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Get It, Use It, Share It: National Provider Identifier (NPI)

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

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

The Care Transitions Intervention

Background

Older patients often require care from different practitioners in multiple settings. Yet during times when they are most vulnerable and their informal caregivers are often overwhelmed, systems of care fail patients by not ensuring that: (1) the critical elements of the care plan developed in one setting are transferred to the next; and (2) the essential steps that need to take place before and after transfer are executed. Because patients and their caregivers are often the only common thread moving across settings, together they comprise an appropriate target for an intervention.

The Intervention

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

How does CTI work?

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

Intervention Outcomes

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

The Care Transitions Intervention is currently being piloted at MMC by MaineHealth Elder Care Services. The MMC PHO will soon begin a pilot offering the Care Transitions Intervention to Greater Portland Medical Group patients and their caregivers. This intervention does not attempt to change the delivery of healthcare, but rather it is designed to make sure that the excellent care provided in the hospital is preserved after older patients leave the hospital.

More information about Care Transitions can be found at: <http://caretransitions.org>. Coleman, E., Smith, J., Frank, J., Min, S., Parry, C. & Kramer, A. (2004). Preparing patients and caregiver to participate in care delivered across settings: the care transitions intervention. *Journal of the American Geriatrics Society*, 52:1871-1825, 2004.

MaineHealth Elder Care Services
465 Congress Street, Suite 701, Portland, ME 04101
207-775-1095 · pfha@mmc.org

Highlights of the 2006 Quality Care Recognition Program Results

Specialty Results

- There were a total of 18 practices who received rewards for implementing an electronic system in 2006: 16 practices implemented an electronic prescribing system, 1 practice implemented an electronic medical record and 1 practice implemented an electronic referral system.
- 7 practices completed and received rewards for a referral management project
- 5 practices completed and received rewards for a quality improvement project
- 2 practices completed and received rewards for an improved access project
- 2 practices completed and received rewards for patient satisfaction surveys

Primary Care Results

- Our PHO primary care practice teams are providing outstanding adult diabetes process care: over 60% of the 10,502 patients with diabetes in the CIR are receiving all six recommended evidence-based process measures of care.
- 80% of our adult primary care physicians are delivering quality process care (all six measures) to at least 40% of their patients with diabetes; 20% of the physicians provide this high level of care to 80% or more of their patients!
- During 2006, 382 additional patients with diabetes were managed to the optimal level of control (HbA1c, blood pressure, and LDL all at American Diabetes Association targets), which has been achieved in now 25% of the patients in the CIR. The population of patients at increased risk (because of high levels of HbA1c, BP, or LDL) has decreased from 46% in 2004 to 40% in 2005 to 35% in 2006.
- Documented good performance overall compared to national reports for diabetes process care—Microalbumin 72% vs. 56% , ASA 86% vs. 48% , LDL 85% vs. 79%, HbA1c 91% vs. 87%
- The “at increased risk” population of patients receiving care management decreased from 52% to 47% and the patients at optimal control increased from 14% to 19% this past year. 73% of the 1752 care managed patients with diabetes received all six process measures of care.
- The Care Management Program in 2006 had 27,095 encounters (95% > ‘05) and served 2,588 patients (108% >‘05). The number of physicians served by a care manager went from 166 to 219 and the number of practices served went from 53 to 67.
- The number of patients with cardiovascular disease who have their demographic data loaded into the CIR went from 0 in 2005 to 5,325 in 2006. The percentage of these 5,325 patients with clinical data entry reached 88% by the end of 2006!
- Our primary care practice teams are providing important pediatric asthma process care with documentation of asthma severity classification and appropriate controller medication use (93% performance for the latter, compared to 50% reported nationally). While the rate of documentation of flu vaccine (44%) is double the nationally reported rate of 22%, the documentation of flu shots as well as school plans and action plans fell over the past year.
- Compared to 49.6% at year end 2005, 33% of patients with pediatric asthma received all six recommended process care measures by year end 2006. 7% of physicians caring for pediatric asthma delivered all six process measures to 80% or more of their patients.
- 75% of primary care physicians were trained in the use of the PHQ-9 depression assessment instrument
- 30% of patients with diabetes were screened for depression using the PHQ-9 screening
- 78% of pediatric patients with asthma and 91% of adult patients with diabetes had tobacco use assessed for the household
- For those patients using or exposed to tobacco, 28% of pediatric patients with asthma and 16% of patients with diabetes had tobacco treatment offered.

2006 Quality Care Recognition

The MMC Physician-Hospital Organization is pleased to recognize the recipients of the 2006 Referral Management and Quality Initiative Rewards. There were 15 project recipients for the year. The project teams and titles of the projects are listed below. Numbers within the parenthesis () indicate the projects for each practice.

Maine Cardiology Associates (4)

Compliance with American College of Cardiology/American Heart Association Performance – a study sample of 377 patients found that all patients exceeded the NCQA guidelines for BP, lipid profile, tobacco use, antiplatelet and beta blocker therapy.

Compliance with the Intersociety Commission for Heart Disease Resources for Longevity and End of Life decay of cardiac pacemakers. Compliance went from 5% to 71%. In the process, two patients were identified who required urgent pacemaker replacement ahead of the recommended ICHDR schedule for replacement.

Echo “Q” – Quantification and Quality Assessment – established the reliability of mitral valve regurgitation quantification, which will now be a standard study

Patient Satisfaction Survey

Maine Center for Cancer Medicine and Blood Disorders

Cancer Risk and Prevention Clinic – Increased numbers of individuals who were offered cancer services by well over the 30% goal. The project assessed the impact of their post counseling care services through utilization of a telephone survey which exceeded the goals set.

Maine Center for Endocrinology & Diabetes (2)

Thyroid Cancer Care Surveillance – reviewed 628 patients charts to evaluate the adequacy of follow-up care and found that 125 (20%) of patients did not return for follow-up. Practices instituted in the office to institute appropriate follow-up care.

Improving Access for New Patient Referrals – reduced waiting time for new patient referrals from 14-33 days to 5 working days. Increased demand for services continues to grow.

Maine Orthopaedic Center (2)

Referral Management Survey for PCPs – streamlined referrals by utilization of an email referral system.

Improved Orthopaedic Access through Referral Management – devised new system to decrease wait time for new patient referrals. Also identified and improved management of non-acute patients.

Martin’s Point Health Care (2)

Portland Health Center Referral Process – completely implemented EMR to manage referral cycle time, which improved. The new measure captures completion of the referral, including notification of the patient and specialist, plus insurance authorizations.

Portsmouth Health Center Continuing Care Clinics – restructured process to reduce wait time for diabetic patients referred to Continuing Care Clinics, so that wait time of 1-2 months was reduced to no wait time at end of the study.

MMC OB/GYN Associates

Communication to Referring Physician Following Patient Consult – data measured for all three divisions. Consultation reports to referring physicians were significantly improved in all divisions.

Portland Gastroenterology Associates

Patient Satisfaction Survey

Spectrum Medical Group, Oncology Division

Cervical Cancer – determined if patients with select stages of cervical cancer treated at MMC received appropriate non-surgical care (radiation or chemotherapy) according to National Comprehensive Cancer Network (NCCN) guidelines. The results are comparable to the hospitals surveyed by the NCCN.

Medomak Family Physicians

Referral Tracking – This practice uses an EMR to implement referrals and transmit clinical data to specialists. 94% of referrals were entered in the EMR, 94% of referrals with clinical information were sent by the end of the second working day. 100% of patients had information transmitted to the specialist prior to the appointment.

For more information contact A. Jan Berlin, M. D. at (207) 771.2004 ext 260 or berlij@mmc.org

2006 Quality Care Recognition

Congratulations to all of the primary care physicians achieving the 2006 goals for evidence-based care delivery.

Quality Diabetes Process Care

Cape Elizabeth Family Medicine
 Carl J. Schuler, DO
 Catherine Crute, MD
 Ciampi Family Practice
 Daniel Merson, DO
 David Hotelling, MD
 Family Health Center of Southern Maine
 Family Medicine Center, Falmouth
 Family Medicine Center, Portland
 Gorham Village Family Health
 Gorham Village Family Health (Portland)
 Gray Family Health Center
 Greater Portland Medical Group, Cape Elizabeth
 Greater Portland Medical Group, Falmouth
 Greater Portland Medical Group, Scarborough
 Greater Portland Medical Group, Westbrook
 Heidi Larson, MD
 Internal Medicine on the Cape
 James Kirsh, DO
 Jeffrey E. Martin, MD
 Jett Family Practice
 Joseph R. deKay, DO
 Lake Region Primary Care
 Louis Hanson, DO
 Mark Braun, MD
 Martin's Point Health Care (Brunswick)
 Martin's Point Health Care (Portland)
 Mary Dowd, MD
 Massabesic Regional Medical Center
 Miles Family Medicine (Damariscotta)
 Miles Family Medicine (Wiscasset)
 Miles Family Practice (Waldoboro)
 Miles Internal Medicine
 Oxford Hills Family Practice
 Oxford Hills Internal Medicine Group
 Pamela Wansker, DO
 Patricia J Phillips DO
 Royal River Family Care, PA
 Scarborough Family Physicians
 Scarborough Health Care
 Seacoast Health Care
 St. Andrew's Family Care Center
 Wellspring Family Medical Associates
 Western Maine Family Practice

Quality Tobacco Care in Pediatric Asthma

Andrew Candelore, DO
 Carl Schuler, DO
 Greater Portland Pediatric Associates (Saco)
 MMG Pediatrics
 Pediatric Associates of Southern Maine

Quality Diabetes Outcomes Care

Cape Elizabeth Family Medicine
 Ciampi Family Practice
 Daniel Merson, DO
 David Hotelling, MD
 Elizabeth Pierce, DO
 Family Health Center of Southern Maine
 Family Medicine Center, Portland
 Gorham Village Family Health
 Gorham Village Family Health (Portland)
 Greater Portland Medical Group, Cape Elizabeth
 Greater Portland Medical Group, Falmouth
 Greater Portland Medical Group, Scarborough
 Greater Portland Medical Group, Westbrook
 Gwendolyn O'Guin, DO
 Heidi Larson, MD
 Internal Medicine on the Cape
 James Kirsh, DO
 John Stanhope, DO
 Maine Centers for Healthcare (Scarborough)
 Mark Braun, MD
 Martin's Point Health Care (Portland)
 Martin's Point Health Care (Portsmouth)
 Mary Dowd, MD
 Miles Family Medicine (Damariscotta)
 Miles Family Medicine (Wiscasset)
 Miles Internal Medicine
 Oxford Hills Family Practice
 Oxford Hills Internal Medicine Group
 Pamela Wansker, DO
 Patricia J Phillips DO
 Portland West Family Practice
 Scarborough Health Care
 Seacoast Medical Care
 St. Andrew's Family Care Center
 Standish Family Practice
 Western Maine Family Practice

Quality Pediatric Asthma Process Care

Bayview Pediatrics
 Carl Schuler, DO
 Family Medicine Center, Falmouth
 Greater Portland Pediatric Associates (Gorham)
 Greater Portland Pediatric Associates (Portland)
 Greater Portland Pediatric Associates (S. Portland)
 Greater Portland Pediatric Associates (Saco)
 Greater Portland Pediatrics Associates (Falmouth)
 Martin's Point Health Care (Brunswick)
 Massabesic Regional Medical Center
 MMG Pediatrics
 Pediatric Associates of Southern Maine
 Scarborough Family Physicians

Quality Depression Care in Diabetes

Andrew Candelore, DO
 Cape Elizabeth Family Medicine
 Catherine Crute, MD
 Ciampi Family Practice
 Internal Medicine on the Cape
 Jett Family Practice
 Massabesic Regional Medical Center
 Miles Family Medicine (Damariscotta)
 Oxford Hills Family Practice
 Pamela Wansker, DO
 Patricia J. Phillips, DO
 Scarborough Health Care
 Seacoast Medical Care

Quality Tobacco Care in Diabetes

Andrew Candelore, DO
 Cape Elizabeth Family Medicine
 Carl Schuler, DO
 Catherine Crute, MD
 Ciampi Family Practice
 Heidi Larson, MD
 Jett Family Practice
 John Stedman, DO
 Lake Region Primary Care
 Louis Hanson, DO
 Martin's Point Health Care (Brunswick)
 Martin's Point Health Care (Portland)
 Massabesic Regional Medical Center
 Miles Family Medicine (Damariscotta)
 Miles Family Medicine (Wiscasset)
 Oxford Hills Family Practice
 Pamela Wansker, DO
 Scarborough Family Physicians
 Scarborough Health Care
 Seacoast Medical Care

Special Thanks

We would like to give special thanks to everyone who has worked so diligently to develop the patient educational tools and the Clinical Improvement Registry clinical content that support patients with diabetes, asthma, depression & those that use tobacco. In addition, thank you to the asthma and diabetes educators and specialty physicians who have made themselves available to connect with primary care physicians and staff. It speaks volumes not only to see the improved care we, as a system, are providing to our patients but also to recognize these efforts as truly collaborative **within** our organization.

Thank You!

All of our physician members and their practice teams who continuously provide helpful feedback to improve the Clinical Improvement Plan

All of our physician members who have provided valuable clinical content and expertise

All of the MaineHealth Clinical Integration and MMC IS teams who have provided the important tools that have contributed to the success of our program

All of our physician champions who have inspired their colleagues to adapt systems to improve care

All who serve on PHO boards and committees and on MaineHealth workgroups

How can local healthcare providers play a role in pandemic influenza planning?

Scientists and public health professionals around the world are concerned about the potential for the highly pathogenic H5N1 avian virus to mutate and lead to a pandemic. As healthcare providers in the most densely populated city in Cumberland County, you will play a critical role in our local response to pandemic influenza. It is therefore imperative that we involve our frontline providers in critical decisions regarding how our healthcare system will respond most effectively. In addition, it is critical for healthcare providers to receive regular communication on local planning and response efforts. In recognition of National Public Health Week, being celebrated April 2-8, 2007, we would like to provide you with an update on local planning efforts. We would also like to provide you with pandemic influenza resources, and to request your participation in local efforts to begin educating and preparing the public.

Update on local Pandemic Influenza Planning Efforts

Exciting work is underway to ensure that we have a feasible and action-oriented pandemic influenza plan to protect our population, and to ensure the most efficient use of limited resources. The Cumberland County Emergency Management Agency (CCEMA), Southern Maine Regional Resource Center for Public Health Emergency Preparedness (SMRRC), and City of Portland, and the Health and Human Services Department, Public Health Division are overseeing planning efforts for Cumberland County and the City of Portland. One of the most critical areas we are addressing is the ability to effectively meet the demands that will be placed on our healthcare system during a pandemic. Based on CDC flu surge models, during a severe pandemic Maine could expect to exhaust existing bed capacity within 2 weeks, and would require a 92% surplus in hospital bed capacity in order to meet demands for acute care. Because existing hospitals will be overwhelmed during a pandemic, an effective local plan will require a coordinated response that involves all levels of healthcare, including private practice physicians, surgical centers, urgent care centers, long-term care facilities, and home health agencies. An effective response will also require us to plan for supplies and equipment, staffing, and space in order to meet excessive demands once our existing healthcare facilities are overwhelmed. Under the leadership of CCEMA, key stakeholders in our medical community and public health community held a historic meeting in March called the Cumberland County Pandemic Influenza Leadership Meeting in order to begin surge capacity planning. Through the work of this steering body we will look at deployable internal resources, as well as coordinated solutions to external community surge challenges, such as the creation of Alternate Care Sites. After surge capacity plans are tested and finalized, we will share those plans with our frontline providers.

Resources available for HealthCare Providers on Pandemic Influenza

For resources on clinical management and treatment of suspect or confirmed pandemic influenza:

Visit the CDC web site at www.cdc.gov/flu/pandemic/healthprofessional.htm for detailed information on Clinical Guidelines, Vaccine Distribution and Use, Antiviral Drug Distribution and Use, and Community Mitigation.

Visit the Maine CDC web site at www.maineclu.gov/pandemic.htm for guidance on laboratory testing of a suspect case of novel pandemic virus. Click on Healthcare Workers, then on Disease Surveillance information from Maine CDC, then on PDF icon.

For resources that can be used to develop internal pandemic influenza plans for your clinic or practice:

Visit www.pandemicflu.gov/plan/healthcare/medical.html for an Influenza Planning Checklist for Medical Offices and Clinics.

For resources that can be used to educate your patients:

Visit www.pandemicflu.gov/plan/individual/checklist.html for CDC Individual and Family Planning Checklists that can be distributed to your patients. Families are encouraged to start preparing now and to create family emergency kits.

Visit <http://publichealth.portlandmaine.gov> starting May 1, 2007 for Pandemic Influenza Facts Sheets and posters. We would like to encourage providers to begin educating your patients about pandemic influenza and preventative measures, such as cough etiquette.

MESSENGER

443 Congress Street
Portland, ME 04101-3546

Phone: 207-771-2004
Fax: 207-771-2005

Mailing Address Line 1

Mailing Address Line 2

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PCP Clinical Improvement Plan Progress Report

Asthma

Population– 8,399 patients in the Clinical Improvement Registry

Office Visit– 69.6% of patients had an office visit within the past 12 months

Tobacco Use– 80.7% of patients are a non-tobacco user; 2.4% using tobacco, 16.9% not recorded

Household Tobacco Use– 65% no tobacco use; 13.9% w/ tobacco use; 21.1% not recorded

Influenza– 42.3% flu shot; 57.1% no flu shot w/in past 12 months; 0.7% contraindicated

Severity– 80.4% patients with an asthma severity classification; 19.6% w/out classification

School Plan– 53.9% patients have plan w/in past 12 months; 49.1% do not have a plan

Action Plan– 63.8% patients have an action management plan w/in past 12 months; 36.2% do not have a plan

Diabetes

Population– 12,342 patients in the Clinical Improvement Registry

Office Visit– 91.8% of patients had an office visit within the past 12 months

BP Control– 91.5% patients had their blood pressure checked at least once in past 12 months

HbA1C– 87.9% patients had at least one test in past 12 months and 52.3% had HbA1c less than 7.0

LDL– 80.8% patients had at least one test in past 12 months and 64.7% had LDL results less than 100

Aspirin– 91.3% patients over 40 w/out ASA allergy or contraindication were prescribed either ASA or Coumadin

Microalbumin– 66.8% patients appropriate for nephropathy screening had a quantitative measure; 71.4% of patients appropriate for ACEI/ARB use were prescribed ACE inhibitor or ARB