medicare, the health insurance program for most of the nation's elderly and many persons with disabilities, is the single biggest payor of Maine's hospitals, accounting for 43% of charges in 2005. Medicare is reported to underpay for hospital services, reimbursing only 89¢ on the dollar.<sup>28</sup> According to the Maine Hospital Association (MHA), Medicare's failure to properly adjust its payments to Maine hospitals to reflect wages paid in Maine is a significant problem. A recent proposal by the Medicare Payment Advisory Committee<sup>29</sup> calls for revising the wage index, which the MHA reports would net Maine an estimated additional \$10 million. But, if the wage index is not resolved, MHA believes Medicare underpayment will remain a significant problem.

The ACHSD recognizes that Maine's physicians also report Medicare underpayment for their services, which is growing as our population ages and Medicare comprises a larger share of physician practices' business.

If Medicare underpays, hospitals and physicians shift costs to private payors. Medicare payment rates also influence Medicaid rates since the state run Medicaid program – which accounted for 15% of hospital charges in 2005 – cannot by law pay more than Medicare. If public programs pay less, private payors pay more. By increasing Medicare rates, private payors will see rate relief.

If efforts to increase Medicare payment succeed, providers that experience Medicare payment increases should be able to demonstrate to consumers, employers, and insurers that cost shifting – and therefore premiums – decrease accordingly.

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<sup>28</sup> DataGen Medicare Margins Analysis forwarded by MHA to GOHPF, 3/26/2008.

<sup>29</sup> The Medicare Payment Advisory Commission (MedPAC) is an independent Congressional agency established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program. In a June 2007 report to Congress, MedPAC fulfilled a requirement of the Tax Relief and Health Care Act of 2006 that MedPAC report on a revision of the wage index. In that report MedPAC "recommends first that the Congress should repeal the existing hospital wage index statute including reclassifications and exceptions, and give the Secretary authority to establish new wage index systems. Second, the Commission recommends that the Secretary should use this new authority to establish a hospital compensation index that: (1) uses wage data representing all employers and industry-specific occupational weights, (2) is adjusted for geographic differences in the ratio of benefits to wage, (3) is adjusted at the county level and smoothes large differences between counties, and (4) is implemented so that large changes in wage index values are phased in over a transition period."

**Goal:** Increase Medicare hospital and physician reimbursement rate.

**Tasks**

- GOHPF will convene an Ad Hoc Medicare Equity Work Group representing: Governor's Office, Legislature, Maine Hospital Association, insurers, consumers, employers, and representatives of Congressional delegation – May, 2008.
- Develop white paper documenting the cause of the Medicare under-funding, the amount, the impact on private payers and identify strategies to resolve – October, 2008.
- Present white paper to appropriate legislative committee, the media and public to generate support – December, 2008.
- Meet with Congressional delegation to brief and develop strategy – January 2009.
- Meet with MedPAC and CMS – February, 2009.
- Assess progress in reaching resolution with CMS – May, 2009.
- Seek Congressional action should CMS discussions fail to yield a solution – June 1, 2009.

**2. Medicare Hospice Benefit**

In 2002 use of hospice for people in Maine was 14% compared to the U.S. average of 28.6% (ranking it 49th). Since this group is eligible for the Medicare hospice benefit, it appears that Maine is receiving less Medicare funds than it would if more of its population over age 65 accessed hospice care. While fewer Maine people die in hospitals (43% in Maine versus 49% nationally) more Maine people die in nursing homes (34% in Maine versus 24% nationally). This suggests that more end of life patients in nursing homes and at home could be receiving Medicare-paid hospice care, possibly alleviating the State and private payers from this cost of care during this time. Since we know that end of life patients want to be stay in their homes whenever possible, increasing hospice utilization could meet patient needs, reduce State and private cost and bring more Medicare dollars into Maine.

A study by the Muskie School of Public Service released in 2007 and a presentation by DHHS Office of Elderly Services identify many of the reasons for underutilization of hospice by Maine citizens including the need for education, outreach and coordination. Although the study's recommendations focus on actions that would increase efforts in these areas, it does not include the barriers and strategies for implementing these recommendations. The State Health Plan therefore creates a work group is to move the study's recommendations forward into strategies to reduce barriers to hospice use in Maine.

**Goal:** Increase Awareness & Utilization of the Benefits of Hospice Care

## **Tasks**

- GOHPF will convene stakeholders involved in promoting the utilization of hospice care including representatives from the Maine Hospice Council, hospitals, nursing homes, social service, Elder Independence of Maine, Office of Elder Services, physicians, palliative care, MaineCare to agree on the benefits of hospice care and the barriers to higher utilization in Maine - June, 2008.
- Prepare and present actionable recommendations to the ACHSD that will increase the utilization of Hospice by Maine citizens – October, 2008.

## **B. Electronic Health Information – HealthInfoNet**

Electronic health records have long been identified as a successful strategy to improve patient care, lower the risk for medical error, and achieve efficiencies. In our analysis of cost drivers, we have noted that peer nations spend about half what the U.S. does on health care yet achieve greater access, and at least as effective quality and health outcomes. Similarly, the U.S. lags significantly behind in adoption of physician use of electronic medical records (EMR) compared to other countries. According to the Commonwealth Fund National Scorecard on U.S. Health System Performance, only 17% of physicians in the U.S. use EMR, compared to 90% in Sweden or 58% in the United Kingdom (2000/2001).

In Maine it is estimated that only about 15% of physician practices use EMR. The reasons for this are many, including cost, utility and ease of use, and rapid changes in technology. Concerns about the importance of protecting patient privacy must be assured as well. In some parts of Maine, physician access has been hindered by lack of broadband access, a problem that will soon be addressed in part by the recent awards by the FCC in northern and western Maine to expand broadband access to health providers (see page 51). But barriers remain.

In Maine, HealthInfoNet (HIN), a new non-profit, is working hard to build a health information superhighway to build connectivity that supports patient management across multiple points of service. Beginning this winter, more than 2,000 healthcare providers, including 15 rural and urban hospitals across Maine and one-third of practicing physicians in Maine, will join with the Maine Center for Disease Control and Prevention in a major 24-month demonstration of the new network. Hospitals and physician practices taking part in the pilot account for more than half of the state's annual inpatient hospital admissions and nearly 40 percent of Maine's outpatient visits each year. Following the successful completion of the demonstration phase, plans call for HealthInfoNet to be expanded to include other providers who care for Maine's 1.3 million residents.



This initiative will be critical to the success of the State Health Plan's goal to develop medical homes and may serve as incentive for physicians to take on the expense and time required to adopt EMR. EMR that helps physicians gain timely patient information from multiple sources of testing and care provision can be value added.

While HIN has made tremendous progress to date, additional time, effort, and resources are necessary to fully realize its promise. To achieve its full potential, the vast majority – if not all – of Maine providers must connect to the HIN superhighway. To achieve that goal, HIN will need to demonstrate to all providers that the benefits of EMR outweigh the costs; and as more providers seek to connect, many physician practices and health facilities will need support.

The 2008-2009 State Health Plan sets in motion critical steps towards achieving these goals.

### **Tasks**

- MQF and HIN will by May 2008 convene a broadly representative stakeholder group representing the Governor's office, HIN and its consumer advisory committee, MQF, FAME, Maine Medical Association, Maine Hospital Association and Maine Osteopathic Association and the Maine Association of Health plans, representatives of payers, pharmacies, businesses, public health, Muskie School of Public Policy, Maine Technology Institute, AARP, long-term care facilities, state agencies responsible for health care services to:
  - Identify a broad-based stable ongoing revenue source for an electronic health information system.
  - Develop a technology investment account to provide assistance to physician practices, long term care facilities and independent pharmacies with the costs of electronic medical records and e-prescribing.
  - Estimate the return on investment from shared electronic clinical information and develop a methodology for measuring the quality and cost impact of shared clinical information.
  - Establish criteria/guidance for physician-based EMR systems to assist physicians in choosing among competing options and explore and review the offerings by several hardware and software EMR vendors to provide no cost or low cost equipment and software to physicians to help assess the value of such product offerings.
  - Provide recommendations to the joint committee on Health & Human Services – December, 2008.
- MQF will serve as the coordinator of the CMS Electronic Health Records Demonstration Project, which will provide technical support and financial

incentives for as many as 100 small to medium size primary care practices to incentivize EHR diffusion and use.

## **C. Using Data to Enhance the Performance of Maine's Public Health and Health Care Systems**

### **1. Deepening the Analysis of Maine's Healthcare Cost Drivers**

The McKinsey Global Institute's 2007 "Accounting for the Cost of Health Care in the United States" provided us with a national view of the drivers that result in the US spending significantly more than other OECD countries.

A Maine-specific health care spending analysis – one that identifies and quantifies specific cost drivers and provides actionable information – would assist the ACHSD in more fully meeting LD 1849's charge to conduct a systemic review of cost drivers in the State's health care system, collect and report on health care cost indicators, identify specific potential "pots of savings" where reductions in total health care spending are achievable, and make specific recommendations to the legislature to reduce the rate of increase in overall health care spending.

Maine's first in the nation all-payor claims database holds great potential to help us understand what is driving health care spending in Maine and – through that understanding – to take actions to reduce growth in spending.

**Goal:** To provide independent data and analysis to explore cost drivers in Maine in order to identify specific actions that can reduce cost growth and to build capacity to provide on going analysis to measure progress over time.

**Tasks:** GOHPF will seek outside funds to support a contract to conduct a comprehensive analysis and assessment of specific cost, utilization, and supply-related factors driving health care spending in Maine. This analysis will result in a report that will inform the ACHSD's March 2009 cost driver report and recommendations.

GOHPF and MQF will convene a work group of Council members, stakeholders, funders, and others to:

- advise in the development of an appropriate study approach and methods,
- secure funding for the study, and
- contract with qualified researchers to develop and implement the study.

The workgroup shall complete its work by January 31, 2009.

The report shall include, but not necessarily be limited to:

- Data at the statewide level, to provide a systemic view of cost drivers.
- Data at the health delivery system level and the CDC/DHHS district level (these “District Healthcare Utilization Profiles” will be used in the District Health Forums mentioned in the Variation Chapter) to allow for locally actionable interventions, when appropriate.
- Benchmarks of health systems performance – with specific goals for each – using data on preventable ED-use, hospitalization, rehospitalization, and other measures which can be used as benchmarks. Identifying which utilization is preventable shall be one of the first tasks undertaken by the workgroup.
- Data on use of imaging and other high cost services.
- Costs and spending associated with all utilization measures, broken out by payor group.
- An inventory of what services are located where, to be created with the assistance of the Maine Hospital, Medical, Osteopathic, Ambulatory Surgical, and Primary Care Associations (note: obtaining this information can be performed outside of an RFP, but the information would be included in the report prepared by the contractor). This inventory, along with existing Community Needs Assessments, can be used to conduct gap analyses to identify both redundancies and unmet needs.
- Updated data on hospital efficiency, as measured by cost per discharge, as shown on page 29.
- Once report is complete, the ACHSD will hold public hearings to decide what actions should be taken. These hearings will be linked to the District Health Forums discussed in the Variation Chapter. Spring, 2009.

## **2. Using Maine’s Existing Research and Analytic Capacity to Greatest Effect**

Maine has a range of data research and analytic capacity, both within state government (Maine Health Data Organization; the Maine Quality Forum; DHHS’s Office of Substance Abuse, Maine CDC/DHHS, and Office of Quality Improvement) and in the private sector (the Maine Health Information Center; the Muskie School’s Institute for Health Policy; Maine Center for Public Health; the University of New England’s Center for Health Policy, Planning and Research; and the MaineHealth, EMMC, MaineGeneral “One Maine” initiative). However, these groups might be more “siloeed” and less cost effective than is desirable to achieve coordinated and non-duplicative analysis.

**Goal:** Maine needs to develop a system that has dynamic capacity for collection, analysis, and applied solutions to address the complex questions of healthcare. We need to explore whether collaboration and cross-functioning across program

boundaries could result in increased analytic capacity with the same or lower costs to the system.

**Tasks:** MQF and GOHPF will convene a workgroup that includes, but is not necessarily limited to, the above-named parties to make recommendations on how to improve Maine's public and private health data collection and analysis resources so they work more effectively, efficiently, and across the system.

Issues to be addressed include, but are not necessarily limited to:

- To what extent are current data collection and analysis efforts siloed and/or redundant? How can efforts be coordinated to be more strategic and/or efficient?
- Should a uniform public-private process, system, and approach for conducting statewide, regional, and local health system needs assessments be developed?
- The possibility of developing a capacity-building training and technical support program to enhance the ability of state, regional and local organizations to effectively use health data, analysis, and research in programming and practice.
- Can and should Maine seek to become a national leader in health and claims data research and analysis, promoting economic development by bringing new work to Maine's research organizations?

The workgroup will convene in spring/summer 2008 and report back to the ACHSD by in fall/winter 2008-09.

**Goal:** Assuring that health data are more accessible and useable at the local level, building upon the success of the HHS District Health Profiles ([www.maine.gov/dhhs/boh/maine\\_dhhs\\_district\\_health\\_profiles.htm](http://www.maine.gov/dhhs/boh/maine_dhhs_district_health_profiles.htm)) developed by Maine CDC/DHHS and current data, epidemiological capacity, and technical assistance systems housed at Maine CDC/DHHS's central office and in District Public Health Units.

### **Tasks**

- Develop strategies for an ongoing health data technical assistance system for CCHCs (Comprehensive Community Health Coalitions) and DCCs- Maine CDC/DHHS working with CCHCs, by December, 2008.
- Implement a query-based web portal for easy access to the public for local public health data - Maine CDC/DHHS by July, 2008.
- Complete Health Status Profiles of populations facing disparities, such as the Medicaid population, elders, and those with disabilities and mental illness as resources allow - Maine CDC/DHHS/DHHS by December, 2009.

- Identify strategies to integrate appropriate collection of racial and ethnic minority health data into existing systems – Maine CDC/DHHS by December, 2009.

## **D. Patient Safety**

The Institute of Medicine, in its landmark 1998 report, “To Err is Human,” documented significant problems of medical mistakes and challenges to patient safety that result in serious, sometimes deadly impact on patients and significant costs to the health care system, finding that serious preventable medical errors – account for more deaths than HIV/AIDS or breast cancer. For that reason, it is crucial that we have strategies to reduce mistakes and improve patient safety.

### **1. Healthcare-Associated Infection**

When a patient is admitted to a healthcare facility, the patient and family may understand that positive results for the patient’s condition aren’t guaranteed. However, few may understand the additional risk of acquiring an infection as a result of receiving treatment in the healthcare setting. Healthcare-associated infection (HAI) is a problem nationally and in Maine. It is one of the ten leading causes of death in the U.S.

The result of HAI is staggering both in terms of individual pain and suffering and the costs of treatment. HAI includes central-line-associated bloodstream infection (CLAB), urinary tract infection (UTI), surgical site infection (SSI), ventilator-associated pneumonia (VAP), and the issues of multidrug-resistant organisms (MDRO), including methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile infection, and vancomycin-resistant enterococcus (VRE). These three major drug-resistant organisms cause 35,000 HAI annually with 12,000 deaths, at a cost of over \$5 billion (CDC/DHHS). In Pennsylvania, patients with HAI have increased length of stay (4.5 vs. 20.6 days), mortality (2.3% vs. 12.9%), and cost (\$31,000 vs. \$185,000).

Current performance measurement: Currently, Maine Quality Forum, through the MHDO, measures hospitals’ compliance with strategies for the prevention of ventilator-associated pneumonia and central line-associated bloodstream infection in high-risk patient populations and the incidence of central line-associated bloodstream infection. Also collected are data on appropriate antibiotic usage in perioperative patients. MQF and MHDO have been meeting regularly with infection-control personnel from Maine hospitals to discuss these data.

Current data required by MQF is summarized in the following table:

## CLINICAL INFECTION-RELATED MEASURES SUBMITTED TO MQF/MHDO BY MAINE HOSPITALS

MEASURE	DEFINITION	STRUCTURE/PROCESS/OUTCOME
HAI 1 *	CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTION IN ICU PATIENTS	OUTCOME
HAI 2	CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTION IN HIGH RISK NURSERY PATIENTS	OUTCOME
HAI 3	PERCENT COMPLIANCE WITH 5 EVIDENCE-BASED INTERVENTIONS FOR PATIENTS WITH CENTRAL LINES IN ICU'S	PROCESS
HAI 4	PERCENT COMPLIANCE WITH 4 INSERTION RELATED INTERVENTIONS IN PERIOPERATIVE PATIENTS	PROCESS
HAI 5	PERCENT COMPLIANCE WITH ALL 4 INTERVENTIONS IN PATIENTS ON VENTILATORS (TO PREVENT PNEUMONIA)	PROCESS
SCIP 1 **	PROPHYLACTIC ANTIBIOTIC WITHIN 1 HOUR PRIOR TO SURGICAL INCISION	PROCESS
SCIP 2	PROPHYLACTIC ANTIBIOTIC SELECTION	PROCESS
SCIP 3	PROPHYLACTIC ANTIBIOTICS DISCONTINUED WITHIN 24 HOURS FOLLOWING SURGERY	PROCESS
SCIP 6	SURGERY PATIENTS WITH APPROPRIATE HAIR REMOVAL	PROCESS

\* Healthcare Associated Infection

\*\* Surgical Care Improvement Project (CMS)



Currently there is considerable pressure on the infection control and epidemiology community in Maine to report publicly hospital-specific data on healthcare associated infection. This approach suffers from inadequate risk adjustment and problems with accurate diagnosis and risks diverting scarce infection control resources from attention to processes that have proven association with improved outcomes. Instead of concentrating on public reporting of outcomes, Maine Quality Forum has adopted the following as its approach to the problem of healthcare associated infection in Maine:

**Goals:** The goals of HAI intervention strategies are to reduce the rate of Healthcare Associated Infections (HAI), especially Multi Drug Related Organisms (MDRO), and increase compliance with known prevention strategies.

### Tasks

- MQF will improve dissemination of information regarding HAI which has already been collected. MQF, along with Maine's hospitals and infection control physicians and nurses, has established a method of reporting this information which allows hospital-specific data to be viewed. This will be available on the MQF website within three months. June, 2008

- MQF, along with three of Maine’s health systems, has committed to the development of a hospital infection control collaborative which all Maine hospitals will be welcome to join. This group will:
  - promote best practices and share resources for infection control, outbreak analysis, and antibiotic use, and will continue to refine and modify public reporting criteria and methods;
  - develop standards for hospital infection control and prevention programs by which all hospitals’ programs can be measured; MQF will serve as reviewer and arbiter of these programs and will report publicly on the presence of approved programs in Maine’s hospitals;
  - explore and assess other reporting options such as the national Healthcare Safety Network, an internet-based surveillance and reporting system supported by the national Center for Disease Control and Prevention begun in 2007.

Part of the reason for the emergence of antibiotic-resistant strains of microorganisms is injudicious use of antibiotics. Over the last twenty years, more numerous and more complex antibiotics have been developed. Principles governing their use, such as dosage and duration, have also become more complicated. As a result, correct use of antimicrobial drugs is beyond the training of many physicians. Several larger institutions in Maine have developed resources for physicians to help with antibiotic management, called antibiotic stewardship programs, which provide consultation and supervision of treatment by infectious disease specialists and clinical pharmacologists. In our own and other states, these programs have clearly demonstrated their ability to diminish complications.

**Tasks:** An infectious disease collaborative could support spread of such programs to other hospitals, lending further expertise to that which many smaller hospitals have in their pharmacy services.

- The Maine Quality Forum will continue to work with providers to develop a more robust set of process and outcome indicators to add to those listed above, as these measures are developed and validated.

## 2. Sentinel Event Reporting

As noted earlier, the Institute of Medicine “To Err is Human” report found that serious preventable medical errors – also known as “sentinel events” – account for more deaths than HIV/AIDS or breast cancer.

According to the report, these errors occur because our health care system is complex, and ever changing and our systems do not always adapt quickly enough. The IoM points out that protecting patient safety is not about blame – it’s about building safe systems to prevent the error in the first place.

A pre-requisite for safety is a robust reporting system, so that errors are known, reported, and analyzed and systems are improved to prevent recurrence. The IoM calls for a two tiered approach to reporting: the first a voluntary system with patient and health facility information protected that assures internal reporting and improvement processes for “near misses” – those medical errors that don’t cause serious illness nor death. By protecting that kind of reporting, health facilities are assured the opportunity to build system reforms to prevent errors. However, errors may still occur and when those errors cause death or serious disability, the IoM argues for mandatory and public reporting.

In 2002, the National Quality Forum adopted -- through a consensus process involving consumers, providers, purchasers, policy makers, and researchers -- a list of 27 “serious reportable events”. This list provides a framework for standardized data collection and reporting within and across states. The list was later expanded to 28 events, and in 2005 NQF adopted a “taxonomy” developed by JCAHO to assist in the classification and investigation of serious reportable events.

Also in 2002, the Maine Legislature enacted a sentinel event reporting law in Maine using a list of events that differed in several ways from NQF. This has been an important and collaborative initiative to begin Maine’s process to assure that medical errors are prevented through robust reporting, confidentiality and training and system review so we learn from our mistakes and errors don’t occur again.

Each year the Department of Health and Human Services has reported to the Maine State Legislature on its progress in working with Maine’s health facilities through the sentinel event reporting system. This year’s report, concludes that Maine significantly under-reports sentinel events and recommends changes to the statutory language to reduce ambiguity about what must be reported. Specifically, it recommends that Maine’s reporting law include the National Quality Forum (NQF) adverse health events list, as was included in the language of LD 2044. This recommendation was initially proposed by the Maine’s Quality Forum in 2005, following an evaluation it conducted with the Muskie School.

The National Quality Forum provides an important benchmark against which Maine can measure its success in reporting and resolving medical errors, but Maine’s law requires events to be reported only when the facility determines errors to be unrelated to the natural course of the patient’s illness or underlying condition or proper treatment of that illness or underlying condition. This “proper treatment” clause enables facilities to review sentinel events and determine whether they are the result of proper treatment. This discretion may lead to under-reporting and is inconsistent with the well-established National



Quality Forum standards and needs to be reviewed, as recommended by DHHS in this year's annual report.

The NQF list is specifically designed to include only those outcomes that the facility should be able to prevent and address. Among other things, NQF's criteria for inclusion in the list of serious reportable events is "of a nature that the risk of recurrence is significantly influenced by the policies and procedures of the healthcare facility." To be included in the list, an event must be "usually preventable," where preventable is defined as "could have been anticipated and prepared for, but that occurs because of an error or other system failure." At least one-half of the 27 states with reporting laws use these national standards.

**Goal:** Review Maine's Sentinel Event Reporting system to improve compliance and utility.

### **Tasks**

- DHHS's Division of Licensing and Regulatory Services will convene a stakeholder workgroup to review the current system and suggest legislative changes and report to the ACHSD by November, 2008.
- DHHS will propose any needed legislative changes by May, 2008.

### **3. Critical Access Hospital (CAH) Collaborative**

Fifteen of Maine's thirty-six acute-care general hospitals have been designated as "critical access" hospitals by the Center for Medicare and Medicaid Services (CMS). This means that they have agreed to abide by certain conditions, including: a maximum bed size, twenty-four hour emergency room coverage, and an average length of stay of ninety-six hours or less. These hospitals are reimbursed on a cost basis by CMS. Critical access status has allowed many small rural hospitals to remain open and continue to provide care in their communities.

Because of their relatively small size and generally lower patient acuity than that of larger hospitals, the performance indicators used to measure quality of care at larger hospitals may be less reliable for analysis of care at small hospitals. However, issues of patient safety are relevant for all hospitals regardless of size.

With this in mind -- and in order to take advantage of various experiences of hospital within the group of critical access hospitals in Maine -- fourteen of Maine's critical access hospitals have convened to collaborate on projects related to patient safety. This collaborative has been supported by the Maine Quality Forum with technical support from the Muskie School's Institute for Health Policy, and by the Office of Rural Health at the Department of Health and Human Services. The Maine Health Access Foundation is providing financial support for

the planning phase. Each hospital in the group is committed to a project in the area of medication safety.

The initial planning process will be finished and reported to the Maine Quality Forum and MeHAF in July, 2008.

Projects will be started at individual hospitals and finished by December, 2009.

## **E. Certificate of Need and the Capital Investment Fund**

Two of the purposes of the State Health Plan expressed in statute are to: (1) assist in the determination of the level of capital investment Maine will make in health care each year, and (2) guide the approval of applications for Certificates of Need by the Department of Health and Human Services. Specifically, the law requires that a Certificate of Need application or request for public financing cannot be provided unless the project meets a range of statutory requirements and is consistent with goals explicitly outlined in the State Health Plan.

Certificate of Need (CON) is a regulatory program currently in effect in 36 states and the District of Columbia that reviews and either approves or denies certain types of projects undertaken by health care facilities. In Maine, CON review is required for the expansion of existing services or facilities that cost more than a certain amount, the establishment of new services, or substantial reductions in capacity of certain types of providers.

The rationale for CON programs is that ample evidence shows that supply of health care services has been shown to increase their use – and thus health care spending – even when their use does not bring corresponding improvements in health outcomes.<sup>30</sup> CON programs aim to ensure that investments are made only in new projects that efficiently meet the needs of the population to be served and have a positive impact on health status.

Historically, only about one-quarter of all capital investments made by hospitals in Maine (the type of provider most often impacted by CON requirements) fall under CON scrutiny, making it all the more important to maximize the usefulness of this planning and cost containment tool to ensure that the largest capital projects (those subject to CON rules) are rigorously reviewed for adherence to planning principles, assisting in the orderly development of a high quality health care system for Maine.

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<sup>30</sup> For instance, the Dartmouth Atlas Project has shown that geographic areas with more specialists and/or beds have higher use of costly services, with no improvement in quality or outcomes. Also, a recent report by the McKinsey Global Institute found that the US has three to six times more scanners than Germany, UK, France and Canada, and 30 to 40% of the US's diagnostic imaging is "inappropriate or noncontributory."

## The Capital Investment Fund

One of the constraints the law puts on Certificate of Need is an annual limit – called the Capital Investment Fund (CIF) – on the third year operating costs (i.e., the annual cost to the health care system once a project is fully implemented). Its purpose is to ensure that the infusion of new capital into Maine's health care system remains balanced with Mainers' ability to financially support the added costs of those new investments.

The CIF value is determined annually by the Governor's Office with review and comment by the ACHSD and after public comment following a process set out in regulation and approved by the Legislature.<sup>31</sup> Depending on the costs of proposed projects the CIF may or may not be large enough to accommodate approval all of pending applications, reinforcing its purpose as a cost containment tool.

For instance, if the CIF is set at \$6 million and combined third year costs of projects under review total a value of \$8 million where no one project exceeds \$2 million in costs, not every project will be able to be approved; only \$6 million worth of projects can go ahead.<sup>32</sup> In that situation, proposals will compete with one another, with those deemed by the Department of Health and Human Services to best meet the CON requirements being approved, with the remaining proposals being turned down and being eligible for reconsideration the following year, provided that the proposals were turned down solely because of lack of CIF funding.<sup>33</sup>

Importantly, just because there is room within the CIF does not mean that a project will be approved; a project will be approved only if it meets certain statutory and regulatory guidelines (see Appendix IV for statutory language pertaining to (1) the role of the State Health Plan as it relates to CON, and (2) the Commissioner's bases for CON decisions) *and* there is sufficient room within the CIF.

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<sup>31</sup> See Appendix 2 to this chapter for a more detailed discussion of the Capital Investment Fund and how its value is determined.

<sup>32</sup> Section 5 of the CIF rule requires that the costs of large projects be spread over multiple years for purposes of debiting against the CIF. This precludes a single large project from monopolizing an entire year's CIF. The maximum "hit" of any one project in a single year is limited to \$2 million; costs from \$2-4 million are debited equally over two years, \$4-6 million over three years, etc. The result of this provision is that the total amount approved in any year can exceed what is available under the CIF that year, but what is available under the following year's CIF is then reduced by some or all of the amount that was not debited under the original year.

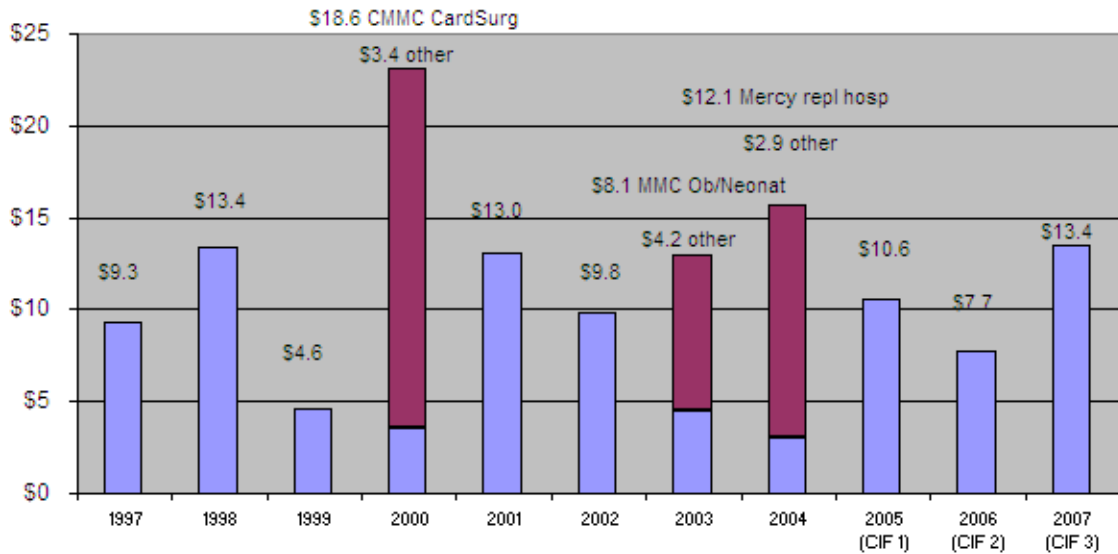
<sup>33</sup>Projects denied for other reasons may not be resubmitted for three years.

Under the first three CIFs (2005, 2006, 2007), no projects were turned down due to insufficient CIF funding. As of the date of this draft, the 2008 CIF has not yet been set.

The CIF's impact so far is shown in the figure below, which shows total third year operating costs of hospital projects approved each year under CON from 1997 – 2007. While the amount fluctuates significantly year to year, it is useful to compare activity under the CIF to activity before the CIF as a reference (all costs shown are 3<sup>rd</sup>-year operating costs, including adjustments for inflation so these are apples to apples comparisons):

- The average amount that has been approved under the first three CIFs is \$10.6 mil.
- This is 17% below the annual average in the eight years before the CIF went into effect (\$12.7 mil).
- In those eight years, several years with high values were driven by extremely large projects (e.g., CMMC's \$18.6 mil project in 2000, Maine Med's \$8.1 mil project in 2003, and Mercy's \$12.1 mil project in 2004); the CIF rule makes room for such projects by allowing their costs to be spread over multiple years.

**Inflation-Adjusted 3<sup>rd</sup> Year Operating Costs (mil) of Approved Hospital CON Projects, 1997-2007**



**Average annual approvals 1997 – 2004 , including 3 extremely large projects: \$12.7 mil; average annual approvals 1997 – 2004**

**Average annual approvals under 3 CIFs: \$10.6 mil**

Each year the CIF is in place, it creates new savings not just in that year, but in future years as well. That is because, once a project is built, it becomes part of the health care system, and its costs become part of annually recurring health care expenses. Looking at the impact of the first three CIFs forward to 2009, the 2005 CIF saves \$2.2 mil in 2006, 2007, 2008, and 2009; the 2006 CIF saves \$2.2 mil in 2007, 2008, and 2009; the 2007 CIF saves \$2.2 mil in 2008 and 2009, totaling almost \$22 mil in cost reductions.

Importantly, these are costs to providers. Payors pay a margin on top of those costs, which will vary based on the type of service.

In reviewing the CIF and receiving public comments each year, the ACHSD heard testimony from hospitals that the process in the current regulation (1) makes it difficult for hospitals to do strategic planning, because the available CIF amount can vary significantly from one year to the next, and (2) results in a number that is too low (based in part on its adjusting for affordability using a cost measure that is based on the Medicare wage index, which the MHA says makes Maine hospitals appear less efficient than other hospitals<sup>34</sup>). Consumer groups, on the other hand, have testified in support of the rule in its current form.

Based on this input, the ACHSD will – prior to the setting of the 2009 CIF amount – examine the possibility of revising the regulation to deal with these issues, including the possibility of a multi-year CIF.

1. GOHPF convenes an ad hoc group to develop options to revise rule for ACHSD consideration.
2. GOHPF presents options to revise rule for ACHSD consideration.
3. If decision is made to revise the rule, GOHPF proposes revised Rule in sufficient time for review by the Legislature in 2009.

#### Setting Priorities for Certificate of Need

As mentioned above, statute requires that a Certificate of Need application cannot be approved unless the project meets a range of statutory requirements and is consistent with goals explicitly outlined in the State Health Plan. Appendix IV contains statutory language pertaining to (1) the role of the State Health Plan as it relates to CON, and (2) the Commissioner's bases for CON decisions.

The purpose of this section of the Plan is to provide clear guidance to the Department and applicants regarding project attributes that will be deemed as consistent with the goals of the Plan, and to prioritize the capital investment

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<sup>34</sup> See chapter III A i for more discussion of the Medicare wage index.

needs of Maine's health care system within the CIF in the event that there is not enough room under the CIF for all meritorious projects to be approved.

It is important to note that the order of the attributes below does NOT reflect the relative order of importance of each attributes, as different attributes might be needed to different degrees in different circumstances and geographic areas. Projects that meet more of these attributes shall receive higher priority than projects that meet fewer of these attributes.

1. **The applicant is redirecting resources and focus toward population-based health and prevention.** This includes addressing – at a population level as opposed to an individual patient level – the most significant health challenges facing Maine – cardiovascular disease, cancer, chronic lung disease, diabetes, depression and substance abuse.
  - “Population-based” means all people in the service area, not just those who become patients. It may also be a specific “at-risk” population within the targeted service area.
  - Applicants that include in their application a new, sustainable investment in public health programs/activities or an additional investment in existing programs/activities will be a higher priority than those applicants simply citing extant activities.
  - Applicants hoping to meet this priority should demonstrate the need for the investment by engaging with their local Comprehensive Community Health Coalitions (CCHCs), also known as the Healthy Maine Partnerships (HMPs) and their community health plans, especially those done using the MAPP Process (Mobilizing for Action through Planning and Partnerships - [http://mapp.naccho.org/mapp\\_glossary.asp](http://mapp.naccho.org/mapp_glossary.asp)).
  - Applicants proposing new or expanded public health initiatives must include evidence the proposed strategies will: meet community needs, engage the public health infrastructure, are effective evidenced-based strategies, and will effectively evaluate the effectiveness and impact of the initiative. Applicants proposing new or expanded public health initiatives must also include in their application a plan to collect data to report the impact of their new efforts. To meet this priority, applicants citing extant activities must present evidence of the effectiveness of their current efforts, as well as an explanation of why new activities are not feasible and/or necessary at this time.
  - An example of an investment that could meet this priority includes, but is not limited to: the creation of an endowment, the interest from which would support evidence-based effective efforts, preferably using existing public health infrastructure, for primary and secondary prevention of chronic disease, with the long-term result being a reduction in the need for the services proposed in the application.

- Smaller hospitals or other applicants who do not have as many resources as larger hospitals could meet the priority to make new investment in public health by, for example, establishing a partnership with or making some form of financial or other contribution to existing public health infrastructure with activities in the service area.
  - CONU may also consider partnerships between hospitals as a possible way to meet this priority, provided that the hospitals present evidence of the effectiveness of their proposed and/or extant public health efforts.
  - Applicants that demonstrate success in coordinating their activities with local public health infrastructure – thereby leveraging existing resources and avoiding redundant efforts – will receive higher consideration than those who fail to do so.
2. **The applicant has a plan to reduce non-emergent ER use.**<sup>35</sup> Because, as noted elsewhere in the plan, ER use for non-emergent services is a cost driver, applicants will receive priority for having a plan to reduce inappropriate utilization. Examples include:
- Partnering with local physicians or clinics to assure after hours primary care.
  - Triageing patients who present at the ED with non-emergent health needs to a clinic to meet such needs after hours within the hospital, with services to be billed at a non-ED rate.
  - For hospitals that own and/or operate practices, evidence that the hospital has taken actions to expand hours, etc and address the particular population that usually uses the ER inappropriately.
  - Applicants hoping to meet this priority must have a plan to measure the effectiveness of their plan.
3. **The applicant demonstrates a culture of patient safety, that it has a quality improvement plan, uses evidence-based protocols, and/or has a public and/or patient safety improvement strategy for the project under consideration and for other services throughout the hospital,** as well as a plan – to be specified in the application – to quantifiably track the effect of such strategies using standardized measures deemed appropriate by the Maine Quality Forum. Measures deemed appropriate include relevant structural, process, and outcome measures chosen from among those approved by the National Quality Forum. In the absence of NQF-endorsed relevant measures, measures developed by medical specialty societies or other medical care quality organizations such as AQA or HEDIS which are related to the project goals should be used.
4. **The project leads to lower cost of care / increased efficiency through such approaches as collaboration, consolidation, and/or**

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<sup>35</sup> This priority does not apply to applicants that do not have Emergency Departments.

**other means.** Projects that clearly demonstrate that they will generate cost savings either through verifiable increased operational efficiencies or through strategies that will lead to lower demand for high cost services in the near and long term. These types of projects may include projects that address areas of local duplication, that include collaboration such as envisioned by the Hospital Cooperation Act, that physically consolidate, down-size, or right-size hospitals or services that serve all or part of the same area, and that demonstrate an appropriate, cost effective use for the “abandoned” infrastructure.

5. **The project improves access to necessary services for the population.** Projects that improve access to necessary services – as defined in 22 MRSA 335(7)(C) – that were previously unavailable to the population – or that expand the availability of extant necessary services to populations who did not previously have access to such services – will be deemed as higher priority than projects that do not.
6. **The applicant has regularly met the Dirigo voluntary cost control targets.**
7. **The impact of the project on regional and statewide health insurance premiums, as determined by BOI, given the benefits of the project, as determined by CONU.**
8. **Applicants (other than those already participating in the HealthInfoNet Pilot) who have employed or have concrete plans to employ electronic health information systems to enhance care quality and patient safety.** Applications of electronic health record systems might include computerized physician order entry, pharmacy systems, PACS (picture archive and communications systems), and systems which allow information transfer between physician offices and the hospital. Preference will be given to applicants demonstrating commitment and progress toward full implementation of interoperable Certification Commission for Health Information Technology (CCHIT)-certified electronic health records in their institutions and a plan for integration with the statewide health information exchange.
9. **Projects done in consultation with a LEEDS certified-architect that incorporate “green” best practices in building construction, renovation and operation to minimize environmental impact both internally and externally.**

**In the event that there is not enough room under the CIF for all meritorious projects to be approved,** and projects rank similarly in terms of



possessing the attributes outlined above, the Department should first work with applicants to see if it is possible to remove lower priority components of the application, with the goal of fitting all projects within the CIF. If that fails, the Department should base its ranking of projects specifically according to consideration of each project's aggregate impact on the following four areas: costs/efficiency; quality and patient safety; health status; and access to services.

Meritorious projects that are not approved solely due to insufficient room under the CIF will be eligible for approval under the subsequent CIF.<sup>36</sup>

Finally, the Plan recommends that the Department use its authority to collect data from applicants whose projects are approved to document how actual outcomes compare to outcomes projected in the application, and that the Department report annually to the ACHSD.

### **The Role of the Maine Quality Forum, Maine Center for Disease Control and Prevention, and the Bureau of Insurance**

- MQF shall provide guidance to CONU on quality, patient safety, inappropriate increases in service utilization, and any other areas deemed appropriate by MQF and CONU.
- Maine CDC/DHHS shall provide a written assessment of the extent to which projects address specific health problems as measured by health needs in the area to be served by projects, whether projects will have a positive impact on the health status indicators of the population to be served, the extent to which the application meets the SHP priorities from a public health standpoint and any other areas deemed appropriate by CDC/DHHS and CONU.
- BOI shall provide a written assessment of the impact of the project on the cost of health insurance in the state.

These assessments become part of the record that is used by the Commissioner in making final CON approval determinations. However, these assessments are not the sole considerations relied upon by the Commissioner, who may disagree with the findings of these agencies and who is not bound by their findings. When the Commissioner's final decision on a CON application runs counter to comments and recommendations in the record, that final written decision should address the reasons for departing from those comments and advice.

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<sup>36</sup> Projects denied for other reasons may not be resubmitted for three years.

## **Chapter III. Accountability: Delivering on Our Promises**

The State Health Plan is more than a written document. It represents the hope of Maine people to have better health and access to quality and affordable healthcare. Turning the plan into action and action into results is the work of the many groups identified throughout the Plan. The role of the ACHSD is to hold the many contributors accountable for the work they will do and the results they intend to deliver. The Council will accomplish this through meetings with stakeholders and progress reports. Additionally, the ACHSD will support the work of these groups when and if they encounter barriers to delivering the results promised.

The following chart summarizes the tasks laid out in the preceding pages, to be accomplished during the next biennium, including time frames and responsible person/group. The ACHSD will use this chart in overseeing the important work of putting the plan into action.

Longer term progress towards meeting goals will be assessed in a range of ways. For instance, we can measure our progress towards becoming the healthiest state by tracking how we perform relative to other states for the many health measures included in Appendix II. To assess our progress in moving towards achieving an efficient, effective and high-performing health delivery system, the ACHSD will look at the Commonwealth Fund's recently developed measures of state health system performance and investigate how they might be further developed to track Maine's progress. Performance targets for public health infrastructure performance will be developed over time. And importantly, the ACHSD will collect evidence on an ongoing basis of how each task advances the goals, ensuring accountability and refinements to strategies and tasks over time.

As the ACHSD reviews the work of the many groups, it will report to the Governor and Legislature and the public what it is learning about the successes and barriers to becoming the healthiest state with an efficient and effective health delivery system, as well as the support needed to achieve these goals. The commitment and work that lie ahead are great and the need to be successful is even greater.

<b>Tasks</b>	<b>Due Date</b>	<b>Responsibility</b>
<b>Streamlined statewide public health infrastructure</b>		
<u>Statewide Coordinating Council:</u>		
<ul style="list-style-type: none"> <li>Convene and staff the Public Health Statewide Coordinating Council (SCC) with defined leadership and action plan to advise on the ongoing implementation of the public health infrastructure and assure efficient and effective public health functions.</li> </ul>	June 08	CDC/DHHS, GOHPF
<ul style="list-style-type: none"> <li>SCC will report annually to the Governor's Advisory Council on Health Systems Development on matters related to public health infrastructure.</li> </ul>	Dec 2008	SCC, CDC/DHHS, GOHPF
<ul style="list-style-type: none"> <li>Determine the most cost effective approach to having a unified public health plan that meets the criteria of the U.S. DHHS Healthy People decadal initiative (upcoming Healthy People 2020) as well as a statewide health assessment every 5 years, as desired by some health systems and others, such as the OneMaine Collaborative.</li> </ul>	Dec 2008	CDC/DHHS, GOHPF, SCC, ACHSD, and others such as OneMaine Collaborative
<u>District Coordinating Councils:</u>		
<ul style="list-style-type: none"> <li>Public Health DCCs will be designated and functional in each of the 8 HHS Districts and serve as a district-wide representative body for collaborative planning and decision-making for functions that are more efficiently and effectively performed at the district level.</li> </ul>	Dec 2008	CDC/DHHS and SCC
<ul style="list-style-type: none"> <li>Public Health DCCs will have working relationships and participation with the major health care systems in the District, including behavioral/mental health care providers.</li> </ul>	Dec 2008	CDC/DHHS and SCC
<ul style="list-style-type: none"> <li>Public Health DCCs will conduct an assessment of adult and childhood immunization needs in the district, using data from Maine CDC/DHHS, with long term goal that 90% of all Maine children and adults will have received recommended immunizations.</li> </ul>	Dec 2009	Public Health DCCs
<u>Local Health Officer (LHO) System:</u>		
<ul style="list-style-type: none"> <li>Complete the modernization of LHO statutes – Maine CDC/DHHS with the Legislature.</li> </ul>	June 2008	CDC/DHHS
<ul style="list-style-type: none"> <li>Complete the rule-making for LHO requirements.</li> </ul>	June 2008	CDC/DHHS
<ul style="list-style-type: none"> <li>Implement LHO annual training program in each HHS District.</li> </ul>	June 2009	CDC/DHHS
<ul style="list-style-type: none"> <li>Complete the formation of Maine CDC/DHHS Public Health Units with co-located staff and District Public Health Liaisons within each HHS District in DHHS Offices.</li> </ul>	Dec 2009	CDC/DHHS
<ul style="list-style-type: none"> <li>Complete Maine CDC/DHHS organizational realignment to most effectively and efficiently serve the needs of the public and to work hand in hand with the public health infrastructure.</li> </ul>	Dec 2009	CDC/DHHS
<b>Patient Centered Medical Home</b>		
<u>Development of a Patient Centered Medical Home model</u>		
<ul style="list-style-type: none"> <li>Formation of a wider steering group to guide the pilot.</li> <li>Identification of key principles for a Maine-based model which is consistent with emerging national models and supports principles that are unique to Maine.</li> <li>A structured process for obtaining direct input from patient and consumers about their vision for the medical home.</li> <li>Identification of clear goals for the pilot.</li> </ul>	Oct 2008	MQF

<ul style="list-style-type: none"> <li>• A framework for evaluation of the pilot, including specific performance measures and data sources.</li> <li>• Maine Quality Forum will evaluate the capability of the paid-claims database and other datasets to measure improvements in unwarranted care variation as a result of adoption of the medical home model.</li> <li>• Convening of all major private and public payers in Maine to discuss a common framework of reimbursement policies and methods.</li> <li>• Exploration of the opportunity to participate in the planned Medicare medical home demonstration project.</li> <li>• Recommendations for benefit design elements needed to support effective implementation of the medical home.</li> </ul>		
<b>Implementation of a Patient Centered Medical Home pilot</b> <ul style="list-style-type: none"> <li>• A methodology to identify practices to participate in the pilot.</li> <li>• A plan and methods to support the practice transformation needed to become a medical home.</li> <li>• A plan for linking pilot practices with local community resources and the public health infrastructure.</li> <li>• Funding sources to support the pilot project.</li> </ul>	spring 2009	MQF
<b>Coordination of Public Health and Behavioral Health Systems</b>		
<ul style="list-style-type: none"> <li>• Identify resources to continue the depression and mental health questions on the Maine CDC/DHHS' Behavioral Risk Factor Surveillance System ongoing telephone questionnaire.</li> </ul>	Oct 2008	Maine CDC/DHHS Office of Quality Improvement & Office of Adult Mental Health Services
<ul style="list-style-type: none"> <li>• Develop a public health strategic plan, using an inclusive stakeholder process, on how to further integrate behavioral health into existing public health work.</li> </ul>	Dec 2009	CDC/DHHS by
<ul style="list-style-type: none"> <li>• Implement a joint DCC (Public Health District Coordinating Council) - CSN (Mental Health Community Service Network) initiative in at least one HHS District as a pilot.</li> </ul>	Dec 2009	CDC/DHHS and Adult Mental Health Services/DHHS
<b>Other Maine-based Integration Initiatives</b>		
<ul style="list-style-type: none"> <li>• ACHSD, the MQF Advisory Council, and the Patient Centered Medical Home Steering Committee will invite MeHAF to share information and lessons learned from the Integration Initiative grants as information becomes available.</li> </ul>	starting in 2009	ACHSD, MQFAC, MeHAF, and the Patient Centered Medical Home Steering Committee
<ul style="list-style-type: none"> <li>• ACHSD the MQF Advisory Council, and the Patient Centered Medical Home Steering Committee will invite MeHAF and the University of Southern Maine to present findings from the study of barriers to integration. The focus will be on those barriers with policy implications relevant for state and ACHSD action and oversight.</li> </ul>	Summer/Fall 2008	
<b>Worksite Wellness</b>		
<ul style="list-style-type: none"> <li>• Draft evidence Based criteria to guide employer sponsored worksite wellness programs.</li> </ul>	Summer 2008	Maine Council on Worksite Wellness
<b>Supporting Dirigo's Goal of Universal Access During Challenging Economic Times</b>		
<ul style="list-style-type: none"> <li>• Identify efficiencies to reduce program costs, to sustain and, if possible, grow coverage including but not limited to such options and strategies as: establishment of an asset test; restructuring the subsidy structure; incentivizing small employers</li> </ul>	Oct 08	DHA Board of Trustees

to take up coverage; targeting enrollees to cover more uninsured; maximizing MaineCare financing as appropriate and investigating innovations in product design, resulting in proposals to reduce cost/create efficiencies to maximize coverage of un and underinsured.		
<ul style="list-style-type: none"> <li>• Work with stakeholders and examine current regulations governing the small group market. If reforms are not enacted in 2008 in the individual market, potential strategies to increase the availability of affordable products in that market will be included in the review and report to the ACHSD and the Joint Committee on Insurance and Financial Services. Deliverable "policy option" proposal by...</li> </ul>	Oct 08	GOHPF and BOI
<ul style="list-style-type: none"> <li>• MaineCare Services will continue its efforts to improve the overall health care status of its members by implementing a system-wide approach to care management. The initiatives include expanding its Primary Care Case Management, followed by the development with stakeholder groups and in participation with the MQF-convened initiative, to create a Patient Centered Medical Home model to ensure a comprehensive, optimal cost- and outcome-oriented approach to healthcare for MaineCare members. Policy Development for this model with an implementation date of...</li> </ul>	Jan 2009	MaineCare
<ul style="list-style-type: none"> <li>• Monitor implementation of this State Health Plan recognizing that the plan includes key strategies to make health care more affordable and accessible in Maine.</li> </ul>	Quarterly, ongoing	ACHSD
<ul style="list-style-type: none"> <li>• Work with the National Governors Association and our Congressional Delegation to provide information based on the Dirigo Health Reform experience, and track, analyze, and advocate for national solutions to achieve universal access to health care.</li> </ul>	ongoing	GOHPF and ACHSD
<ul style="list-style-type: none"> <li>• ACHSD requests that BoI, to the extent that resources permit, provide the Council with information gathered from insurance carriers' 945 reports regarding previously uninsured enrollees.</li> </ul>	ongoing	BoI
<ul style="list-style-type: none"> <li>• ACHSD (1) invites BOI to present to the ACHSD information regarding the experience of carriers electing to file small group rates under the optional guaranteed loss ratio provisions of the Insurance Code; and (2) urges BOI, to the extent that resources permit, to review and report on historical changes in insurance carrier profitability.</li> </ul>	ongoing	BoI
<b>Implementation of the Oral Health Improvement Plan</b>		
<ul style="list-style-type: none"> <li>• Working with partners, refine the Plan's strategies.</li> <li>• Develop a timeline that will keep the Plan active and current.</li> <li>• Identify specific activities, key players and areas of responsibilities.</li> <li>• Recommendations to Governor.</li> </ul>	Dec 2008	Maine CDC, Maine Dental Access Coalition, Governor's Task Force on Expanding Access to Oral Health Care
<b>Rural Health Plan</b>		
<ul style="list-style-type: none"> <li>• Hold three regional listening sessions to obtain input, comments, and suggestions from the larger rural health community and finalize the Rural Health Plan.</li> </ul>	July 2008	CDC/DHHS Office Rural Health & Primary Care
<ul style="list-style-type: none"> <li>• Develop a plan for Maine's federally funded Rural Hospital Flexibility Program with a two to three year strategic vision consistent with the Rural Health Plan.</li> </ul>	September 2008	
<ul style="list-style-type: none"> <li>• Convene the Healthcare Workforce Forum and foster more effective partnerships between higher education institutions and health care providers.</li> <li>• Create a work group charged with the development of rural quality and performance relevant indicators.</li> </ul>	June 2009	

<b>Telemedicine</b>		
• Identify and invite key leaders in telemedicine to an ongoing forum to begin by...	Oct 2008	CDC/DHHS Office Rural Health & Primary Care
• Work with forum members to develop a strategic plan with timeline of specific action steps and areas of responsibility by...	April 2009	
• Keep apprised of developments in implementation of FCC grant.	ongoing	
• Annual progress report to ACHSD starting in April 2009.	ongoing	
<b>Possible Role for Federally Qualified Health Centers (FQHCs) in Providing Veterans' Care</b>		
• Investigate the possibility of FQHCs' contracting with the VA Affairs to provide care for Maine veterans.	Summer 2008	GOHPF & MePCA
<b>Emergency Department Over-Utilization</b>		
<ul style="list-style-type: none"> <li>• Convene a group of stakeholders representing emergency department personnel, primary care physicians, Behavioral Health, EMT, MaineCare, large and small hospitals, payors, police, medical specialties, medical clinics. <ul style="list-style-type: none"> <li>- Identify the extent, costs, and characteristics of non-emergent care provided in emergency departments and the demographics of patients accessing non-emergent care in emergency department settings. Study should also investigate extent to which ED-use leads to increased tests and use of imaging, as well as associated costs.</li> <li>- Analyze the cost and availability of 24/7 non-emergent care in both urban and rural areas.</li> <li>- Complete a cost comparison analysis of non-emergent care in hospital emergency departments Vs 24/7 non-emergent care venues.</li> <li>- Identify potential venues for 24/7 non-emergent care including primary care offices, clinics, hospital based clinics, and FQHCs, and – recognizing that different parts of the state have different infrastructures and face different issues – complete a cost analysis on providing 24/7 non-emergent care in these venues.</li> <li>- Report to ACHSD on cost saving and availability of 24/7 non-emergent care. ACHSD will determine if the cost savings and quality of care improvements justify furthering the study to identify strategies for reducing non-emergent care in emergency departments.</li> </ul> </li> </ul>	Convene June 2008, rpt Nov 2008	GOHPF / workgroup
• Identify incentives, regulations, and/or other strategies to create a supply of 24/7 non-emergent care, where appropriate, and prepare a report for the ACHSD.	Feb 2009	GOHPF / workgroup
• Report to the Legislature recommendations for creating 24/7 non-emergent care availability in Maine.	March 2009	ACHSD
<b>Reducing Variation in Medical Practice</b>		
<u>Areas Where There Are National Consensus Standards about "What Is the Right Rate"</u>		
• Analyze Maine variation in primary care and cardiac care practice -- areas where there are national consensus standards about "what is the right rate" -- through the all payor claims database.	July 1, 2008	MQF
• Once the analysis is complete, MQF will convene a workgroup consisting of members of the Pathways to Excellence primary care and cardiology providers group and other interested practitioners to develop strategies to promote the right rate of care in all communities.	Sep 30, 2008	
<ul style="list-style-type: none"> <li>• Activities will then be ongoing.</li> <li>• Process for measuring progress will be ongoing analysis of the claims database (on a biannual basis).</li> <li>• As new consensus standards relevant to other medical specialties emerge at the national level, MQF will develop plans to measure and promote the right rate of care in the those specialties as well.</li> </ul>		
<u>Areas Where There Are Not Yet National Consensus Standards</u>		
• MQF's 11 "Butterfly charts"		
- Update all charts data to include 2004-2007 data.	end of 2008	MQF

<ul style="list-style-type: none"> <li>- Determine which services are high priority/short term focus areas, based on consideration of gains in both patient safety and costs savings, as well as changes from the 1999-2003 data.</li> </ul>	March 2009	MQF/MQFAC
<ul style="list-style-type: none"> <li>- Convene appropriate stakeholders to generate discussion about lessening the variation for the designated high priority/short term focus areas.</li> </ul>	May 2009	MQF
<ul style="list-style-type: none"> <li>- Activities will then be ongoing.</li> <li>- Process for measuring progress will be ongoing analysis of the claims database (on a biannual basis).</li> </ul>		MQF
<ul style="list-style-type: none"> <li>• Data from the District Healthcare Utilization Profiles: Hold forums in each of the 8 HHS Districts with District Coordinating Councils (DCCs) to review District Health Utilization Profiles (see data chapter), to engage stakeholders (e.g., healthy Maine Partnerships, Quality Counts, and others) in addressing district-specific issues, and get input regarding specific actions that ACHSD can recommend in its future recommendations.</li> </ul>	Spring 2009	ACHSD, MQF and Maine CDC/DHHS
<b>Prototypes for Evidence Based Medicine - In A Heart Beat and Stroke Systems of Care</b>		
<ul style="list-style-type: none"> <li>• Spokespersons in community organizations will be trained through train the trainer model. MQF, CDC/DHHS Cardiovascular Health Program, Active Community Engagement Workgroup.</li> </ul>	March 2008	MQF, CDC/DHHS Cardiovascular Health Program, Active Community Engagement Workgroup
<ul style="list-style-type: none"> <li>• Explore and develop outreach strategy for high risk populations and develop a consistent message to be utilized by health systems and health care providers.</li> </ul>	June 2009	MQF, CDC/DHHS Cardiovascular Health Program, Active Community Engagement Workgroup
<ul style="list-style-type: none"> <li>• Evaluate the impact on the public's knowledge and ability to take appropriate action using the Behavioral Risk Factor Surveillance System survey</li> </ul>	Dec 2009	Maine CDC/DHHS
<ul style="list-style-type: none"> <li>• Progress toward collective state-wide initiatives surrounding stroke systems of care will be compiled and reported by the "Stroke Care in Maine" workgroup yearly with the goal of inclusion in the next biennial State Health Plan</li> </ul>		Stroke Care in Maine
<b>Finding the Right Place of Care for the Elderly and Disabled in Need of Assistance</b>		
<ul style="list-style-type: none"> <li>• Compile a "Maine Elders Health Profile."</li> </ul>	Dec 2008	CDC/DHHS
<ul style="list-style-type: none"> <li>• Gather key common data elements across all populations with long term care needs.</li> <li>• Establish/implement functional eligibility criteria for Private Non-Medical Institutions.</li> </ul>	Oct 2009 July 2009	DHHS Long Term Supports Leadership Team
<ul style="list-style-type: none"> <li>• Use projection model developed by the Lewin Group, in collaboration with the Muskie School, to project need for and to plan for home care, community residential options, and nursing facility care.</li> <li>• Identify/implement strategies to strengthen home care and affordable, homelike living options for Maine's elders.</li> <li>• Initiatives will be in place to honor and support direct care workers.</li> <li>• Extend the reach of evidence-based programs throughout the state.</li> </ul>	Dec 2008 Dec 2008 Oct 2008 July 2009	DHHS Office of Elder Services
<b>Medicare Equity Project - Hospital Reimbursement</b>		
<ul style="list-style-type: none"> <li>• Convene an Ad Hoc Medicare Equity Work Group representing: Governor's Office, Legislature, Maine Hospital Association, insurers, consumers, employers, and representatives of Congressional delegation.</li> </ul>	May 2008	GOHPF
<ul style="list-style-type: none"> <li>• Develop white paper documenting the cause of the Medicare under-funding, the amount, the impact on private payers, and identify strategies to resolve.</li> </ul>	Oct 2008	Medicare Equity Work Group
<ul style="list-style-type: none"> <li>• Present white paper to appropriate legislative committee, the media and public to generate support.</li> </ul>	Dec 2008	
<ul style="list-style-type: none"> <li>• Meet with Congressional delegation to brief and develop strategy.</li> </ul>	Jan 2009	

<ul style="list-style-type: none"> <li>• Meet with MedPAC and CMS.</li> </ul>	Feb 2009	
<ul style="list-style-type: none"> <li>• Assess progress in reaching resolution with CMS.</li> </ul>	May 2009	
<ul style="list-style-type: none"> <li>• Seek Congressional action should CMS discussions fail to yield a solution.</li> </ul>	June 2009	
<b>Medicare Equity Project - Medicare Hospice Benefit</b>		
<ul style="list-style-type: none"> <li>• Convene stakeholders involved in promoting the utilization of hospice care including representatives from the: Maine Hospice Council, hospitals, nursing homes, social service, Elder Independence of Maine, Office of Elder Services, physicians, palliative care, MaineCare to agree on the benefits of hospice care and the barriers to higher utilization in Maine.</li> </ul>	June 2008	GOHPF
<ul style="list-style-type: none"> <li>• Prepare and present actionable recommendations to the ACHSD that will increase the utilization of Hospice by Maine citizens.</li> </ul>	Oct 2008	workgroup
<b>HealthInfoNet</b>		
<ul style="list-style-type: none"> <li>• Convene a broadly representative stakeholder group representing the Governor's office, HIN and its consumer advisory committee, MQF, FAME, Maine Medical Association, Maine Hospital Association and Maine Osteopathic Association and the Maine Association of Health plans, representatives of payers, pharmacies, businesses, public health, Muskie School of Public Policy, Maine Technology Institute, AARP, long-term care facilities, state agencies responsible for health care services to: <ul style="list-style-type: none"> <li>○ Identify a broad-based stable ongoing revenue source for an electronic health information system.</li> <li>○ Develop a technology investment account to provide assistance to physician practices, long term care facilities and independent pharmacies with the costs of electronic medical records and e-prescribing.</li> <li>○ Estimate the return on investment (ROI) from shared electronic clinical information and develop a methodology for measuring the quality and cost impact of shared clinical information.</li> <li>○ Establish criteria/guidance for physician-based EMR systems to assist physicians in choosing among competing options and explore and review the offerings by several hardware and software EMR vendors to provide no cost or low cost equipment and software to physicians to help assess the value of such product offerings.</li> <li>○ Provide recommendations to the joint committee on Health &amp; Human Services.</li> </ul> </li> </ul>	Start spring 2008, rpt Dec 2008	MQF and HIN
<ul style="list-style-type: none"> <li>• Maine Quality Forum will serve as the coordinator of the CMS Electronic Health Records Demonstration Project, which will provide technical support and financial incentives for as many as 100 small to medium size primary care practices to incentivize EHR diffusion and use.</li> </ul>		MQF
<b>Deepening the Analysis of Maine's Healthcare Cost Drivers</b>		
<ul style="list-style-type: none"> <li>• Convene a work group of Council members, stakeholders, funders, and others to: <ul style="list-style-type: none"> <li>○ advise in the development of an appropriate study approach and methods,</li> <li>○ secure funding for the study, and</li> <li>○ contract with qualified researchers to develop and implement the study.</li> </ul> </li> </ul>	Start spring 2008, rpt Jan 2009	GOHPF and MQF
<b>Using Maine's Existing Research and Analytic Capacity to Greatest Effect</b>		
<ul style="list-style-type: none"> <li>• Convene a workgroup that includes, but is not necessarily limited to, the MHDO; DHHS's Office of Substance Abuse, Maine CDC/DHHS, and Office of Quality Improvement; the Maine Health Information Center; the Muskie School's Institute for Health Policy; Maine Center for Public Health; the University of New England's Center for Health Policy, Planning and Research; and the MaineHealth, EMMC, MaineGeneral "One Maine" initiative to make recommendations on how to improve Maine's public and private health data collection and analysis resources so they work more effectively, efficiently,</li> </ul>	Start spring/summer 2008, rpt fall/winter 2008-09	MQF and GOHPF



and across the system.		
<ul style="list-style-type: none"> <li>Develop strategies for an ongoing health data technical assistance system for CCHCs (Comprehensive Community Health Coalitions) and DCCs.</li> </ul>	Dec 2008	CDC/DHHS working with CCHCs
<ul style="list-style-type: none"> <li>Implement a query-based web portal for easy access to the public for local public health data.</li> </ul>	July, 2008	Maine CDC/DHHS
<ul style="list-style-type: none"> <li>Complete Health Status Profiles of populations facing disparities, such as the Medicaid population, elders, and those with disabilities and mental illness as resources allow.</li> </ul>	Dec 2009	Maine CDC/DHHS
<ul style="list-style-type: none"> <li>Identify strategies to integrate appropriate collection of racial and ethnic minority health data into existing systems.</li> </ul>	Dec 2009	Maine CDC/DHHS
<b>Healthcare-Associated Infection</b>		
<ul style="list-style-type: none"> <li>Improve dissemination of information regarding HAI which has already been collected. MQF, along with Maine's hospitals and infection control physicians and nurses, has established a method of reporting this information which allows hospital-specific data to be viewed. This will be available on the MQF website within three months.</li> </ul>	June 2008	MQF
<ul style="list-style-type: none"> <li>MQF, along with three of Maine's health systems, has committed to the development of a hospital infection control collaborative which all Maine hospitals will be welcome to join. This group will: <ul style="list-style-type: none"> <li>promote best practices and share resources for infection control, outbreak analysis, and antibiotic use, and will continue to refine and modify public reporting criteria and methods;</li> <li>develop standards for hospital infection control and prevention programs by which all hospitals' programs can be measured; MQF will serve as reviewer and arbiter of these programs, and will report publicly on the presence of approved programs in Maine's hospitals;</li> <li>explore and assess other reporting options such as the national Healthcare Safety Network, an internet-based surveillance and reporting system supported by the national Center for Disease Control and Prevention begun in 2007.</li> </ul> </li> </ul>	ongoing	MQF, along with three of Maine's health systems
<ul style="list-style-type: none"> <li>Continue to work with providers to develop a more robust set of process and outcome indicators, as these measures are developed and validated.</li> </ul>	ongoing	MQF
<b>Sentinel Event Reporting</b>		
<ul style="list-style-type: none"> <li>Convene a stakeholder workgroup to review the current system and suggest legislative changes and report to the ACHSD.</li> <li>DHHS will propose any needed legislative changes to the legislature.</li> </ul>	Convene spring 2008, rpt Nov 2008, legislation by Dec 2008	DHHS's Division of Licensing and Regulatory Services
<b>Critical Access Hospital (CAH) Collaborative</b>		
<ul style="list-style-type: none"> <li>Initial planning process will be finished and reported to the Maine Quality Forum and MeHAF.</li> </ul>	July 2008	CAHs, USM, & CDC/DHHS Office Rural Health & Primary Care
<ul style="list-style-type: none"> <li>Projects will be started at individual hospitals and finished by...</li> </ul>	Dec 2009	
<b>Certificate of Need and the Capital Investment Fund</b>		
<ul style="list-style-type: none"> <li>Convene an ad hoc group to develop options to revise rule for ACHSD consideration.</li> <li>Present options to revise rule for ACHSD consideration.</li> <li>If decision is made to revise the rule, propose revised Rule.</li> </ul>	for 2009 Legislative review	GOHPF

## Appendix I - What We Accomplished

Importantly, making Maine the healthiest state is not just the responsibility of state government. Driving the engine of engagement and success are many organizations - government, private, and non-profit. The ACHSD recognizes the collaborative efforts of the many groups involved in health system reform throughout the State and believes that it is the unique willingness of Maine people to work together collaboratively, that will enable Maine to achieve its goals.

Accordingly, each State Health Plan reflects the input and work of many Maine people. Each Plan seeks to recognize and build off of the tremendous efforts going on all around our great state. From the beginning with the "Tough Choices" initiative that engaged hundreds of Maine people in discussing the State's healthcare challenges, to the Public Health forums, Maine Quality Forum trainings, the Healthy Communities Projects, and many more initiatives, there has been ongoing dialogue about the future of health and healthcare delivery in Maine. This has created a strong foundation for the effort and energy it will take to turn ideas into action and action into results.

This appendix provide a progress report on specific tasks and goals – some undertaken by state government, some by private and non-profit organizations, and some by partnerships with wide-ranging membership – that were laid out in the last Plan. For example, the 2006-07 State Health Plan convened or identified ad hoc groups such as:

- Public Health Workgroup
- Telemedicine Workgroup
- Rural Health Workgroup
- Oral Health Workgroup
- In-A-Heartbeat Committee
- HealthInFoNet Board
- Maine Quality Forum Advisory Council
- Steering Committee on "Integrating Maine's Mental, Behavioral & Physical Health Systems"

These groups meet to discuss and find solutions to some of Maine's most pressing health and healthcare challenges. It is the role of the ACHSD to hold these groups accountable for the results they have promised. During the past two years efforts have been initiated that will build the infrastructure for longer term success while delivering shorter term results that are fueling the hope and commitment to continue the work.

That this appendix does not mention the many other successful undertaking of private organizations that were not mentioned in the last Plan in no way connotes a lack of recognition of their value. The State Health Plan identifies these accomplishments as a way of informing interested stakeholders of the ongoing work and to recognize the results achieved.

### **A. Public Health Infrastructure**

With Maine's health care spending the second highest in the nation fueled in part by high rates of preventable chronic illness, one of the major goals of the 2006-2007 State Health Plan was to build an efficient and effective statewide public health infrastructure. Because we understand that changing health status requires local action between providers and patients, informing and empowering consumers and supporting healthy behavior options, we have built a public health infrastructure that brings information, education and support to the local and regional level through Public Health Districts and Healthy Community Partnerships. Building upon Maine's successes in addressing such public health issues as youth smoking, teen pregnancy, and infant mortality, a streamlined system can leverage private-public partnerships to effectively address a myriad of issues such as chronic diseases, emerging infectious diseases and environmental hazards. With the work of the Public Health Work Group and many others, much has been accomplished.

Some highlights of achievements 2006 - 2007:

- The 40-member Public Health Work Group (PHWG), convened by the Governor's Office on Health Policy and Finance and Maine CDC/DHHS, created a road map on how to complete the implementation of the consolidated, more efficient and effective statewide public health infrastructure. For details see the PHWG Report to the Legislature, January 2008:  
[www.maine.gov:8080/dhhs/boh/phwg/phwg%20report/phwg%20group%20report.pdf](http://www.maine.gov:8080/dhhs/boh/phwg/phwg%20report/phwg%20group%20report.pdf).
- By consolidating over 150 grants and contracts to 28, Maine CDC/DHHS and Office of Substance Abuse in DHHS, working with Maine Department of Education, created a more efficient and effective Healthy Maine Partnership system, which is now a statewide network of Comprehensive Community Health Coalitions. Funding to address tobacco, substance abuse, physical activity, nutrition, school health coordinators, cancer screening, chronic disease prevention are now combined into the Healthy Maine Partnership contracts.
- Maine CDC/DHHS obtained input from Local Health Officers (LHOs) on how to update the LHO system by conducting two surveys of LHOs (with a response

of about 200) and holding 10 forums with LHOs (with a total of over 150 LHOs), including one in each of the eight HHS Districts.

- Maine CDC/DHHS created a LHO resource webpage ([http://maine.gov/dhhs/boh/local\\_health\\_officers.htm](http://maine.gov/dhhs/boh/local_health_officers.htm)).
- Maine Legislature and Governor modernized the LHO statutes related to LHO requirements for education, training, and experience.
- For more 2006-2007 achievements and details, see Public Health Work Group webpage and Reports to the Legislature:  
<http://maine.gov/dhhs/boh/phwg/index.htm#report>

### ***B. Integrating Patient Centered Care – MaineCare's High Cost User Care Management Benefit***

Knowing that many MaineCare recipients are not receiving the right care in the right place at the right time, MaineCare launched a pilot program to determine if it could increase health and reduce costs among its highest costs users. The pilot was designed to manage the care of these recipients through an integrated approach and monitor participants' health and cost outcomes.

MaineCare contracted with a care management vendor for the highest cost users, which includes the top 10% of adults and the top 5% of children, totaling 17,000 members. This population accounts for nearly 80% of MaineCare's costs. The benefit is designed to address the needs of chronically ill MaineCare members and links traditional medical care with a public health approach, taking advantage of information technology to facilitate, track, and improve member care. Using a predictive modeling tool that primarily focuses on medical claims data, pharmacy data, and health risk assessments, the vendor is able to predict with 70% reliability members who have treatable conditions and are likely to generate the highest costs.

Success will be determined with these guiding principles:

- improvement in member quality of life
- improvement in member health outcomes
- producing cost savings
- adherence to evidence-based guidelines

The benefit began with a pilot of 300 members selected throughout the fall and early winter of 2006. To date 260 remaining members included in that first year's 300 member pilot have shown positive results ,with reductions in inpatient hospitalizations and emergency room use. In October of 2007, expansion to the larger population of 10% of adults and 5% of children began. To date, 3000 members have enrolled with a total of about 17,000 planned. As of the date of publication of the State Health Plan, it is too early to determine program outcomes for the members beyond the original 300 member pilot.

## **C. Variation Analysis**

### **1. Charting Variation in Care**

With the understanding that utilization of healthcare services is a major driver of healthcare costs and that utilization is greatly influenced by supply (what providers offer), the Maine Quality Forum has taken a leadership role in identifying and quantifying the extent to which medical practices vary in the Maine marketplace. Utilizing the Maine Health Data Organization (MHDO) discharge data, MQF has developed “butterfly” charts (see page 27 for example) that demonstrate the wide variation in practices geographically for a range of specifically services and has posted them on its web site for use by consumers, payors, and providers.

Maine’s paid claims database is a rich source of insight into “effective care” (effective care services are those which have proven value and are related to better outcomes) and “supply-sensitive care” (care utilization subject to variation related to the supply of services). This has been demonstrated by a pilot analysis of this data that was done by Health Dialog Analytic Solutions for MQF. This analysis demonstrated wide variations in the provision of effective care by primary care practitioners and by cardiologists. A sub-analysis by the Center for Outcomes Research and Evaluation at Maine Medical Center showed wide variation in the use of advanced imaging (CT and/or MRI) across regions of the state. Such variation often reflects supply of the service; it may also reflect a regional practice variation that may or may not be warranted. This imaging analysis has been used to inform assessment of the quality implications of Certificate of Need applications in Maine.

### **2. A Prototype for Evidence-Based Medicine - In a Heartbeat Accomplishments**

Maine Quality Forum’s In a Heartbeat project, aimed at ensuring that all Maine heart attack patients receive correct, appropriate, timely, and coordinated care regardless of location, began with a statewide conference in November 2006, which convened public health workers, emergency service personnel, and members of the nursing, primary care, and cardiology community to develop plans for this initiative. Since that time, working in three groups (AMI Community Engagement (ACE) workgroup, Heartbeat AMI Response and Treatment (HART) workgroup, and Data and Metrics workgroup) under the direction of an executive committee, the In a Heartbeat teams have accomplished the following:

- Reviewed baseline information on impediments to timely care, and found that only 12% of Maine citizens know heart attack symptoms and would call 911 if they occur.

- Developed evidence-based messaging and public education resources to spread consistent statewide information on heart attack symptoms and the importance of calling 911.
- Conducted a nine-site pilot to evaluate resources and the outcomes of educational outreach, demonstrating the effectiveness of this approach in increasing awareness of heart attack risks, symptoms, and appropriate treatment.
- Launched a statewide “train the trainer” initiative to increase numbers of individuals equipped to deliver consistent information on heart attack symptoms and care throughout Maine.
- Began a statewide initiative to train EMS personnel in electrocardiogram interpretation for earlier heart attack diagnosis; over two hundred emergency medical personnel have been trained and certified so far.
- Achieved agreement among EMS personnel and hospitals on indications for AMI patient transfer between hospitals and protocols to guide care during transfers.
- Developed an evidence-based treatment protocol based on national medical specialty society guidelines to ensure best care for all heart attack patients in Maine.
- Developed a clinical data collection tool to monitor In a Heartbeat progress and measure the quality of care for all heart attack patients in Maine.

#### ***D. Creating Access to Affordable Health Care***

Assuring health coverage for every Mainer is a prerequisite to making Maine a healthier state. About 11% of Mainers still lack health coverage, and Maine is a national leader in covering the uninsured. Universal coverage is within our reach. Of those who lack coverage, about 23% are below the poverty level and may be eligible for and not enrolled in MaineCare; about 46% are below 300% of the federal poverty level and, if they are employed in small business, are sole proprietors or individuals, may qualify for the subsidized DirigoChoice product, and about 38,000 are over 300% of the federal poverty level. The uninsured are not a monolithic group and, as a result, the Dirigo Health Reform set out a three part strategy to reach universal access to health care. First, the MaineCare program provides essential coverage for those Mainers least able to afford care. The subsidized DirigoChoice product is designed to provide access to insurance coverage on a sliding fee scale based on ability to pay. It targets individuals, sole proprietors and small business with fifty or fewer employees because that’s where most uninsured are found. But for those in large business and for those beyond 3 times the rate of poverty (income over \$31,000 for an individual) Dirigo Health Reform includes efforts to contain costs of health care, to regulate health insurance costs and to achieve market reforms and prevent disease to help make coverage more affordable.

During the past two years, goals established in the last State Health Plan have been met:

- GOHPF and the Dirigo Health Agency participated in the Commonwealth Fund evaluation conducted and recently released by Mathematica Policy Research. The evaluation was shared with the Dirigo Health Agency Board of Directors and with the broad public through a Academy Health webcast titled, "Leading the Way: Maine's Experience in Expanding Coverage." GOHPF and DHA participated and provided additional information. Over 100 people from across the nation participated in the webcast.
- DirigoChoice developed a lower cost product for small businesses that included a \$2500 deductible, increased marketing through a mail campaign and aggressive outreach, and secured funding from Anthem to start a call center specifically trained to inform interested consumers and link them to producers.
- Savings from the first three years of Dirigo Health Reform were found by the Superintendent of Insurance to total \$111 million. In 2007 the Superintendent's decision regarding 2007 savings, however, resulted in revenues insufficient to grow the program. As a result, enrollment was temporarily suspended pending new funds (although new dependents of current enrollees and new employees of covered employers are currently able to enroll as are non-subsidized employees).
- As of December 2007, Dirigo Health had served a total of 28,152 individuals, including 5,545 MaineCare parents. Approximately 61% of enrollees were formerly under- or uninsured. Under-insured is defined as having a deductible exceeding 5% of income when household income is below 200% of the federal poverty level.
- Dirigo's rate regulation in the small group market is succeeding. Insurers are required to either submit rates for prior approval or guarantee that at least 78% of premiums will be paid out in claims. Under the second option, insurers not meeting the 78% target must refund the difference. All of the major insurers offering small group coverage chose the second option. All but one of these met the 78% target. The remaining insurer returned \$6.6 million in refunds to premium payers.
- GOHPF did not establish a Health Policy Leadership Forum, as proposed, because of the enactment of LD 1849 which expanded the scope and membership of the Advisory Council on Health Systems Development. By adding representatives from insurers, business, hospitals, and the Legislature and expanding the Council's charge to examine cost drivers and make recommendations to reduce costs, the ACHSD meets the intent of the Health Leadership Forum and has convened expert panels to discuss cost drivers.

### ***E. Workplace Health – Helping Small Businesses Support Employee Wellness***

Maine received a grant from the National Governors Association (NGA) to develop a pilot program for worksite health promotion in the small business environment. In Maine, over 90% of our businesses employ less than 25 people. Toward that end, our project proposed that offering a systematic approach to worksite health promotion and wellness programs would enhance the appropriate use of health care services, increase work place productivity, improve recruitment and retention rates, and decrease workers compensation injuries.

Maine small businesses lack the technical expertise and/or experience to complete such a project. Our project model included developing a systematic approach to improving health outcomes, creating a work culture that can sustain a wellness program, and increasing education and awareness while assisting participating business with the potential for achieving or stabilizing health care costs. Such a project can reduce the costs of doing business in terms of productivity, employee turnover and job satisfaction.

During the past two years, goals established in the last State Health Plan have been met:

- Develop a Toolkit - A toolkit was developed and distributed to all Dirigo small businesses throughout the state. Feedback received on the toolkits and trainings was extremely positive.
- Establish an Advisory Committee comprised of Small Business Consumers. Accomplished by DHA business advisory group.
- Recruit 100 companies out of the 200 Eligible Companies in Maine's DirigoChoice. This Goal has been partially met. Legislative circumstances surrounding Dirigo Health prevented us from further outreach.
- Hold Regional Meetings to Establish Networking Opportunities. Four regional meetings were held that focused on providing education and training to Dirigo Companies to help them utilize the Toolkit. The new contractor for Dirigo – Harvard Pilgrim Health Care – also attended the meetings and discussed wellness programs covered under their health plan. Meetings were held around the state in the evenings to maximize attendance.
- Statewide trainings occurred and allowed for personal contact with local resources as well as an opportunity to discuss implementing a wellness program for employees.

### ***F. Healthcare Workforce***

The 2006-2007 State Health Plan noted that in 2005 the Legislature enacted, PL 327, An Act to Ensure an Adequate Supply of a Skilled Health Care Workforce,



which directed the Department of Labor, working in conjunction with the Department of Health and Human Services, to annually compile a detailed health care occupations report to help ensure that Maine has the right workforce over time to properly address Maine's health needs. That legislation embraces an approach of gathering more data on our current workforce and using the data in a sustained, consistent manner to model future need for healthcare professionals in Maine and to develop strategies to meet that need.

In 2006, representatives from health professions, licensing boards, employers, health education programs and Maine Department of Labor (DOL), were convened by the Department of Health and Human Services to discuss implementation of PL 327 and a series of meetings followed that lead to the development and publication of the State's first Healthcare Occupations Report on January 31, 2007. The report is available online at: <http://mainegov-images.informe.org/labor/lmis/pdf/HealthcareReport.pdf>

### ***G. Integration Initiatives***

The Maine Health Access Foundation held a day-long kickoff event for its Integration Initiative on April 27, 2006. Following the kick-off, MeHAF convened a broad-based Steering Committee including representation from patients, providers, business, insurers, state officials, policy analysts, researchers and others. The steering committee helped MeHAF define integration, articulate barriers and opportunities to advance integration, and outline benchmarks to assess how Maine's health care system is moving toward improved integration. This group developed a consensus vision for integration that is summarized in "Integrated Health Care in Maine: Vision, Principles and Values, and Goals and Objectives" (available at [www.mehaf.org/pictures/integration\\_vision.pdf](http://www.mehaf.org/pictures/integration_vision.pdf)).

The perspectives of the public about integration were gathered by making grants to grassroots organizations to host discussion groups with Maine residents in 2006. Through this grant program, MeHAF solicited input from over 1,400 Maine patients, families and community members on what patient-centered care means to them. The findings from these discussion groups have been compiled into a report that was released in January 2008 and is available at [www.mehaf.org](http://www.mehaf.org).

In 2007, MeHAF awarded \$5.2 million to support twenty projects to advance patient-centered care in Maine through the integration of primary, behavioral, and specialty care; work began in January 2008. Grants were made to many of the organizations in the state that are taking a leadership role in promoting patient-centered care and integration, and range from a project that will establish seamless primary, emergency, dental, and behavioral health care focused around a new dental clinic in Rumford to advancing models of providing mental health services in primary care settings; and more.

## ***H. Rural Health***

The 2006-07 State Health Plan recommended that a Rural Health Work Group (RHWG) be established to develop policy recommendations that addressed the challenges that face Maine's small and rural hospitals and the interacting infrastructure that form the backbone of the rural healthcare delivery system.

A 14 member group appointed by the Governor's Office of Health Policy and Finance and the Office of Rural Health and Primary Care, Maine Center for Disease Control/DHHS deliberated and worked over 12 months to produce A Plan for Improving Rural Health in Maine. The RHWG was charged to consider strategies that could be undertaken by communities, insurers, businesses, health systems, and healthcare professionals in order to meet the urgent and emergent needs of rural Mainers. Broadly representative of rural health care providers, public health practitioners, and consumers, the RHWG developed goals and recommendations regarding rural health policies, reimbursement policy, licensing policy and other related issues to be undertaken to strengthen Maine's rural health system.

The draft plan is available for comment at:

[http://mainegov-images.informe.org/dhhs/boh/orhpc/documents/RHP\\_2.21.pdf](http://mainegov-images.informe.org/dhhs/boh/orhpc/documents/RHP_2.21.pdf)

A series of listening sessions will occur in the spring of 2008 to gather additional input from a wider group of rural stakeholders.

## ***I. Telemedicine Workgroup***

Maine's 2006-07 State Health Plan created this workgroup "to develop strategies to help Maine achieve an appropriately-developed, utilized and reimbursed telemedicine infrastructure that serves the best interest of patients."

The workgroup met six times, and formed a number of committees to work on specific regulatory, policy, and infrastructure issues, and issued its final report in March 2008. Its recommendation has been incorporated into this State Health Plan.

## ***J. Health Status Report***

Maine continues to have a high incidence of the most costly chronic diseases – cancer, stroke, diabetes, and chronic lung disease. However, as a result of previous efforts to prevent these diseases, we are beginning to see a decline in the occurrence of these diseases. If we are to continue the progress demonstrated in the chart below, we will need to be successful at creating better health habits and preventive care especially among targeted populations.

### Health Status Table

Measure	Base - line	Goal from Previous SHP	Most Current Data (age-adjusted)	Rank	US Avg	Benchmark State
Cancer Deaths/100,000 <sup>1</sup>	232.3 (1999)	223.1 (2008)	201.6 (2005)	42nd best	184.4 (2004)	139.9 Utah
% Women 40 or Older Who had a Mammogram in Past 2 Years	81.9% (2004)	85.0% (2008)	81.8 (2006)	4th best	74.9 %	82.5% Mass.
Coronary Disease Deaths/100,000 <sup>1</sup>	169.7 <sup>3</sup> (2000)	166.0 (2008)	124.2 2005	13th best	157.2 (2004)	93.2 Minn.
Stroke Disease Deaths/100,000 <sup>1</sup>	56.6 (2000)	52.0 (2008)	42.9 (2005)	28th best	48.0 (2004)	32.6 NY
Diabetes Deaths/100,000 <sup>1</sup>	81.7 (2000)	66.0 (2008)	76.8 (2005)	18th best	70 (2004)	45.0 Ariz.
% Adult Who Took Diabetes Self-Management Course	56.6% (2000)	80.0% (2008)	58.6% (2006)	14th best	55.5 % (2004)	75.7% Minn.
Asthma-related hospitalizations/10,000	9.5 (2000)	6.5 (2008)	8.6 No new data (2005)	NA	NA	NA
Chronic Lung Disease Deaths/100,000 <sup>1</sup>	159.0 (1998)	150.0 (2010)	140.2 (2005)	38th best	122.8 (2004)	94.7 NJ
% Teens Not Overweight or Obese <sup>5</sup>	75.2% (2001)	79.0% (2008)	74.7% (2005)		71.2 % (2005)	
% Teens Who Smoke <sup>6</sup>	16.2% (2005)	14.0% (2010)	No new data	4th best	20.5 % (2005)	7.4% Utah
% Mainers Reporting Physical Activity	78.4% (2004)	85% (2008)	79.1% (2006)	11th best	76.2 %	83.8% Minn.

## **Appendix II - Health Status & Demographics by Public Health District**

Maine's demography influences our health, and therefore has influence on our health policy and strategies.

For instance, by population, Maine is small (2006 estimates of just over 1.3 million, accounting for <0.5% of the total US population), but by square miles we are large (accounting for about 1% of the total US square mileage). Maine is rural, with the lowest population density in New England and with 41.3 people per square mile versus a national average of 79.6.

By several measures we are one of the oldest states in the nation. We have the fourth highest proportion of people 65 and older (14.6% - about 193,000 people - compared with 12.4% nationally). At 41, we are the oldest by median age in the country, compared with the national average of 36.4.

Maine has a high average proportion of people with disabilities, with 19.4% (239,646 Mainers) who are 5 years and older with disabilities, versus 15.1% nationally.

Maine has one of the smallest populations of racial minorities (second smallest, next to Vermont), with 95.8% of our population being white, compared with 73.9% nationally. However, we are becoming more diverse, and have close to the national average of Native Americans (0.6% vs 1.0%) and have areas of the state that have higher proportions of Native Americans (4.1% in Washington County) as well as non-whites (10.9% in Androscoggin County).

By several measures, Maine is poorer economically than the national average. Median household income ranks 32nd (and is just over \$3,000 less than the national average), and per capita annual income is about \$2,000 less than the national average. Maine has the lowest proportion in New England of people 25 and older with a bachelor's degree, and the only New England state with that proportion worse than the national average (25.8% in Maine versus 27% nationally). This is significant, given the close ties between education and poverty.

Some of our health status indicators and high health costs are related to these demographics. However, we can become the healthiest state in the nation if we integrate these demographic factors into our strategies as we move forward. For instance, in most instances, these demographic factors result in major priority populations for addressing health issues - those who are poor, who are elderly, who are disabled, who are racial minorities, and who live in rural areas.

# 2008 MAINE STATE PROFILE of SELECTED PUBLIC HEALTH INDICATORS

Maine Center for Disease Control and Prevention/DHHS

DEMOGRAPHICS	DISTRICT								COMPARISONS	
	Aroostook ± Margin of Error	Central ± Margin of Error	Cumberland ± Margin of Error	Downeast ± Margin of Error	Midcoast ± Margin of Error	Penquis ± Margin of Error	Western ± Margin of Error	York ± Margin of Error	MAINE State ± Margin of Error	UNITED STATES
US Census: Official Population Estimates										
Total Population [2006]	73,008	173,317	274,598	87,085	151,882	164,765	194,687	202,232	1,321,574	299,398,484
Total Percent of Maine Population [2006]	5.5	13.1	20.8	6.6	11.5	12.5	14.7	15.3	100%	n/a
Population Density (people per square mile) [2006]	10.9	36.2	328.7	21.0	84.1	22.4	45.9	204.1	42.8	79.6 [2000]
Median Age (*see Tech notes) [2006]	43.0	41.1*	40.7	42.9*	42.3*	41.9*	40.0*	41.1	41.1	36.4
<b>Selected Ages</b> (US Census Official Population Estimates) [2006]										
<5 Years of Age (percent and count)	4.8 (3,478)	5.2 (9,059)	5.6 (15,254)	5.0 (4,379)	5.1 (7,731)	5.3 (8,701)	5.5 (10,745)	5.4 (10,898)	5.3 (70,245)	6.8 (20,417,636)
65 Years & Older (percent and count)	17.4 (12,673)	14.5 (25,175)	13.6 (37,237)	16.6 (14,462)	15.7 (23,912)	14.0 (23,007)	14.4 (28,007)	13.9 (28,166)	14.1 (192,639)	12.4 (37,260,352)
<b>Race/Ethnicity Counts</b> (one race alone or in combination with one or more other races, except where noted.** US Census Official Population Estimates) *see Tech notes [2006]										
White (one race alone or in combination)	71,059	170,767	264,065	84,587	149,851	160,820	190,829	198,734	1,290,712 (97%)	81.4%
Black (one race alone or in combination)	481	1,209	5,772	553	1,111	1,433	2,624	1,681	14,864 (1.1%)	13.4%
American Indian & Alaskan Native (one race alone or in combination)	1,419	1,601	2,115	2,194	1,322	2,118	1,609	1,175	13,553 (1%)	1.5%
Asian (one race alone or in combination)	633	1,438	5,413	736	959	1,725	1,747	2,149	14,800 (1.1%)	5.0%
Native Hawaiian & Other P.I. (one race alone or in combination)	19	97	310	29	51	126	94	80	806 (<1%)	0.3%
Hispanic (of any race)**	636	1,400	3,891	827	1,424	1,369	1,965	2,017	13,529 (1%)	14.8%
Non-Hispanic (total)**	72,372	171,917	270,707	86,258	150,458	163,396	192,722	200,215	1,308,045 (99%)	85.1%
Franco-American [2000]	25,374	46,580	47,185	9,083	19,132	46,580	58,457	52,868	305,259 (22%)	0.8%

## 2008 MAINE STATE PROFILE of SELECTED PUBLIC HEALTH INDICATORS

Maine Center for Disease Control and Prevention/DHHS

MORE DEMOGRAPHICS: Percent and Count	DISTRICT								COMPARISONS	
	Aroostook ± Margin of Error	Central ± Margin of Error	Cumberland ± Margin of Error	Downeast ± Margin of Error	Midcoast ± Margin of Error	Penquis ± Margin of Error	Western ± Margin of Error	York ± Margin of Error	MAINE State ± Margin of Error	UNITED STATES
Median Annual Household Income [2004]	\$ 32,629	\$ 36,147	\$ 49,870	\$ 33,834	\$ 41,690	\$ 34,717	\$ 36,670	\$ 48,363	\$ 41,287	\$ 44,334
Families Living in Poverty (all ages, percent) [2004]	14.9 (±0.3) 10,918	13.1 (±0.2) 22,497	9.0 (±0.1) 24,708	12.6 (±0.2) 10,943	10.7 (±0.2) 16,142	13.2 (±0.2) 21,715	12.4 (±0.2) 23,915	9.0 (±0.1) 17,963	11.3 (±0.1) 148,801	11.5
Children on Free or Reduced Lunch Program (percent of enrolled school children) [2005]	47.7 (±1.2) 5,551	41.0 (±0.8) 11,613	25.9 (±0.5) 10,483	41.9 (±1.1) 5,037	35.9 (±0.8) 7,471	39.1 (±0.8) 10,068	45.8 (±0.7) 13,466	27.6 (±0.7) 7,547	36.4 (±0.3) 71,236	17.5
Adults with Lifetime Educational Attainment Less Than High School (percent) [2000]	23.1 (±0.4) 11,868	16.1 (±0.3) 18,378	9.8 (±0.1) 17,900	15.3 (±0.3) 9,185	13.0 (±0.2) 13,146	14.9 (±0.2) 16,073	18.6 (±0.2) 23,561	13.5 (±0.2) 17,177	14.6 (±0.1) 127,419	9.4 (±0.1)
Single-Parent Households with Children <18 years (percent) [2000]	7.7 (±0.3) 2,323	10.4 (±0.2) 7,007	8.4 (±0.2) 9,117	8.8 (±0.3) 3,157	9.0 (±0.2) 5,372	9.5 (±0.2) 6,197	10.4 (±0.2) 7,887	9.1 (±0.2) 6,788	9.2 (±0.1) 47,848	7.2
Householders ≥ 65 Living Alone (percent) [2000]	13.1 (±0.4) 3,977	10.5 (±0.2) 7,145	10.2 (±0.2) 11,015	12.2 (±0.3) 4,386	11.0 (±0.4) 6,549	10.4 (±0.2) 6,829	10.9 (±0.2) 8,317	9.7 (±0.2) 7,233	10.7 (±0.1) 55,451	9.2
People Who Speak a Language Other Than English (percent of those >5 years old) [2000]	24.1 (±0.3) 16,880	6.8 (±0.1) 10,735	5.9 (±0.1) 14,888	4.3 (±0.1) 3,498	3.5 (±0.1) 4,798	4.4 (±0.1) 6,818	11.1 (±0.2) 19,771	9.4 (±0.1) 16,578	7.8 (±0.1) 82,512	17.9
Adults With a Disability (percent) [2006]	24.6 (±7.3) 6,924	23.0 (±4.3) 33,513	23.0 (±3.9) 35,594	28.5 (±4.3) 17,830	23.0 (±3.3) 25,250	30.4 (±4.9) 32,729	20.0 (±3.7) 38,280	21.8 (±4.3) 32,913	23.8 (±1.6) 237,910	15.1

# 2008 MAINE STATE PROFILE of SELECTED PUBLIC HEALTH INDICATORS

Maine Center for Disease Control and Prevention/DHHS

<b>MATERNAL/CHILD HEALTH INDICATORS</b>	<b>Aroostook</b> ± Margin of Error	<b>Central</b> ± Margin of Error	<b>Cumberland</b> ± Margin of Error	<b>Downeast</b> ± Margin of Error	<b>Midcoast</b> ± Margin of Error	<b>Penquis</b> ± Margin of Error	<b>Western</b> ± Margin of Error	<b>York</b> ± Margin of Error	<b>MAINE State</b> ± Margin of Error	<b>UNITED STATES</b>	<b>Benchmark State</b> (healthiest)
Infant Mortality (rate per 1,000 live births) [2001-2005]	6.1 (±2.6)	5.2 (±1.5)	5.2 (±1.2)	4.4 (±2.0)	5.3 (±1.6)	6.0 (±1.6)	6.0 (±1.5)	5.8 (±1.4)	5.5 (±0.5)	6.8 [2004]	UT 4.5 [2005]
Live Births with Low Birth Weight <2500 grams (percent of live births) [2006]	6.6 (±1.9)	6.5 (±1.1)	6.8 (±0.8)	6.0 (±1.5)	7.0 (±1.3)	7.3 (±1.2)	6.6 (±1.0)	7.4 (±1.2)	6.8 (±0.4)	8.2 [2005]	AK+OR+ WA 6.1 [2005]
Infants Born to Women Receiving First Trimester Prenatal Care (percent) [2006]	90.4 (±2.2)	80.9 (±1.8)	89.7 (±1.1)	86.3 (±2.2)	88.7 (±1.5)	85.3 (±1.7)	88.9 (±1.3)	88.3 (±1.4)	87.4 (±0.6)	83.9 [2005]	RI + MA 89.3 [2005]
Teen Births Ages 15-17 (rate per 1,000 female population) [2003-2005]	14.0 (±3.4)	13.7 (±2.2)	8.7 (±1.5)	9.2 (±2.5)	11.8 (±2.2)	11.4 (±2.1)	15.1 (±2.2)	7.5 (±1.5)	11.2 (±0.7)	21.4 [2005]	NH 7.0 [2005]
<b>HEALTH &amp; WELLNESS INDICATORS</b>											
Adolescent Smoking Prevalence (percent of 6-12 graders) [2006]	15.3 (±0.6)	14.4 (±0.5)	11.9 (±0.3)	16.0 (±0.6)	14.8 (±0.5)	16.1 (±0.6)	13.3 (±0.4)	12.5 (±0.4)	13.8 (±0.2)	23.0 [2005]	UT: 7.4 ID: 15.8 [2005] HS only
Adult Smoking Prevalence (percent who are current smokers) [2006]	28.4 (±7.8)	23.1 (±4.7)	16.3 (±3.7)	24.8 (±5.7)	18.2 (±3.1)	26.7 (±4.9)	17.6 (±3.9)	21.7 (±5.5)	21.0 (±1.6)	20.1	UT: 9.8 CA: 14.9
High School Youth Overweight or Obese (percent) [2005]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	25.0	26.3	CO 20.1
Adults Overweight or Obese (percent) [2006]	55.0 (±8.2)	63.9 (±5.7)	52.8 (±5.1)	60.9 (±6.1)	60.9 (±4.1)	64.7 (±5.3)	59.4 (±5.3)	64.9 (±5.5)	60.2 (±2.0)	61.6	CO + UT 54.9
Adults Reporting Fair or Poor Health Status in last 30 days (percent) [2006]	15.4 (±5.4)	16.5 (±4.0)	11.0 (±2.9)	16.7 (±4.3)	11.7 (±2.5)	18.7 (±4.0)	11.7 (±2.8)	11.0 (±3.5)	13.6 (±1.3)	14.7	MN 10.8

# 2008 MAINE STATE PROFILE of SELECTED PUBLIC HEALTH INDICATORS

Maine Center for Disease Control and Prevention/DHHS

CHRONIC DISEASE INDICATORS	Aroostook ± Margin of Error	Central ± Margin of Error	Cumberland ± Margin of Error	Downeast ± Margin of Error	Midcoast ± Margin of Error	Penquis ± Margin of Error	Western ± Margin of Error	York ± Margin of Error	MAINE State ± Margin of Error	UNITED STATES	Benchmark State (healthiest)
Overall Cancer Incidence (age-adjusted rate per 100,000) [2000-2004]	514.2 (±20.9)	524.5 (±14.6)	500.4 (±11.6)	572.9 (±20.4)	513.4 (±15.0)	553.1 (±15.6)	505.7 (±13.4)	495.3 (±13.4)	517.7 (±5.2)	458.2 [2004]	AZ: 383.3 NM: 409.0 [2004]
Overall Cancer Mortality (age-adjusted rate per 100,000) [2000-2004]	199.0 (±12.7)	206.4 (±9.1)	208.5 (±7.4)	223.3 (±12.6)	200.1 (±9.3)	217.5 (±9.8)	208.0 (±8.6)	201.5 (±8.6)	207.6 (±3.3)	185.7 [2004]	UT: 139.1 HI: 147.5 [2004]
Lung Cancer Incidence (age-adjusted rate per 100,000) [2000-2004]	84.5 (±8.4)	79.7 (±5.7)	77.3 (±4.6)	88.8 (±8.0)	74.2 (±5.7)	92.9 (±6.4)	82.5 (±5.4)	72.8 (±5.2)	80.6 (±2.1)	67.4 [2004]	UT: 28.3 NM: 45.3 [2004]
Lung Cancer Mortality (age-adjusted rate per 100,000) [2000-2004]	62.4 (±7.2)	58.5 (±4.9)	59.8 (±4.1)	61.7 (±6.7)	57.2 (±5.0)	69.4 (±5.5)	65.4 (±4.8)	59.0 (±4.7)	61.5 (±1.8)	61.0 [2004]	UT: 26.2 NM: 35.8 [2004]
Colorectal Cancer Incidence (age-adjusted rate per 100,000) [2000-2004]	65.9 (±7.5)	58.7 (±4.9)	54.0 (±3.8)	61.8 (±6.7)	57.7 (±5.0)	67.1 (±5.5)	50.2 (±4.3)	60.7 (±4.8)	58.4 (±1.8)	49.5 [2004]	UT: 37.4 AZ: 39.4 [2004]
Colorectal Cancer Mortality (age-adjusted rate per 100,000) [2000-2004]	24.5 (±4.6)	19.9 (±2.9)	22.2 (±2.5)	23.8 (±4.2)	18.9 (±2.9)	20.5 (±3.1)	17.2 (±2.5)	20.4 (±2.8)	20.5 (±1.1)	17.9 [2004]	UT: 12.2 HI: 13.4 [2004]
Sigmoidoscopy or Colonoscopy Screening Ever Had by Adults Age 50 and Older (percent) [2006]	53.2 (±10.0)	71.8 (±6.3)	74.3 (±5.1)	54.1 (±7.6)	61.8 (±5.1)	71.8 (±6.3)	60.0 (±6.5)	64.4 (±6.9)	64.6 (±2.4)	57.1 (median % of states responding)	RI 69.2
Female Breast Cancer Incidence (age-adjusted rate per 100,000) [2000-2004]	116.7 (±14.2)	136.0 (±10.3)	134.8 (±8.2)	136.0 (±10.3)	134.6 (±10.7)	136.7 (±10.7)	127.5 (±9.4)	132.1 (±9.5)	132.5 (±3.6)	117.7 [2004]	AZ: 102.9 ID: 105.1 [2004]
Female Breast Cancer Mortality (age-adjusted rate per 100,000) [2000-2004]	16.9 (±5.3)	23.0 (±4.2)	25.1 (±3.5)	23.0 (±4.2)	17.3 (±3.8)	26.5 (±4.7)	25.7 (±4.2)	23.6 (±4.0)	23.7 (±1.5)	24.4 [2004]	HI: 15.6 AK: 18.7 [2004]



# 2008 MAINE STATE PROFILE of SELECTED PUBLIC HEALTH INDICATORS

Maine Center for Disease Control and Prevention/DHHS

CHRONIC DISEASE INDICATORS (cont'd)	Aroostook ± Margin of Error	Central ± Margin of Error	Cumberland ± Margin of Error	Downeast ± Margin of Error	Midcoast ± Margin of Error	Penquis ± Margin of Error	Western ± Margin of Error	York ± Margin of Error	MAINE State ± Margin of Error	UNITED STATES	Benchmark State (healthiest)
Mammogram in Past Two Years Among Women 40 and Older (percent) [2006]	85.2 (±7.3)	84.7 (±5.5)	85.1 (±4.3)	75.5 (±8.0)	77.3 (±5.1)	84.7 (±5.5)	83.3 (±5.5)	81.5 (±5.7)	82.0 (±2.0)	76.5 (median % of states responding)	MA 84.8
Pap Smear in Past 3 Years Among Women 18 and Older (percent) [2006]	90.9 (±5.7)	89.6 (±5.3)	91.6 (±3.3)	88.1 (±5.5)	83.7 (±4.5)	89.6 (±5.3)	92.6 (±4.3)	90.4 (±4.3)	89.1 (±1.6)	84.0 (median % of states responding)	ME 89.1
Prostate Cancer Incidence (age-adjusted rate per 100,000) [2000-2004]	174.7 (±18.3)	182.0 (±13.2)	161.1 (±10.2)	190.8 (±17.6)	173.6 (±13.0)	173.8 (±13.4)	192.8 (±12.6)	159.2 (±11.6)	174.5 (±4.6)	145.3 [2004]	AZ: 109.7 MO: 117.2 [2004]
Prostate Cancer Mortality (age-adjusted rate per 100,000) [2000-2004]	21.7 (±7.0)	28.1 (±5.7)	29.8 (±4.8)	31.3 (±7.7)	33.8 (±6.2)	28.9 (±6.3)	25.0 (±5.0)	27.2 (±5.3)	28.5 (±2.1)	25.4 [2004]	HI: 18.9 FL: 22.0 [2004]
Major CVD Deaths (rate per 100,000) [2005] ICD-10 codes 100-178	286.8 (±33.0)	254.0 (±21.8)	204.6 (±15.5)	262.8 (±29.0)	236.8 (±21.2)	282.2 (±24.1)	251.4 (±20.3)	215.5 (±18.8)	242.0 (±7.6)	286.6 [2004]	MN 210.1 [2004]
Stroke Hospitalizations (rate per 10,000) [2005]	24.9 (±3.1)	18.8 (±1.9)	21.7 (±1.6)	19.5 (±2.5)	19.5 (±2.0)	20.6 (±2.0)	22.2 (±1.9)	17.8 (±1.6)	20.7 (±0.7)	n/a	n/a
Acute Myocardial Infarction Hospitalizations (rate per 10,000) [2005]	57.1 (±4.7)	37.7 (±2.7)	19.6 (±1.5)	41.1 (±3.7)	24.2 (±2.0)	31.9 (±2.5)	22.9 (±2.0)	22.0 (±1.9)	29.2 (±0.8)	n/a	n/a
High Blood Pressure Among Adults (percent) [2005]	28.7 (±6.9)	25.3 (±4.5)	18.7 (±3.1)	28.9 (±5.5)	25.5 (±3.5)	29.6 (±4.7)	25.0 (±3.9)	28.5 (±4.7)	25.4 (±1.6)	25.5 (median % of states responding)	UT 18.4
High Cholesterol Among Adults (percent) [2005]	35.0 (±7.8)	36.4 (±5.1)	29.3 (±4.1)	39.8 (±6.3)	36.5 (±4.3)	39.1 (±5.5)	42.9 (±5.1)	36.4 (±5.5)	36.4 (±2.0)	35.6 (median % of states responding)	LA 30.3

## 2008 MAINE STATE PROFILE of SELECTED PUBLIC HEALTH INDICATORS

Maine Center for Disease Control and Prevention/DHHS

CHRONIC DISEASE INDICATORS (cont'd)	Aroostook ± Margin of Error	Central ± Margin of Error	Cumberland ± Margin of Error	Downeast ± Margin of Error	Midcoast ± Margin of Error	Penquis ± Margin of Error	Western ± Margin of Error	York ± Margin of Error	MAINE State ± Margin of Error	UNITED STATES	Benchmark State (healthiest)
Diabetes Prevalence Among Adults (non-gestational; percent) [2004-2006]	11.4 (±2.7)	7.7 (±1.6)	6.0 (±1.2)	7.1 (±1.6)	6.7 (±1.2)	8.7 (±1.6)	6.4 (±1.4)	7.1 (±1.6)	7.3 (±0.6)	7.5 [2006]	CO 5.3 [2006]
Diabetes Hospitalizations (age-adjusted per 10,000) [2005]	13.5 (±2.4)	11.3 (±1.5)	9.6 (±1.1)	8.5 (±1.8)	11.3 (±1.6)	12.3 (±1.6)	11.5 (±1.5)	7.5 (±1.2)	10.5 (±0.5)	n/a	n/a
Adults with Diabetes Who Have Received a Hemoglobin A1c Test at Least Once Yearly (percent) [2004-2006]	90.2 (±9.8)	94.8 (±5.1)	93.1 (±4.3)	93.2 (±5.5)	88.9 (±5.3)	88.0 (±6.5)	91.2 (±5.1)	95.6 (±3.3)	91.9 (±2.0)	n/a	MO 95.5 [2006]
Adults With Diabetes Who Have Taken a Diabetes Management Course (percent) [2004-2006]	56.1 (±11.4)	63.2 (±7.8)	60.3 (±8.2)	57.0 (±11.8)	60.4 (±8.2)	59.6 (±8.4)	54.9 (±8.2)	50.7 (±9.2)	58.1 (±3.1)	n/a	MN 77.4 [2006]
Adults with Asthma (percent) [2006]	10.4 (±4.1)	9.1 (±3.1)	8.2 (±2.5)	11.8 (±3.7)	10.5 (±2.5)	12.4 (±3.3)	8.7 (±3.1)	8.3 (±2.7)	9.6 (±1.2)	8.5	LA 5.9
Child and Youth Asthma (<18 years old, percent) [2003]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	10.7 (±1.5)	8.9 [2005]	ID 5.0 [2003]
Asthma Emergency Department Visits (age-adjusted rate per 10,000) [2004]	101.0 (±2.4)	83.7 (±2.6)	51.6 (±1.7)	86.3 (±3.8)	53.3 (±2.3)	71.5 (±2.5)	77.3 (±1.6)	44.9 (±1.8)	66.1 (±1.4)	64.0	n/a
Adults With a Routine Dental Visit in Past Year (percent) [2006]	61.2 (±7.8)	65.4 (±5.3)	75.4 (±5.1)	69.7 (±5.5)	69.8 (±3.7)	66.9 (±5.1)	70.7 (±4.5)	74.4 (±4.9)	70.2 (±1.8)	70.3	CT 80.5

## 2008 MAINE STATE PROFILE of SELECTED PUBLIC HEALTH INDICATORS

Maine Center for Disease Control and Prevention/DHHS

ENVIRONMENTAL HEALTH INDICATORS	DISTRICT								MAINE State ± Margin of Error	UNITED STATES
	Aroostook ± Margin of Error	Central ± Margin of Error	Cumberland ± Margin of Error	Downeast ± Margin Of Error	Midcoast ± Margin of Error	Penquis ± Margin of Error	Western ± Margin of Error	York ± Margin of Error		
Emergency Department Visits for Carbon Monoxide Poisoning (rate per 100,000) [2001-2005]	15.9 (±2.3)	6.9 (±1.9)	4.7 (±1.2)	5.2 (±4.9)	6.3 (±1.9)	6.9 (±1.9)	8.0 (±1.9)	6.5 (±1.7)	6.9 (±0.7)	n/a
Elevated Blood Lead Levels Among Screened 1-Year Old Children (percent) [2005-2006]	0.3 (±0.4)	1.9 (±0.8)	1.1 (±0.4)	1.0 (±0.7)	1.9 (±0.8)	1.6 (±0.6)	1.7 (±0.6)	1.4 (±0.5)	1.4 (±0.2)	1.58 (<72 mos. Old) [2005]
Housing Units in Structures Built <1950 (numbers, representing high risk for lead) [2000]	15,244	29,569	45,159	20,370	29,527	27,996	37,155	28,112	35.7%	22.3%
Homes with Private Wells Tested for Arsenic (percent) [2003]	n/a	45.6 (±9.7)	n/a	n/a	36.6 (±9.4)	n/a	47.1 (±9.4)	n/a	44.6 (±3.9)	n/a
District Community Water Systems Meeting all Health Based Standards (percent) [2007]	78	80	87	76	80	94	84	65	80	n/a
District Community Water Systems with Source Water Protection in Place (percent) [2007]	74	78	84	93	88	87	81	84	84	n/a

# 2008 MAINE STATE PROFILE of SELECTED PUBLIC HEALTH INDICATORS

Maine Center for Disease Control and Prevention/DHHS

INFECTIOUS DISEASE INDICATORS	DISTRICT								MAINE State ± Margin of Error	UNITED STATES	Bench- mark State (healthiest)
	Aroostook ± Margin of Error	Central ± Margin of Error	Cumberland ± Margin of Error	Downeast ± Margin of Error	Midcoast ± Margin of Error	Penquis ± Margin of Error	Western ± Margin of Error	York ± Margin of Error			
Kindergarteners Exempted from Childhood Vaccination for Philosophical Reasons (count) [2007]	3	43	105	58	60	25	36	43	373	n/a	n/a
Children Immunized with the 4:3:1:3:3:1 Vaccination Series by 24 Months of Age (percent) [2001-2003] <small>(4:3:1:3:3:1 means at least 4 DTP/DT/DtaP, 3 Polio, 1 Measles-containing, 3 Hib, 3 Hepatitis B, and 1 Varicella vaccine)</small>	82.9	n/a	78.6	n/a	n/a	n/a	n/a	82.1	75.7 [2006]	77.0 [2006]	MA 86.9 [2006]
Influenza Vaccine Past Year for Adults over 65 years (percent) [2006]	69.4 (±13.5)	70.3 (± 9.8)	79.9 (± 6.7)	69.4 (± 13.5)	70.6 (± 6.9)	77.7 (± 8.2)	65.6 (±9.2)	69.9 (±9.6)	72.3 (±3.1)	69.6	CO 75.9
Pneumococcal Vaccine Ever Among Adults 65 Years of Age or Older (percent) [2006]	63.4 (±14.7)	73.9 (±10.4)	68.3 (±8.6)	63.4 (±14.7)	66.7 (±7.3)	77.2 (±9.2)	63.3 (±10.0)	62.2 (±10.2)	67.9 (±3.5)	66.9	OR 74.7
Chlamydia (total number) [2006]	64	255	652	95	213	303	447	280	2,304	n/a	n/a
Late Diagnosis of HIV (number, AIDS diagnosis within 12 months of first HIV diagnosis) [2001-2005]	5	10	31	5	11	9	13	12	96	n/a	n/a
Lyme Disease (crude rate per 100,000; 5-year count in parentheses) [2002-2006]	2.4 (9)	7.8 (66)	22.5 (299)	20.8 (89)	24.5 (177)	3.6 (29)	6.0 (56)	56.7 (529)	18.8 (1,200)	6.7 [2006]	n/a
Salmonella (crude rate per 100,000; 5-year count in parentheses) [2002-2006]	11.4 (42)	14.2 (119)	13.4 (178)	7.5 (32)	10.5 (76)	8.9 (72)	9.7 (91)	11.8 (110)	11.3 (720)	15.5 [2006]	n/a

# 2008 MAINE STATE PROFILE of SELECTED PUBLIC HEALTH INDICATORS

Maine Center for Disease Control and Prevention/DHHS

INJURY AND VIOLENCE INDICATORS	DISTRICT								MAINE State ± Margin of Error	UNITED STATES	Bench- mark State (healthiest)
	Aroostook ± Margin of Error	Central ± Margin of Error	Cumberland ± Margin of Error	Downeast ± Margin of Error	Midcoast ± Margin of Error	Penquis ± Margin of Error	Western ± Margin of Error	York ± Margin of Error			
Motor Vehicle Traffic Crash Deaths (age-adjusted rate per 100,000 and average number per year) [2001-2005]	16.4 (±4.8) 12 avg/yr.	15.0 (±2.6) 26 avg/yr.	9.7 (±1.6) 27 avg/yr.	19.2 (±4.7) 17 avg/yr.	16.7 (±3.0) 25 avg/yr.	13.8 (±2.5) 23 avg/yr.	14.9 (±2.4) 30 avg/yr.	12.4 (±2.2) 24 avg/yr.	13.8 (±0.9) 185 avg/yr.	14.5 [2005]	MA 7.8 [2001-05]
Hip Fracture Hospitalizations Among 65+ Year Olds (rate per 100,000 and 5 yr. count) [2001-2005]	707.8 (±65.6) 447	762.7 (±49.0) 932	827.7 (±41.9) 1,497	754.5 (±63.8) 538	739.0 (±49.5) 856	780.6 (±51.6) 878	745.2 (±45.2) 1,044	649.4 (±43.1) 874	751.3 (±17.5) 7,066	778.4 [2003-05]	n/a
Reported Rapes (rate per 10,000 female population and average number per year) [2001-2005]	2.3 (± 0.5) 16 avg/yr.	5.7 (±0.7) 50 avg/yr.	3.4 (±0.3) 85 avg/yr.	2.3 (±0.6) 10 avg/yr.	3.0 (±0.5) 23 avg/yr.	3.1 (±0.5) 26 avg/yr.	7.7 (±0.8) 76 avg/yr.	3.0 (±0.4) 55 avg/yr.	2.8 (±0.1) 340 avg/yr.	n/a	n/a
Domestic Assaults Reported to the Police (rate per 10,000 population and count) [2005]	36.7 (± 4.4) 269	55.8 (± 3.5) 964	40.6 (±2.4) 1,115	22.7 (±3.2) 198	27.0 (±2.6) 411	26.7 (±3.6) 440	50.7 (±3.2) 986	53.2 (±3.2) 1,076	41.3 (± 1.1) 5,549	n/a	n/a

# 2008 MAINE STATE PROFILE of SELECTED PUBLIC HEALTH INDICATORS

Maine Center for Disease Control and Prevention/DHHS

SUBSTANCE ABUSE AND MENTAL HEALTH INDICATORS	DISTRICT								MAINE State ± Margin of Error	UNITED STATES	Bench- mark State (healthiest)
	Aroostook ± Margin of Error	Central ± Margin of Error	Cumberland ± Margin of Error	Downeast ± Margin of Error	Midcoast ± Margin of Error	Penquis ± Margin of Error	Western ± Margin of Error	York ± Margin of Error			
Adults With 14 or More Days of Frequent Mental Distress in the Past Month (percent) [2006]	13.6 (±5.1)	9.7 (±3.0)	11.3 (±3.2)	7.0 (±2.8)	10.3 (±2.6)	12.1 (±3.7)	8.7 (±2.6)	8.4 (±3.4)	10.0 (±1.2)	10.2 (±0.6)	MN 6.7
Adults With Current Symptoms of Moderate or Severe Depression (percent) [2004-2006]	5.8 (±3.3)	9.1 (±2.9)	6.5 (±2.7)	7.8 (±3.1)	6.1 (±2.2)	13.3 (±3.9)	5.6 (±2.0)	7.0 (±3.1)	7.6 (±1.0)	n/a	ND 5.6 [2006]
Suicide Deaths (age 10 and older, rate per 100,000) [2001-2005]	12.7 (±3.9)	16.2 (±2.9)	12.0 (±2.0)	15.2 (±3.9)	16.9 (±3.1)	15.0 (±2.8)	13.9 (±2.9)	13.5 (±2.4)	13.9 (±1.0)	12.6	NY 7.2
Previous 30-Day Alcohol Use Among 9 <sup>th</sup> -12 <sup>th</sup> Graders (percent) [2006]	37.3	36.7	41.6	38.0	43.9	40.7	39.2	42.3	40.3	43.3 [2005]	UT: 15.8 HI: 34.8 [2005]
Adults Who Have Participated in Binge Drinking in the Past 30 Days (percent) [2004]	25.2	27.8	27.3	26.3	27.6	29.8	31.4	24.1	27.8	14.4 (median%)	KY 8.6
Binge Drinking Within the Last 2 Weeks Among 9 <sup>th</sup> -12 <sup>th</sup> Graders (percent) [2006]	18.4	19.5	22.0	20.8	23.9	22.9	21.7	22.3	21.6	25.5 Last 30 days [2005]	UT: 8.8 HI: 18.8 [2005]
Previous 30-Day Prescription Drug Misuse Among 9 <sup>th</sup> -12 <sup>th</sup> Graders (percent) [2006]	5.4	8.0	7.6	6.5	9.4	8.5	8.8	9.6	8.2	n/a	n/a
Substance Abuse Admissions (number among all ages) [2006]	1,275	1,204	2,426	1,141	878	1,391	901	802	10,018	n/a	n/a

## 2008 MAINE STATE PROFILE of SELECTED PUBLIC HEALTH INDICATORS

Maine Center for Disease Control and Prevention/DHHS

ACCESS TO CARE INDICATORS	DISTRICT								MAINE State ± Margin of Error	UNITED STATES	Bench- mark State (healthiest)
	Aroostook ± Margin of Error	Central ± Margin of Error	Cumberland ± Margin of Error	Downeast ± Margin of Error	Midcoast ± Margin of Error	Penquis ± Margin of Error	Western ± Margin of Error	York ± Margin of Error			
Access to Primary Care Physician (population to physician ratio) [2003]	1,034:1	971:1	759:1	880:1	1,189:1	939:1	1,091:1	1,269:1	978:1	1,351:1 [2000]	MA 187.3 per 100,000 [2005]
Adults With No Health Insurance (percent) [2006]	6.3 (±7.4)	12.2 (± 8.5)	5.8 (± 4.4)	15.3 (± 8.5)	11.6 (± 5.8)	12.2 (± 7.8)	12.9 (± 6.0)	6.9 (± 6.7)	10.4 (± 2.6)	14.5 (median %)	MN 8.2
PUBLIC HEALTH PREPAREDNESS INDICATORS											
Hospitals with Pandemic Influenza <b>Plan In Process or No Response</b> (percent) [2007]	0	67	14	60	0	25	0	0	25	n/a	n/a
Hospitals with <b>Draft</b> Pandemic Influenza <b>Plan Completed</b> (percent) [2007]	0	33	14	40	50	75	20	33	35	n/a	n/a
Hospitals with Pandemic Influenza <b>Plan Completed</b> (percent) [2007]	100	0	72	0	50	0	80	67	40	n/a	n/a

## Sources and Technical Notes for Maine CDC/DHHS Public Health Indicators

For more information about these statistics, please visit the Technical Notes and Sources pages at the back of the 2007 Maine CDC/DHHS *Health District Profiles*, from which some of these data were selected. *Please note:* in some cases the indicators here have been updated or revised as new data became available. The *Profiles* and this table are found at [www.mainepublichealth.gov](http://www.mainepublichealth.gov), are downloadable onto CDs and may be reproduced without permission. This data should replace that in the *Profiles*. Other notes:

There are three (3) DHHS Districts whose jurisdictional borders follow a single county [Aroostook, Cumberland, and York] and five (5) DHHS Health District jurisdictions that cover either 2, 3, or 4 counties [Central, Downeast, Midcoast, Penquis, Western Districts.]	Highlighted cells are those that may be significantly different than the state rate because the data fall outside the margin of error.	Race/ethnicity estimates herein reflect one type of Census format so that when a person of more than one race is counted, he or she is counted in more than one racial category. This will result in a total count higher than the actual total population count for the jurisdiction when it comes to race/ethnicity.	What is measured to compare disease burden by District is not always what should be measured to compare state to national data (which is not always age-adjusted.)	Differences in methodology for data calculations may be too great to directly compare District or State data with US or Benchmarking State data sets such as found in <i>Healthy People 2010</i> , or the Commonwealth, Kaiser, or United Health Foundation indicators ranking projects. They are still informative so they have been included.	Indicators change over time, especially those that depend in coding regulations, which themselves change.	Data for the single county Districts are sometimes calculated differently than those of multi-county Districts. For example, median ages are not comparable across Districts, but still provide useful information.	Many other complicated factors, such as when the population (Census) changes, means rates are not always comparable
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**AMERICAN COMMUNITY SURVEY [ACS]** [www.census.gov/acs/www/index.html](http://www.census.gov/acs/www/index.html). A mail survey about communities in between the 10-year Census and conducted by the U.S. Census Bureau. ACS surveys the same selected Maine counties every year; so state level ACS data are estimates, and county-level ACS data are not available for all counties.

**BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM [BRFSS]** [www.cdc.gov/brfss](http://www.cdc.gov/brfss). An annual, national telephone survey of randomly selected, residential, non-institutionalized adults aged 18 and older to collect uniform data on preventive health behaviors and risk factors. Responses are voluntary and based on self-report. Conducted in Maine by Maine CDC/DHHS.

**HOSPITAL DISCHARGE DATASETS** [www.mhdo.org](http://www.mhdo.org). A database of all hospitalizations and emergency department visits in Maine facilities; for this table restricted to Maine residents. Compiled in Maine by the Maine Health Data Organization.

**MAINE CANCER REGISTRY** <http://apps.nccd.cdc.gov/uscs/>. A Maine CDC/DHHS program charged with collecting data on cancer incidence and deaths within the state of Maine and among Maine residents.

**MAINE DEPARTMENT OF PUBLIC SAFETY** [www.maine.gov/dps](http://www.maine.gov/dps). Provides criminal justice, law enforcement, fire safety, and emergency response services and compiles data.

**MAINE GENERAL POPULATION DRUG AND ALCOHOL SURVEY** [www.maine.gov/dhhs/osa/data/pubrpts.htm](http://www.maine.gov/dhhs/osa/data/pubrpts.htm). The Maine Office of Substance Abuse's [OSA/DHHS] statewide quantitative research study on drug and alcohol use and abuse issues.

**MAINE YOUTH DRUG AND ALCOHOL USE SURVEY/MAINE YOUTH TOBACCO SURVEY [MYDAUS/YTS]** [www.maine.gov/dhhs/osa/data/mydaus/index.htm](http://www.maine.gov/dhhs/osa/data/mydaus/index.htm). Provides comprehensive data on substance use among Maine's 6<sup>th</sup>-12<sup>th</sup> graders. Conducted by Maine CDC/DHHS and Maine OSA/DHHS.

**NATIONAL CENTER FOR HEALTH STATISTICS [NCHS]** [www.cdc.gov/nchs](http://www.cdc.gov/nchs). The US CDC provides statistics compiled from data submitted by individual states, primarily in Maine from Maine CDC/DHHS.

**PREGNANCY RISK ASSESSMENT MONITORING SYSTEM [PRAMS]** [www.maine.gov/dhhs/bohodr/prams.htm](http://www.maine.gov/dhhs/bohodr/prams.htm). A state-wide representative survey of new mothers conducted on an ongoing basis in Maine by Maine CDC/DHHS since 1987 on maternal experiences and attitudes before, during, and shortly after pregnancy.

**U.S. CENSUS BUREAU** [www.census.gov](http://www.census.gov). The Census Bureau provides data on the people and economy of the United States in great detail.

**YOUTH RISK BEHAVIOR SURVEY [YRBS]** [www.cdc.gov/HealthyYouth/yrbs/](http://www.cdc.gov/HealthyYouth/yrbs/). An every other year survey conducted at the state level in every state to collect uniform data on health risk behaviors among youth. It surveys publicly-funded Maine middle and high schools and the students attending those schools. Conducted by the Maine Department of Education with funding from the US CDC.



## Appendix III - Links to Recent Maine State Government Health Plans and Reports

Cancer Plan for Maine, 2006-2010

<http://mainegov-images.informe.org/dhhs/boh/ccc/documents/2006%20Final%20Cancer%20Plan.pdf>

Cardiovascular Disease: Heart Healthy and Stroke-Free in Maine - Updated Strategic Plan for Cardiovascular Health in Maine 2006-2010

[http://healthymainepartnerships.org/mcvhp/documents/CVD\\_Plan\\_final.pdf](http://healthymainepartnerships.org/mcvhp/documents/CVD_Plan_final.pdf)

Cardiovascular Disease: Summary Findings from Improving Care for Patients with Hypertension and High Cholesterol in the Primary Care Setting in Maine 2006

<http://healthymainepartnerships.org/downloads/Provider%20Patient%20Eval%20Report%20-.pdf>

Cardiovascular Disease: Summary Findings from Signs and Symptoms of Heart Attack and Stroke Mini-Grants in Maine 2006

<http://healthymainepartnerships.org/downloads/ExecutiveSummary-SignsandSympt.pdf>

Cardiovascular Disease: Summary Findings from Three Evaluation Assessments - Maine Heart Check Assessment, Employee Health Survey, Worksite Wellness Coordinators 2005

<http://healthymainepartnerships.org/downloads/PilotEvalDocument5020.doc>

Diabetes Health System Strategic Plan for Maine 2005

<http://mainegov-images.informe.org/dhhs/bohdcfh/dcp/documents/Diabetes%20Strategic%20Plan%20-%20FINAL2.pdf>

District Health Profiles, Maine 2007

[http://www.maine.gov/dhhs/boh/maine\\_dhhs\\_district\\_health\\_profiles.htm](http://www.maine.gov/dhhs/boh/maine_dhhs_district_health_profiles.htm)

Drinking Water State in Maine: 2008 State Revolving Fund Plan

<http://mainegov-images.informe.org/dhhs/eng/water/Templates/newFinancialResources/2008SRF/2008%20Draft%20Intended%20Use%20Plan.pdf>

Early Childhood Comprehensive System Plan for Maine 2007

[http://www.maine-eccs.org/invest\\_early\\_in\\_maine\\_2007.pdf](http://www.maine-eccs.org/invest_early_in_maine_2007.pdf)

Healthy Maine 2010 – Maine's Public Health Plan for the Decade

<http://www.maine.gov/dhhs/boh/healthyme2k/hm2010a.htm>

Hepatitis: Viral Hepatitis Prevention and Control: An Action Plan for Maine 2005-2007

<http://mainegov-images.informe.org/dhhs/boh/januarycomplete.pdf>

HIV Community Planning Group HIV Prevention Plan, Maine, 2004-2008

<http://www.mehivcpg.org/Plan%2004-08.pdf>

HIV Community Planning Group HIV Prevention Plan Update 2007

<http://www.mehivcpg.org/State%20of%20Maine%202007%20Plan%20web%20update.pdf>

Infectious Diseases in Maine 2007

[http://mainegov-images.informe.org/dhhs/boh/documents/Final\\_Annual%20Report\\_2006.pdf](http://mainegov-images.informe.org/dhhs/boh/documents/Final_Annual%20Report_2006.pdf)

Injury Prevention Program Strategic Plan for Maine 2007

[http://mainegov-images.informe.org/dhhs/bohdcfh/inj/documents/MIPPOctober2007PlanCD\(2\).pdf](http://mainegov-images.informe.org/dhhs/bohdcfh/inj/documents/MIPPOctober2007PlanCD(2).pdf)

Oral Health Improvement Plan for Maine 2007

[http://mainegov-images.informe.org/dhhs/boh/files/odh/MEOralHealth\\_Plan07.pdf](http://mainegov-images.informe.org/dhhs/boh/files/odh/MEOralHealth_Plan07.pdf)

Physical Activity & Nutrition Plan for Maine 2005-2010

[http://www.healthymainepartnerships.org/panp/PANP\\_plan\\_2005\\_2010.aspx](http://www.healthymainepartnerships.org/panp/PANP_plan_2005_2010.aspx)

Public Health Emergency Preparedness for Maine - Evaluation Report 2007

<http://www.maine.gov/dhhs/boh/newpubs.htm>

Sentinel Events Reports 2007

[http://www.maine.gov/dhhs/dlrs/medical\\_facilities/sentinelevents/home.html](http://www.maine.gov/dhhs/dlrs/medical_facilities/sentinelevents/home.html)

Teen and Young Adult Sexual Health in Maine 2006

[http://www.maine.gov/dhhs/bohdcfh/tya/documents/Final\\_Complete\\_Report.doc](http://www.maine.gov/dhhs/bohdcfh/tya/documents/Final_Complete_Report.doc)

Rural Health Work Group

[www.ruralhealthplan.maine.gov/mCDC/DHHS](http://www.ruralhealthplan.maine.gov/mCDC/DHHS)

Healthcare Occupations Report

<http://mainegov-images.informe.org/labor/lmis/pdf/HealthcareReport.pdf>

## **Appendix IV - Statutory language pertaining to (1) the role of the State Health Plan as it relates to CON, & (2) the Commissioner's bases for CON decisions**

**2 MRSA 103 includes language about the SHP and CON. Relevant sections are as follows:**

**Requirements.** The plan must:

- Establish and set annual priorities among health care cost, quality and access goals;
- Prioritize the capital investment needs of the health care system in the State within the capital investment fund, established under section 102;
- Outline strategies to:
  1. Promote health systems change;
  2. Address the factors influencing health care cost increases; and
  3. Address the major threats to public health and safety in the State, including, but not limited to, lung disease, diabetes, cancer and heart disease;
- Be consistent with the requirements of the certificate of need program described in Title 22, chapter 103-A.

**Uses of plan.** The plan must be used in determining the capital investment fund amount pursuant to section 102 and must guide the issuance of certificates of need by the State and the health care lending decisions of the Maine Health and Higher Education Facilities Authority. A certificate of need or public financing that affects health care costs may not be provided unless it meets goals and budgets explicitly outlined in the plan.

**22 MRSA 335 (CON statute) includes the following language pertaining to the Commissioner's bases for CON decisions:**

**1. Basis for decision.** ... the commissioner shall approve an application for a certificate of need if the commissioner determines that the project:

- A. Meets the conditions set forth in subsection 7;
- B. Is consistent with and furthers the goals of the State Health Plan;
- C. Ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers;
- D. Does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum, as established in Title 24-A, section 6951; and
- E. Can be funded within the capital investment fund...

**7. Review; approval.** ...the commissioner shall issue a certificate of need if the commissioner determines and makes specific written findings regarding that determination that:

...C. There is a public need for the proposed services as demonstrated by certain factors, including, but not limited to:

- (1) Whether, and the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project;

- (2) Whether the project will have a positive impact on the health status indicators of the population to be served;
- (3) Whether the services affected by the project will be accessible to all residents of the area proposed to be served; and
- (4) Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project;

D. The proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

- (1) The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;
- (2) The availability of state funds to cover any increase in state costs associated with utilization of the project's services; and
- (3) The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available; and

E. The project meets the criteria set forth in subsection 1.

In making a determination under this subsection, the commissioner shall use data available in the State Health Plan under Title 2, section 103, including demographic, health care service and health care cost data, data from the Maine Health Data Organization established in chapter 1683 and other information available to the commissioner. Particular weight must be given to information that indicates that the proposed health services are innovations in high-quality health care delivery, that the proposed health services are not reasonably available in the proposed area and that the facility proposing the new health services is designed to provide excellent quality health care.

In making all determinations under this subsection, the commissioner must be guided by the State Health Plan as described in Title 2, section 103.

### **The Capital Investment Fund**

Statute requires several discrete considerations when setting the CIF. First, it calls for consideration of the average age of plant or infrastructure (bricks and mortar). Average age of plant indicates the relative age, in years, of hospitals' plant and infrastructure. A lower average age implies a newer fixed asset base and less of a need for replacement in the near term.

Other considerations when setting the CIF include the opportunity for improved operational efficiencies in the state's health care system and technological developments and the dissemination of technology in health care.

One of the big concerns in setting the CIF is that Mainers not be put at a clinical disadvantage relative to the dissemination of cutting edge technology. The law directs the Governor's Office to consult with the Maine Quality Forum in setting the value of the Fund, specifically with regard to information about new technologies. The Maine Quality Forum did not identify any technological developments or opportunities for improved operational efficiencies that would necessitate special adjustments to the CIF.

The concern about technology must be approached with thoughtfulness and balance. Often new technologies require certain levels of patient volume to ensure delivery of the service is of high quality and to promote patient safety. In a rural state like Maine where the population is dispersed across a substantial geographic area, it is difficult for providers to achieve and maintain even minimum levels of activity needed to promote quality care. While it might be more convenient for patients to have cutting edge technology in their own backyards, it is not always safe or cost effective.

Finally, the process that GOHPF uses for determining the CIF value each year was set through the rulemaking process in 2004 when GOHPF issued a proposed rule, held public hearings, and issued a revised rule along with response to comments. The legislature also approved the rule.

- The rule specifies that to calculate the CIF GOHPF takes the average of the third year operating costs approved for hospitals under the CON process in each of the past 5 years, then adjusts it for two things: (1) the difference between costs per patient in Maine versus New England, and (2) the difference in Maine's growth in income and Maine's health care spending per capita.
- The rationale for this methodology is to increase our health care system's affordability by bringing: (1) our costs more in line with New England's and (2) growth in our health care spending closer to growth in our income.
- GOHPF can issue a different value based on the several considerations below, as well as on input from the ACHSD and from expert consultants.
  - The State Health Plan.
  - The opportunity for improved operational efficiencies in the state's health care system.
  - The average age of the infrastructure of the state's health care system.
  - Technological developments and the dissemination of technology in health care.
  - Unused balance remaining in the Capital Investment Fund from a prior year.
- 17-24 days after issuing the proposed value, GOHPF and ACHSD hold a joint public hearing whose purpose is to get input on the proposed CIF value. GOHPF then accepts written comments for 10 days and subsequently has a maximum of 120 days to issue a final value.

## Appendix V - Accounting for Age

CMS data shows Maine had the second highest per capita spending in the US, 24% higher than national per capita spending.

The Council asked staff to age-adjust spending data to reflect that Maine has an older (and therefore more expensive) population.

The table shows each state's "expected" per capita spending if spending on each person in that state were equal to average national spending on an individual in the same age group. It also shows how each state's actual spending compares to the expected spending.

Some states' actual spending was higher than the expected level; some actual spending was lower than the expected level.

Maine's actual spending is 15% higher than expected. That means that age only "explains" about one third of Maine's higher spending.

	Actual	Expected	Difference
<b>US</b>	<b>\$5,283</b>	<b>\$5,283</b>	<b>NA</b>
DC	\$8,295	\$5,194	60%
AK	\$6,450	\$4,503	43%
<b>MA</b>	<b>\$6,683</b>	<b>\$5,453</b>	<b>23%</b>
NY	\$6,535	\$5,379	21%
DE	\$6,306	\$5,369	17%
<b>ME</b>	<b>\$6,540</b>	<b>\$5,672</b>	<b>15%</b>
<b>CT</b>	<b>\$6,344</b>	<b>\$5,538</b>	<b>15%</b>
<b>RI</b>	<b>\$6,193</b>	<b>\$5,559</b>	<b>11%</b>
<b>VT</b>	<b>\$6,069</b>	<b>\$5,476</b>	<b>11%</b>
MN	\$5,795	\$5,259	10%
MD	\$5,590	\$5,180	8%
NJ	\$5,807	\$5,407	7%
OH	\$5,725	\$5,409	6%
WI	\$5,670	\$5,398	5%
WV	\$5,954	\$5,736	4%
PA	\$5,933	\$5,722	4%
KY	\$5,473	\$5,297	3%
NE	\$5,599	\$5,430	3%
TN	\$5,464	\$5,301	3%
ND	\$5,808	\$5,653	3%
<b>NH</b>	<b>\$5,432</b>	<b>\$5,312</b>	<b>2%</b>
IL	\$5,293	\$5,222	1%
IN	\$5,295	\$5,263	1%
MO	\$5,444	\$5,417	1%
KS	\$5,382	\$5,382	0%
NC	\$5,191	\$5,207	0%
WY	\$5,265	\$5,347	-2%
WA	\$5,092	\$5,201	-2%
LA	\$5,040	\$5,174	-3%
MS	\$5,059	\$5,207	-3%
SC	\$5,114	\$5,282	-3%
SD	\$5,327	\$5,536	-4%
MI	\$5,058	\$5,275	-4%
IA	\$5,380	\$5,636	-5%
AL	\$5,135	\$5,385	-5%
CO	\$4,717	\$4,957	-5%
GA	\$4,600	\$4,873	-6%
TX	\$4,601	\$4,884	-6%
VA	\$4,822	\$5,171	-7%
FL	\$5,483	\$5,936	-8%
CA	\$4,638	\$5,029	-8%
OK	\$4,917	\$5,369	-8%
MT	\$5,080	\$5,558	-9%
HI	\$4,941	\$5,427	-9%
OR	\$4,880	\$5,391	-9%
NV	\$4,569	\$5,085	-10%
AR	\$4,863	\$5,462	-11%
ID	\$4,444	\$5,113	-13%
UT	\$3,972	\$4,605	-14%
NM	\$4,471	\$5,272	-15%
AZ	\$4,103	\$5,288	-22%

## Appendix VI – Glossary

**Access** - An individual's ability to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of providers), and sociological (discrimination, language barriers).

**Agency for Healthcare Research and Quality (AHRQ)** - A federal agency authorized in 1999 to support research focused on quality, safety, efficiency and effectiveness of health care. To learn more about this agency, visit their website at [www.ahrq.gov](http://www.ahrq.gov)

**Area Health Education Center (AHEC)** - An organization or organized system of health and educational institutions whose purpose is to improve the supply, distribution, quality, use and efficiency of health care personnel in medically underserved areas. An AHEC's objectives are to educate and train the health personnel needed by the underserved areas and to decentralize health workforce education, thereby increasing supply and linking the health and educational institutions.

**Behavioral Risk Factor Surveillance System (BRFSS)** - the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Conducted by the 50 state health departments as well as those in the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands with support from the CDC/DHHS, BRFSS provides state-specific information about issues such as asthma, diabetes, health care access, alcohol use, hypertension, obesity, cancer screening, nutrition and physical activity, tobacco use, and more. Federal, state, and local health officials and researchers use this information to track health risks, identify emerging problems, prevent disease, and improve treatment. For more information, visit <http://www.CDC/DHHS.gov/brfss/>.

**Benchmark** – an objective that is measurable and identifies a step you hope to achieve as you move towards your ultimate goal

**BOI – Bureau of Insurance** – Maine bureau within the Department of Professional and Financial Regulation charged with regulation of the insurance industry.

**Care management, case management** assigns the administration of care for a patient to a single person (or team) to coordinating all necessary health care and supportive services needed. Case or care management tries to enhance access to care and improve the continuity and efficiency of services. Case or care managers may arrange needed services for patients, assess the patient's needs, arrange for support services (housing, benefit programs, job training, etc.), and monitor medication and use of services. They are often used in primary care to assist with the coordination of care among multiple providers for patients with chronic illness.

**CarePartners** - a program being implemented in three Maine Counties in collaboration with MaineHealth to improve low income and uninsured Mainers' access to health care services and their health status. Under the program, low income Mainers are provided with access to comprehensive healthcare services, care management and low cost or free pharmaceuticals. Persons are eligible for CarePartners if they are uninsured, have a household income under 175% of the Federal Poverty Level, live in the program service area for at least six months, meet an assets test, and are not eligible for coverage through their employer or school. All persons enrolled in CarePartners are assigned a Primary Care Provider, (PCP) and Care Manager. The Care Manager helps enrollees to access needed health care, social and economic

services in the community. All healthcare services, except for office visits and prescriptions are free. Patients pay \$10 for an office visit and \$5 for a month's supply of prescription drugs. For more information on this program, visit [www.communitiesincharge.org/Documents/PhaseII%20PressRelease/Portland.htm](http://www.communitiesincharge.org/Documents/PhaseII%20PressRelease/Portland.htm).

**Maine Center for Disease Control and Prevention - Maine CDC/DHHS** - Maine's public health agency and is located in Maine DHHS. Maine CDC's mission is to preserve, protect, and promote the health of all Maine people. Divisions within the agency include: Chronic Disease, Environmental Public Health, Family Health, Infectious Disease, and Public Health Systems. Maine's Offices of Minority Health, Local Public Health, and Rural Health and Primary Care are also located in the Maine CDC.

**Certificate of Need (CON)** – an approval process for the expansion of existing services or facilities that cost more than a certain amount, the establishment of new services, or substantial reductions in capacity of certain types of providers

**Capital Investment Fund (CIF)** – an annual limit set on the third year operating costs of capital investments projects receiving CON approval in any given year

**CONU (Certificate of Need Unit)**– the office that reviews the CON application

**Chronic illness** – disease of slow progression and long duration

**Co-morbidity** - The co-existence of two or more diseases, including chronic illness.

**Community-based care** - The blend of health, public health, and social services provided to an individual or family in their place of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.

**Consumer** - Someone who uses or buys products and services, natural or manufactured. In the State Health Plan the words payors and stakeholders are inclusive of consumers.

**Cost-based reimbursement** - Payment made by a health plan payer or to health care providers based on the actual costs incurred in the delivery of care and services to plan beneficiaries. Medicare and Medicaid often pay rural providers, such as Critical Access Hospitals and Federally Qualified Health Centers, on a cost basis.

**Critical Access Hospital (CAH)** - The CAH program was designed to improve rural health care access and reduce hospital closures. Critical Access Hospitals provide essential services to a community and are reimbursed by Medicare on a "reasonable cost basis" for services provided to Medicare patients.

**DHHS - Department of Health and Human Services** The department of Maine State government responsible for programs and services that support the health and well being of our neediest population

**Dirigo Choice** - health care coverage designed to give Maine businesses with 50 or fewer employees, the self-employed, and individuals an affordable, high-quality option for health coverage. Enrollees receive discounts on monthly payments and reductions in deductibles and out-of-pocket expenses based on their income and family size. Discounts can be as high as



100%. DirigoChoice is a voluntary program with health insurance coverage provided through Anthem Blue Cross and Blue Shield of Maine.

**Dirigo Health Initiative** - In addition to improving access to health care for Maine residents, the Dirigo Health Initiative was developed to contain costs and improve health care quality for Mainers. Through the initiative the Governor plans to contain costs by reducing bad debt and free care, strengthening the Certificate of Need process, developing a capital investment fund, and creating transparency in prices. The strategies for improving quality are to improve the use of data and information technology to measure quality, to support the development of electronic medical records for all Mainers, and to provide informational resources to providers and consumers to assist them in making informed health care choices. The initiative will also include a biennial State Health Plan to identify health problems and create strategies to make Maine the healthiest state in the country.

**Disease management** - The process of identifying and delivering the most efficient and effective combination of resources and interventions for the treatment or prevention of a specific disease. Disease management can be provided by physicians and other health care providers, but is also frequently used by health insurance providers to improve care and contain costs.

**DCC – District Coordinating Councils** – Councils in each of the 8 public health districts that work with local groups to find solutions to health and healthcare problems in their districts

**Electronic Medical Records (EMR)** - A set of databases that contains the health information for patients from a variety of clinical service delivery processes, including laboratory data, pharmacy data, patient registration data, radiology data, surgical procedures, clinic and inpatient notes, preventive care delivery, emergency department visits, billing information, and so on. EMRs may also include clinical applications that can act on the data contained within the record, including clinical decision support systems, computerized provider order entry, and a reporting system.

**Evidence-based Medicine** - The explicit and judicious use of current best evidence/practice in making decisions about the care of individual patients. The approach must balance the best external evidence with the desires of the patient and the clinical expertise of providers.

**Federally Qualified Health Center (FQHC)** - A health center in a medically underserved area that is eligible to receive cost-based Medicare and Medicaid reimbursement and fees adjusted to ability to pay, governed by a community board comprised of 51% patients, and provide comprehensive primary health care and supportive services.

**GOHPF – Governor’s Office on Health Planning and Finance** – responsible for the coordination and planning of state health systems, the publishing of a biennial State Health Plan and making recommendations to the Governor and Legislature on improving Maine’s health systems

**Health Information Exchange (HIE)** - Health information exchange (HIE) refers to the sharing of clinical and administrative data across the boundaries of health care institutions and other health data repositories. Many stakeholder groups (ors, patients, providers, and others) realize that if such data are shared health care processes would improve with respect to safety, quality, cost, and other indicators.

**HealthInfoNet** - An independent, nonprofit organization created to develop a statewide clinical information sharing infrastructure for Maine. This infrastructure will permit the sharing of patient health care information across health care providers and organizations.

**Health Information Technology** - Health information technology (Health IT) allows comprehensive management of medical information and its secure exchange between health care consumers and providers through the use of technology.

**Health Care Network** - An affiliation of providers through formal and informal contracts and agreements.

**Health Professional Shortage Area (HPSA)** - Areas or communities with diminishing health care services for primary care, mental health, and dental health. Once designated a shortage area, the community becomes eligible for state and federal assistance to recruit and retain health professionals and access to additional reimbursement dollars.

**Home Health Care/Home Health** - Health services provided in the home to the aged, disabled, or sick that do not need institutional care. The most common services are nursing care, speech, physical, occupational and rehabilitation therapy, homemaker services, and social services.

**Hospice** - Hospice in the United States has grown from a volunteer-led movement to improve care for people dying alone, isolated, or in hospitals, to a significant part of the health care system. In 2005 more than 1.2 million individuals and their families received hospice care. Hospice is the only Medicare benefit that includes pharmaceuticals, medical equipment, twenty-four hour/seven day a week access to care and support for loved ones following a death. The majority of hospice care is delivered at home. Hospice care is also available to people in home-like hospice residences, nursing homes, assisted living facilities, veterans' facilities, hospitals and prisons.

**Institute for Healthcare Improvement (IHI)** - A nonprofit organization created to improve health care quality. The organization developed the 100,000 lives campaign to assist hospitals in reducing preventable deaths. They recently developed the 5 million lives campaign with a goal of preventing five million incidents of medical harm by the end of 2008.

**Interoperability** - The ability of different information technology systems and software applications to communicate, to exchange data accurately, effectively, and consistently, and to use the information that has been exchanged.

**Joint Commission on Accreditation for Health Organizations (Joint Commission)** - An independent, not-for-profit organization that evaluates and accredits a variety of health care organizations, including hospitals, ambulatory care, long-term care, and laboratory services). The Joint Commission develops its own accreditation standards, which include a number of required patient safety goals.

**Leapfrog Group, The** - is a voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. The organization's four leaps are focused on computerized physician order entry, evidence-based hospital referral, ICU physician staffing, and an assessment of providers' progress on achieving the National Quality Forum's 30 Safe Practices. For more information about the Leapfrog Group visit <http://www.leapfroggroup.org/>.

**LHO – Local Health Officer**

a person employed by each municipality for the main purposes of linking municipal public health threats to Maine CDC/DHHS resources. LHOs are supervised by Maine CDC/DHHS

**MaineCare** - Maine's Medicaid program. Medicaid provides low-income children, pregnant women, and parents with health insurance coverage for little or no cost. The program also covers low income elderly and the disabled. Adults without children may be eligible through the non-categorical needy waiver, but this program has been limited in recent years.

**Maine Direct Care Worker Coalition** - An organization with representatives from long-term care which promotes policy and practices that respect and value direct care workers in order to sustain quality direct care in Maine.

**MEHAF - Maine Health Access Foundation** - founded in April 2000, MeHAF provides grant funding and other programs to address access to health care for Mainers, especially the uninsured and medically underserved. The organization provides approximately \$5 million in grant and program funding annually. For more information visit <http://www.mehaf.org/>.

**Maine Health Alliance** - a health care provider organization which promotes the ability of its member providers to deliver locally accessible, high quality, cost effective services in a changing health care environment. The organization achieves these objectives by interacting with purchasers of health care, improving care management, and other activities.

**MHDO – Maine Health Data Organization** - independent executive agency charged with collecting clinical and financial health care information and to exercise responsible stewardship in making this information accessible to the public.

**MHMC -Maine Health Management Coalition** - A non-profit coalition of 34 employers that includes doctors, hospitals, insurers, and public and private employers. The coalition has focused on reducing the costs and improving the quality of health care in Maine. They have developed the Pathways to Excellence programs for primary care providers and hospitals. For more information visit <http://www.mhmc.info/>.

**Maine Primary Care Association (MPCA)** - an association of health centers providing comprehensive primary care to all, regardless of insurance coverage or the ability to pay. They provide a variety of outreach and community level programs.

**Maine Quality Forum (MQF)** - An independent division of Dirigo Health, whose mission is to advocate for high quality healthcare and help each Maine citizen make informed healthcare choices and continue Maine's leadership in assuring high quality healthcare for its citizens.

**Maine State Employees Health Plan** - A health insurance plan that provides health insurance for employees of Maine State Government

**Medicaid** - a federal health coverage program for individuals and families with low incomes and resources. It is an entitlement program that is jointly funded by the states and federal government, and is managed by the states.

**MaineCare** – Maine's Medicaid program

**Medicare** - a social insurance program administered by the United States government, providing health insurance coverage to people who are either age 65 and over, or who meet other special criteria.

**Primary care** - a term used for the activity of a health care provider who acts as a first point of consultation for all patients.

**Prevention** - any activity which reduces the burden of mortality or morbidity from disease

**Public Health** - the study and practice of managing threats to the health of a community and pays special attention to the *social context* of disease and health, and focuses on improving health through society-wide measures

**Quality Counts** – a multi-stakeholder organization whose major mission is advancement of the “care model” (planned care model) for chronic disease management.

**Regional Health Information Organization (RHIO)** – multi-stakeholder organizations expected to be responsible for motivating and causing integration and information exchange in the nation’s revamped healthcare system.

**Rural Health Clinic (RHC)** - The Rural Health Clinics (RHCs) program is intended to increase primary care services for Medicaid and Medicare patients in rural communities.

**SCC – State Coordinating Council** – the statewide group that advises on the implementation of the public health infrastructure and assure efficient and effective public health functions

**Telehealth/Telemedicine** - a rapidly developing application of [clinical medicine](#) where medical information is transferred via telephone, the Internet or other networks for the purpose of consulting, and sometimes remote medical procedures or examinations.

**Underinsurance** – not having sufficient health insurance coverage requiring out of pocket expenses that exceed affordability based on income.