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## THE SUPPLEMENTAL INSURANCE ALTERNATIVE

A *Family USA* study (11/06) revealed **Maine health insurance premiums increased at a rate 5.7 times that of wages from 2000-2006**. The average family plan now exceeds \$15,000 annually. Employee health insurance benefits increasingly dominate employer budgets. Many employers are choosing combinations of high deductible healthcare plans, flexible spending accounts, and supplemental insurance products to offset these annual increases.

The product that is becoming increasingly visible in the Maine market is supplemental insurance. Supplemental products provide coverage for accident, cancer, critical illness, hospital confinement, and dental-vision plans. Many plans provide selectable benefit levels from basic to robust. As an example, an accident plan may provide fixed benefits for ambulance, ER, surgical, physical therapy, rehabilitation, appliances and office visits. Lodging and transportation reimbursement benefits may be available if the triggering event occurs more than 100 miles from home. Coverage is usually a limited benefit (number of visits, number of days inpatient, number of tests and a fixed amount for each benefit (\$XX for an office visit; \$XXX for a day in the hospital, etc.) or a lump sum amount. While the coverage is not 100% of the cost, it can offset a substantial part of the cost in some cases. They can help fill the gap in coverage for commercial products with high front end deductibles. With relatively modest premiums, they can help individuals access health care services that they would otherwise pay for completely out of pocket.

All product insurers offer discounts for payroll deducted premiums. Most products offer post-employment portability and have premiums ranging from \$1 to \$10 weekly. Life, disability, and long term care (LTC) insurances are also offered at competitive rates.

Payments are mailed to the insured 7-10 days after receipt of claims forms in most cases. The physician's portion of the claims form is usually less than one page and requires typical coding and a signature while wellness and minor claims are filed on-line by the patient. All major supplemental insurers have on-line billing and administration services. Third party claims assignment for payment is rare, but many health care providers when aware of supplemental coverage defer payments 30 days allowing patients to receive claim checks prior to payment due dates.

Supplemental benefits have been available for over 50 years providing employers and consumers the option to select benefits they need and take them from job to job when required. For more information the author may be contacted at: [lifewriter@maine.rr.com](mailto:lifewriter@maine.rr.com).

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## GREATER PORTLAND MEDICAL GROUP CASE STUDY

Over the past 12 months, the doctors and staff at Greater Portland Medical Group in Scarborough have been able to screen almost 80% of their diabetic patients for depression using the Patient Health Questionnaire (PHQ-9). This is an impressive number for sure, and I was recently able to visit the office and meet with the physicians and staff to learn how these results are accomplished.

The office uses the Centricity (formerly Logician) electronic health record and each afternoon one of the staff (the patient service representative who checks patients in and out) reviews the next day's schedule and the records of those patients followed in the Clinical Improvement Registry (CIR). A summary sheet is printed along with a blank PHQ-9, if needed, to be ready for the patient's arrival the next day. In their office, PHQ-9's are given annually to patients with diabetes and cardiovascular disease (CVD), to patients at their health maintenance exams and at each new or follow-up visit for depression or anxiety.

When the patient arrives, he or she is given a clipboard (with a diabetic report card and the PHQ-9 if it is due) and waits for the medical assistant in the waiting room. The patient completes the PHQ-9 in the waiting room. The MA then collects the PHQ-9 when rooming the patient. The results are entered into the medical record, along with the vital signs, before the doctor comes to see the patient. The paper copy is left for the doctor to review.

The process appears to be self-sustaining because, like it or not, the physician is kept out of the process and does not have to be the one who administers the PHQ-9 tool or enters the data. The practice manager has also been printing out monthly reports from the CIR for each of the physicians and posting them in the lunchroom for the staff and physicians to review. At first, there was some hesitation about making the data "public," but over time it seems to have been accepted by all. By reviewing the data on a regular basis, they are able to find where patients may need screening or follow-up and then can schedule them for a visit.

The processes seem to work smoothly because: A) the entire office functions as a team with agreed upon tasks for everyone; B) data collection and reporting is part of the daily routine; and C) monthly reports alert the office to the gaps so they can plan for improvement. Is there something here you could learn for your office?

Peter Amann, MD (*Caring for ME - Depression*)

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## STATUS OF THE PROFSOFT PILOT EVALUATION

Over a year ago, the Maine Health Management Coalition (MHMC) proposed a pilot study involving ProfSoft to study the efficiency or cost of care delivered by its providers. ProfSoft is an analytical product which uses Episode Treatment Groups (ETGs) to assess resource utilization/cost data as a performance improvement tool. One of the reasons for this study was the knowledge that insurers were already accessing claims data to profile and tier specialty physicians, yet the methodology was hidden by the payers. This study would give us an opportunity to view our own data in an effort to understand the process.

Six provider groups, including the Maine PHO, contracted with the Maine Health Information Center (MHIC) to map claims data provided by MHMC. The data represented approximately 350,000 covered lives which included all Anthem claims. This study allowed access to practitioner data by name. The specialties studied were Cardiology, Cardiothoracic Surgery, Gastroenterology, General Surgery, Neurosurgery and Orthopaedic Surgery. Within the PHO, Tim Hannan and Jen Moore were our trained analysts. As much work was needed to clean up the data, it was not ready until late May. The PHO identified and recruited physician champions to evaluate their own data and give input as to its reliability and usefulness. Those physicians included Drs. Michael Becker, George Babikian, Rajiv Desai, Donald Endrizzi, Sean Hanley, Robert Hawkins, Alan Kilby, Robert Kramer, Jamie Kuhn, John Lualdi, Jay Powers, Parker Roberts and Stephen Rodrigue. Our physician champions, to whom we owe much thanks, delivered a report including reasons for continuing and terminating the project. These recommendations were presented to the Community Physicians of Maine, which voted to continue but keep the data internal. The MMC PHO Board voted to continue the project for one additional year.

The ProfSoft Governance Group goals for 2008 include standardized reports at an actionable level to identify variations; separation of physicians from hospital claims data to include in peer groups; group level reporting, which is not now available; identification of national and/or regional benchmarks for comparison and application of reporting capabilities to primary care physicians without detracting from the ongoing specialty work. For questions regarding the ProfSoft initiative, contact A. Jan Berlin, MD at 482-7063.

## NEW PUBLIC HEALTH RESOURCE FOR LOCAL HEALTHCARE PROVIDERS

The City of Portland HHSD, Public Health Division has developed a new ToolBox for Healthcare Providers on their website. The ToolBox can be accessed via the following link: [www.portlandmaine.gov/hhs/toolboxproviders2.asp](http://www.portlandmaine.gov/hhs/toolboxproviders2.asp)

The provider toolbox includes the following information:

- I. Alerts and Clinical Updates on local and statewide disease outbreaks.
- II. Provider registration for City Watch. City Watch is free software used by the City of Portland to communicate with key stakeholders. We encourage all primary care providers in Cumberland County to register for this free service. We will use City Watch to provide you with pertinent clinical information regarding local disease outbreaks and public health emergencies.
- III. Health Alert Network (HAN) updates from the Maine CDC regarding disease outbreaks and public health emergencies.
- IV. Updates on Seasonal Influenza, including weekly surveillance reports and the availability of vaccine in our community.
- V. Updates on Immunizations.
- VI. Resources on Pandemic Influenza, including resources for clinicians, resources for patients, and updates on local planning efforts.
- VII. Links to CDC Health Information. This includes patient handouts and information on a wide variety of diseases. Information is available in 9 different languages.
- VIII. Listing of clinical and non-clinical services provided by the City of Portland HHSD, Public Health Division.

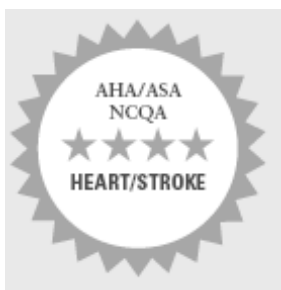
## NATIONAL COMMITTEE FOR QUALITY ASSURANCE

The MMC PHO would like to congratulate our first members to submit and achieve recognition by the National Committee on Quality Assurance. **We would also like to extend our congratulations to Maine Centers for Diabetes for being the very 1st group in Maine to get recognition.** NCQA recognized physicians are among an elite class of physicians nationwide who have demonstrated a high level of performance in providing care. The NCQA seal is a widely recognized symbol of quality that affords physicians many benefits including qualifying for many national and regional pay-for-performance efforts. Dozens of health plans nationwide now highlight recognized physicians in online and printed physician directories and include these physicians in their preferred networks. We are very proud to have physicians of this caliber working to deliver best practice care in our communities.



### Diabetes Physician Recognition Program (DPRP)

Dr. T. McInerney- Greater Portland Medical Group, Cape Elizabeth  
Dr. J. Reynolds- Greater Portland Medical Group, Cape Elizabeth  
Dr. C. Wellins- Greater Portland Medical Group, Cape Elizabeth  
Dr. R. Hemphill- Greater Portland Medical Group, Falmouth  
Dr. B. Farino- Greater Portland Medical Group, Scarborough  
Dr. C. Freme- Greater Portland Medical Group, Scarborough  
Dr. R. Engel- Greater Portland Medical Group, Westbrook  
Dr. S. Hayes- Greater Portland Medical Group, Westbrook  
Dr. R. Sturges- Greater Portland Medical Group, Westbrook  
Dr. E. Paluso- Lakes Region Primary Care  
Dr. T. Piraino- Lakes Region Primary Care  
Dr. M. Lee- Seacoast Medical Care, PA  
Dr. W. Lee- Seacoast Medical Care, PA



### Heart/Stroke Recognition Program (HSRP)

Dr. T. McInerney- Greater Portland Medical Group, Cape Elizabeth  
Dr. J. Reynolds- Greater Portland Medical Group, Cape Elizabeth  
Dr. C. Wellins- Greater Portland Medical Group, Cape Elizabeth  
Dr. R. Hemphill- Greater Portland Medical Group, Falmouth  
Dr. B. Farino- Greater Portland Medical Group, Falmouth  
Dr. R. Engel- Greater Portland Medical Group, Westbrook  
Dr. S. Hayes- Greater Portland Medical Group, Westbrook  
Dr. R. Sturges- Greater Portland Medical Group, Westbrook  
R. W. Lee- Seacoast Medical Care, PA

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to better serve our communities.*

We're on the Web  
[www.mmcpHO.org](http://www.mmcpHO.org)

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## PCP Clinical Improvement Plan Progress Report

### Asthma

Population– 7,853 patients in the Clinical Improvement Registry

Office Visit– 79.3% of patients had an office visit within the past 12 months

Tobacco Use– 91.6% of patients are a non-tobacco user; 1.9% using tobacco, 6.5% not recorded

Household Tobacco Use– 74.7% no tobacco use; 15.7% w/ tobacco use; 9.6% not recorded

Influenza– 48.7% flu shot; 50.5% no flu shot w/in past 12 months; 0.8% contraindicated

Severity– 91.8% patients with an asthma severity classification; 8.2% w/out classification

School Plan– 91.4% patients have plan w/in past 12 months; 8.6% do not have a plan

Action Plan– 34.7% patients have an action management plan w/in past 12 months; 65.3% do not have a plan

### Diabetes

Population– 12,578 patients in the Clinical Improvement Registry

Office Visit– 93.1% of patients had an office visit within the past 12 months

BP Control– 92.6% patients had their blood pressure checked at least once in past 12 months

HbA1C– 88.4% patients had at least one test in past 12 months and 57.8% had HbA1c less than 7.0

LDL– 81.1% patients had at least one test in past 12 months and 65.3% had LDL results less than 100

Aspirin– 91.4% patients over 40 w/out ASA allergy or contraindication were prescribed either ASA or Coumadin

Microalbumin– 67.1% patients appropriate for nephropathy screening had a quantitative measure; 70.7% of patients appropriate for ACEI/ARB use were prescribed ACE inhibitor or ARB