**Maine Quality Forum**

 -MEASURING TO IMPROVE-

**To:** Dirigo Board of Trustees

**From:** Karynlee Harrington

**RE:** Maine Quality Forum February Progress Report

**1. Patient Centered Medical Home (PCMH) and Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration**

**February Update**: Earlier this month the SIM Maine Leadership Team (MLT) reached out to the conveners of the PCMH and MAPCP pilot/demo to inform us that the opportunity with CMS to submit a proposal for potential funding after the MAPCP demonstration has been extended to Maine due to our SIM status and as such the MLT has determined that the development of a comprehensive proposal should be overseen by the SIM governance structure. Commissioner Mayhew has appointed a team of stakeholders to comprise the Medicare Alignment Proposal Subcommittee.  The membership of this subcommittee is contained in the attached document-MQF is represented on the committee.  In addition, the attached document contains key core principles that the MLT has endorsed to guide the development of the proposal. Formation of the Medicare Alignment Proposal (MAP) subcommittee is underway.  In the meantime, the MLT has requested that the PCMH conveners continue the work that has been undertaken to complete the development of the concept paper. The concept paper will be submitted to the MAP team for approval and then submitted to CMS/CMMI.   If the State is asked to submit a comprehensive proposal the MAP team will develop.

**January Update:** The MQF is one of the conveners along with the Maine Department of Health and Human Services, Maine Quality Counts and the Maine Health Management Coalition of the Maine’s patient-centered medical home (PCMH) pilot. The MQF is also responsible for the agreement with the Federal Centers for Medicare & Medicaid Services (CMS) for the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration which has brought in over $25 million dollars in upfront funding for the primary care practices that are participating in the PCMH Pilot and see Medicare beneficiaries. The PCMH pilot and MAPCP Demonstration both end December 2016. **Note:** one of the key strategies of the State Innovation Model (SIM) is to strengthen primary care-which we have been working on for many years pre-SIM under the PCMH and MAPCP initiatives. SIM funding will also end December 2016. In preparation for the end of the PCMH pilot, MAPCP demonstration and SIM, in September of 2015, with support from the other conveners the MQF organized a PCMH Summit to synthesize what has been learned nationally and in Maine about the effectiveness of the PCMH/MAPCP model and to discuss the future model and sustainability. Since the summit the conveners have been discussing the merits of developing a concept paper to ultimately submit to CMS for potential funding beyond the MAPCP demonstration. The proposal would leverage our extensive investments in redesigning primary care as foundational to larger health system transformation efforts and take the next step to advance an innovative, alternative multi-payer primary care payment model that supports patient-centered, community health-oriented, and high-value care. We propose to do so by creating the Maine Comprehensive Community Care initiative (CCCi), a multi-stakeholder, community-oriented approach that builds on the significant work to date of the Patient Centered Medical Home (PCMH), Health Home (HH) and State Innovation Model (SIM) efforts, and advances further innovations in care delivery and payment to achieve better care, better health, and lower cost. The drafting of a proposal is in process and will be shared with the Commissioner of DHHS for her approval before taking it to the next step. I will update you next month on our efforts.

**2. New HealthCare Associated Infection (HAI) Training Modules for Extended Care Facilites**

**February Update:** I am pleased to report that we are in the final phases of completing the eight-hour HealthCare Associated Infection curriculum for extended care facilities which includes nursing homes. The curriculum is divided into six stand-alone modules to be completed at the convenience of the participant. **Content areas include**: general infection control and prevention practices; common infectious diseases; Isolation/transmission precautions, surveillance and data collection; performance Improvement, and antibiotic stewardship.  In addition to the stand-alone modules there is a comprehensive set of resources that have been organized by topic that are accessible to the facility.

Earlier this month I met with the team (MQF, Muskie and Maine CDC HAI Prevention Program)  to button up  a few outstanding questions regarding the tool and to develop a roll out strategy including ways to raise awareness of the problems of infection control in our extended care facilities with a goal to recruit infection preventionist to participate in the training.

**A few key dates:**

1. Finalize beta testing of the tool by end of March
2. Develop Brochure describing the tool by March 15th
3. Reach out to identified stakeholders starting now to brief on tool
4. Develop Press Release for April 5th (date may change based on beta testing etc)

I e-mailed Commissioner Mayhew- below are several key points of my message to the Commissioner regarding our new educational tool. The Commissioner would like to meet to discuss.

*Given your focus on quality and improved outcomes, I am reaching out to you to provide you with an overview of our new educational HAI tool.  I would welcome any guidance from you on how best to leverage this tool with the goal of improving quality as it relates to health care associated infections in our extended care facilities which should have a positive impact on the bottom line.*

*Unlike the requirements of acute care facilities the MQF/MHDO does not currently require extended care facilities to report health care associated infections data and therefore we cannot calculate their prevalence. However, a national study which examined Infections In U.S. nursing facilities over a five year period (2006·2010) found increased Infection rates for pneumonia, urinary tract Infections (UTIs), viral hepatitis, septicemia, wound Infections, and multiple drug-resistant organisms (MRDOs).   These are considered preventable Infections that cause deaths and complications (and unnecessary costs) to the residents of extended care facilities.*

*In the Maine Quality Forums 2013  Annual HealthCare Associated (HAI) Report,* <https://mhdo.maine.gov/_externalReports/HAI_report_2013_F.pdf>  *we highlighted the need to enhance training within nursing facilities in response to the rise of healthcare associated Infections (HAI’s) among residents.*

*To begin to address the issue of training within extended care facilities (which includes nursing facilities) the Maine Quality Forum contracted with Muskie who in turn collaborated with the Maine CDC HAI Prevention Program and APIC to develop an online training  program for Infection Preventionists working In Maine's extended care facilities…..*

**January Update:** Our 2013 HealthCare Associated (HAI) Annual Report highlighted the need to enhance training within nursing facilities in response to the rise of healthcare associated Infections among residents. Maine does not require nursing facilities to report HAIs and therefore we cannot calculate their prevalence. However, a national study which examined Infections In U.S. nursing facilities over a five year period (2006·2010) found Increased Infection rates for pneumonia, urinary tract Infections (UTIs), viral hepatitis, septicemia, wound Infections, and multiple drug-resistant organisms (MRDOs). These are considered preventable Infections that cause deaths and complications to nursing facility residents. To begin to address the issue of training within nursing facilities the MQF contracted with Muskie who in turn collaborated with the Maine CDC and other key stakeholders to develop an online training for Infection Preventionists working In Maine's nursing facilities. We just finished creating an eight-hour curriculum that is divided into six stand-alone modules to be completed at the convenience of the participant. Content areas include: general infection control and prevention practices; common infectious diseases; Isolation/transmission precautions, surveillance and data collection; performance Improvement, and antibiotic stewardship. Earlier this month I met with Muskie staff and reviewed the training modules. We also discussed next steps which will include a strategy to roll out this resource and ways to raise awareness of the problems of infection control in our nursing home facilities with a goal to recruit infection preventionist to participate in the training. I will be meeting early February with the staff at Muskie and the Maine CDC to develop a road map for how best to move forward with this much needed resource. I will update you next month on our roll out efforts and provide you with a link to the training modules.

|  |
| --- |
| **3. Maine Patient Experience Matters****February Update:** I will be presenting the Maine Patient Experience Analysis of Patient Experience Over Time from 2012 to 2014  Report and the Quality Improvement (QI) Toolkit to the PCMH Conveners at our next PCMH Conveners meeting which is scheduled for March 16th. I am meeting with my team later this week to finalize the Report. As reported in January directionally the results are positive. Look forward to providing a copy of the report in the March report to the Board along with a copy of the QI Toolkit.**January Update**: Maine Patient Experience Matters is an MQF voluntary initiative designed to collect and publicly report patient experience survey data about primary and specialty healthcare in Maine via our publically accessible website that we developed: [www.mainepatientexperiencematters.org](http://www.mainepatientexperiencematters.org). Understanding patient perspectives about the medical care they receive is important for improving how care is provided and ultimately improving outcomes. Research shows that when patients have a good patient experience (e.g., they can get care when they need it and have providers who listen to their concerns, understand their medical history, and help coordinate care with specialists) they are more likely to seek preventive care, follow doctors’ advice, manage their own health and have better clinical outcomes. The first survey was conducted in 2012. In 2014, the MQF sponsored a second survey to assess changes in patient experience among practices that participated in 2012 as well as expand the number of practices participating for the first time (patient experience is one of the key strategies of SIM). Working with national survey vendors, a national standardized survey instrument was administered to more than 50,400 patients (up from 40,400 in 2012) in 313 Maine primary and specialty practices (up from 287 in 2012). While many practices conduct patient experience surveys, this initiative is the first time that a common instrument, methods and sampling were used to provide statistically valid comparisons across Maine practices. In 2014, MQF broadened the survey guidelines for the initiative to better align with existing provider survey efforts to maximize participation. Several months ago we updated the website to be more user friendly and to include data from both 2012 and 2014 for practices that participated. We also added a link to the Maine Patient Experience matters website in its public reporting website for other quality measures. Although findings vary by practice in 2014, Maine continues to perform above the national average on nearly all patient experience of care measures including access to care, provider communication, helpful and courteous office staff patient provider ratings. While higher than the national average, survey findings also identified areas where there is still room for improvement, such as getting needed care on evenings, weekends and holidays, wait times for appointments, talking with patients about taking care of their own health and attention to mental health needs. We are in the process of finalizing an analysis of how Maine Patient Experience of Care has changed over time between 2012 and 2014 for the subset of practices that participated in the survey both years. In addition to looking at these practices as a whole, the analysis also measures change in performance for pediatric, adult and specialty practices and for practices participating in Maine’s Multipayer Patient Centered Medical Home pilot and MaineCare Health Homes initiative. **Summary of Key findings to date-**Adult primary care practices that had survey data for both years significantly improved on all survey composite areas and on all but one individual question between 2012 and 2014. Adult primary care practices significantly improved in several areas identified as needing improvement in 2012 (e.g. wait times, getting care on evenings, weekends or holidays, attention to mental health needs) Specialty practices significantly improved in 2014 on provider communication, courteous office staff, patient ratings of providers, getting info about after hours care, reminders between visits, and talking about prescriptions, but significantly declined in providing follow-up on test results. Pediatric practices improved significantly on helpful and courteous staff and getting needed care on evenings, weekends, or holidaysOur detailed report is currently being finalized and will be available in February. I plan to post the report on the Maine Patient Experience Matters website in February. We will also work closely with Maine Quality Counts in sharing the results of its analysis with the participating practices. **New Quality Improvement (QI) Toolbox for Practices To Improve Patient Experience in specific areas-**The emphasis of the Maine Patient Experience Matters initiative is to collect and use data in order to inform and improve practices’ provision of patient-centered care. To assist practices in using survey data for quality improvement, the MQF has developed an online QI Toolbox of nationally recognized strategies, locally supported initiatives and case studies to address patient experience concerns identified through the survey. Our online QI Toolbox is designed so practices can find strategies and implement interventions that focus on specific domains or areas where survey results showed that the practice had room for improvement. The examples and evidence included in the toolbox draw heavily from the Agency for Healthcare Research and Quality’s (AHRQ), other best practice literature, resources provided by one of Maine’s certified survey vendor – Avatar, and from local quality improvement efforts supported by health systems and Maine Quality Counts. Physician Practices can access our QI Toolbox on [www.mainepatientexperiencematters.org](http://www.mainepatientexperiencematters.org). We will also be presenting on a webinar on how to use the toolkit which will be hosted by Maine Quality Counts this spring.  |
|  |

**4. Status of RFP Selection Process-**

**February Update:** The Evaluation Team comprised of: Laurie Smith-MQF, Commissioner Head-Commissioner of PFR and Karynlee Harrington-MQF met and through a consensus based process has scored the three RFP’s received. I will be submitting all of our documentation to the States Division of Purchases for review before notifying the bidders. Look forward to announcing the successful bidder in the March report.

**January Update:** Anticipate a contract award will be made by the end of February.

**5. Status of CompareMaine website Release 2.0-**

**February Update:** Working with division of purchases on the best approach between sole source or MOU between MHDO and MQF.

**January Update:** Anticipate finalizing the sole source contract request with Human Services Resource Institute by mid-February. Attached is an overview of the issues we are working on specific to CompareMaine and our next scheduled release (2.0). We are exploring the feasibility of adding the following quality measures to CompareMaine:

Percentage of inpatients who have a hospital-acquired Stage 1 or greater pressure ulcer

 Number of patient falls per patient days

Number of patient falls with injuries per patient days

**6. Status of MQF’s Annual Healthcare Associated Infections (HAI) Report to the Joint Standing Committee on Health and Human Services-**

**February Update:** Our 2016 Annual HAI Report is in the final stages of review. On track to submit to the Health and Human Services Committee early March.

**January Update:** We are in the process of finalizing our annual HAI Report. I anticipate submitting the final report to the Health and Human Services Committee by the first of March.

 **7. MQF Budget-**

**February Update:** No issues of concern to report.

**January Update:**  No issues of concern to report.

**8. Other:**

**February Update:** Nothing new to report.

**January Update:** Lisa Letourneau, executive director of Quality Counts (and our project director for our MAPCP and PCMH work for the last five years) announced earlier this month that she is leaving her role by the end of 2016. In her written announcement she said “the time also is right for me personally; my husband and I plan to take a year off in 2017 to fulfill our dreams of traveling and sharing adventures together. We then look forward to pursuing whatever our next career opportunities may arise following our year off.”

I am on the board of Quality Counts and at our meeting earlier this month the decision was made to convene a search committee of the board and begin a national search to find Lisa’s replacement.