

How Well Is It Working?

A Vision, Goals and Performance Indicators
for Maine's Health Care System

A Preliminary Report of the
Maine Health Care Performance Council

February, 2003

Funding provided through a grant from the Robert Wood Johnson Foundation's
State Coverage Initiatives Program and the Maine Department of Human Services

Prepared by the Maine Development Foundation



Governor Angus S. King, Jr. appointed the Maine Health Care Performance Council in September of 2001 to develop a vision and goals for Maine's health care system, and a set of performance indicators to measure the State's progress towards achieving the vision and goals. This document is a preliminary report of the Council's work.

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The Maine Development Foundation administered the Maine Health Care Performance Council, with Katie Fullam Harris, Program Director, serving as lead. Henry Bourgeois, MDF's President and CEO, was integrally involved, and Dianne Heino was Administrative Assistant to the project. Gino Nalli of the University of Southern Maine Muskie School of Public Service served as lead consultant on the project.

Please visit the Maine Development Foundation's website at: www.mdf.org/mhcpc for background papers, text of presentations and minutes of meetings. This report is also available on the website in pdf format.

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Maine Health Care Performance Council Indicators

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Introduction

Maine's health care "system" of providers, payers and consumers is one of the state's largest and most important enterprises. With an annual expenditure of approximately \$5 billion, this system affects every citizen, business and community in the state and is essential to our quality of life.

How well is it working? We don't know! As this report demonstrates, we have some data on various elements of the system, and we have anecdotal information from our own experience. But there is no comprehensive annual measure of the system's performance that captures its complexity, interdependence and importance.

By most accounts, Maine's health care system is in crisis. The cost of health insurance has increased at a rate far greater than inflation in recent years, and thousands of Maine people are uninsured. This climate has led to a number of questions about the overall performance of the health care system. Yet, in spite of the questions, there is no common set of data that policymakers, purchasers and payors can use to pinpoint those elements that are succeeding, those that need improvement, and how Maine compares to other states.

At the urging of his Year 2000 Blue Ribbon Commission on Health Care, Governor Angus S. King, Jr. created the Maine Health Care Performance Council in September 2001. The Council's mission is to strengthen Maine's health care system by informing the decisions of policymakers, purchasers, and providers. A unique model, the Council achieves its mission by setting and promoting a vision and goals, and developing reliable indicators that measure the performance of Maine's health care system over time. The Council's initial work was financed by a grant from the Robert Wood Johnson Foundation's State Coverage Initiatives Program and administered by the Maine Development Foundation.

This is the Council's preliminary report. It contains the Council's vision and goals for Maine's health care system, and performance indicators to measure Maine's success in achieving the vision and goals. We have attempted to build a foundation to answer the question, "How well is it working?" As a preliminary report, it does not include data for each indicator, nor does it include comparables with other states, or specific targets to achieve in 5 years. These are the next steps for the Council, which, if funding is available, should be completed in one year with the publication of the first annual report.

Over 100 Maine people were engaged in preparing this report; a list is appended. Governor King provided the leadership and insight that guided our work from the beginning. Gino Nalli, MPH, with USM's Muskie School of Public Service, led a team of graduate students and experts whose assistance was invaluable. And, we are deeply indebted to Katie Fullam Harris, program director at the Maine Development Foundation, who tirelessly coordinated the entire effort and authored this report.

This report is in three parts: a short narrative describing the process, data and themes; the Indicators section arranged by the three goal areas; and lists of works cited and contributors.

The Council was deliberate in its decision-making. Health care is a complex field, and the Council worked hard to ensure that its work would be easily understood and relevant to all stakeholders in the system. We hope that you will find this work helpful, and we look forward to continuing our mission to disseminate information about Maine's health care system.

Donald Gerrish
Town Manager, Brunswick

Kevin P. Gildart
Vice President, Bath Iron Works

Process, Data and Themes

The Council's Process

The Maine Health Care Performance Council (the Council) was appointed by Governor Angus S. King, Jr. in September of 2001. The 15 members are primarily comprised of people who do not work directly in the health care system -- employers, payers and consumers. The Council met an average of every six weeks for the sixteen-month period; all meetings were open to the public and reported-on at the web site (www.mdf.org/mhcpc).

In its first four months, the Council learned about the health care system from experts across the State, developed criteria for performance indicators and adopted a vision and goals for the system:

Vision: All Maine people shall participate in a health care system that is integrated, affordable, accountable and accessible.

Goals:

- **Cost:** The health care system should be cost-effective and financed to ensure its long-term sustainability.
- **Quality:** The health care system should produce quality outcomes and information to improve the health of Maine citizens.
- **Participation:** The health care system should be structured to promote appropriate participation by consumers, providers and payors.

From January-June, the Council began to identify performance indicators. Recognizing the need to have people with relevant expertise inform its work, the Council appointed a working group for each of the goal areas. The task of these 10-15 member groups was to draft the first set of indicators that would measure Maine's progress towards achieving the vision and goals. The working groups included Council members, doctors and health care providers, hospital executives, insurance company leaders, public health officials and others with expertise on Maine's health care system. Working groups were staffed by Muskie School graduate students-- Allison Volchok, Christina Booth and Carlotta Drane; Gino Nalli, served as a consultant to the process.

Their work culminated in a large public meeting at which working group leaders presented their suggested indicators to the Council and a panel of legislative and policy leaders. Using criteria developed by the Council, the working groups identified over 400 indicators, of which the Council prioritized 220 for further consideration.

From July-December, the Council narrowed the list of indicators, with the final goal of selecting 60. Gino Nalli led a team of experts -- Maureen Booth and Julie Fralich -- from the Muskie School of Public Service's Center for Health Research and Policy to review the list and use their expertise to recommend 60 indicators.

The Council made limited changes to the work of the Muskie team, and sent the indicators to hundreds of interested parties for public comment in early November. Twenty-nine people sent written comments, which were compiled and reviewed by the Council. The 63 indicators were finalized in December.

The Data Challenge

“Good data drives good decisions.”
Governor Angus S. King, Jr. speaking to the Maine Health Care Performance Council,
September 17, 2001

As the Council began its work, it was advised by a number of leading health experts that finding data to support the indicators would present a significant challenge. Because Maine does not have a single health care system, there are few data sources that capture the entire population or all elements of the system. For example, current data collection efforts in the area of cost often reside with payors, both governmental and private; this results in significant data gaps, e.g. the exclusion of people who lack health insurance, and inconsistent collection efforts that do not always allow for the comparison of data.

The Council operated under the premise that the selection of indicators should reflect the values of the Council and the vision and goals it sought to achieve -- regardless of whether data is currently collected and available. A criterion was that each indicator had to reflect data that could feasibly be collected.

The result is a set of indicators for which the Council believes that standardized data should be collected and available, though systems may not allow for it at this time. Specifically, 17 of the 63 indicators in this report have data that is currently available over time; 23 of the remainder will require special surveys; and 23 will need further analysis.

While there is a clear need for improved data collection efforts in Maine, valuable insight can be gained from the 17 indicators for which public data is currently available. The Council looks forward to expanding that list as technology and systems improve over time. The Council applauds the efforts of the Maine Health Data Organization and the Maine Health Information Center as they work collaboratively to develop a database that compiles information on all health insurance claims, including, we hope, Medicaid and Medicare. This database will be the first of its kind in the country. Once available, the data collected through this effort will apply to many of the indicators identified in this report, and it will provide policymakers, employers and the public with important information about cost, quality and utilization that is not otherwise available.

Content and Themes

The Council focused on several key themes throughout the process.

Focus on the System, not Status. This report is intended to provide a structure to measure the performance of Maine's health care system. This is different from, but complementary to, the excellent work on the health status of Maine's population that is published in the Maine Bureau of Health's *HealthyMaine* reports. *HealthyMaine 2010* sets a public health agenda for Maine, while *How Well is it Working?* provides a framework for measuring the entire system. The Council identified a number of *HealthyMaine* indicators that met its criteria, so the two reports contain some overlapping indicators and data.

Focus on the System, not Individual Providers. This report is intended to provide data on the elements of the health care system(s) in Maine, not individual providers within the system. Many people have requested that the report provide information specific to institutional and individual providers, and/or county-specific data. Though many of the indicators identified could be further refined for such purposes, the intent of this report is to provide general information about the system as a whole, rather than specific providers.

Proxies. Many indicators represent broader issues within the health care system. For example, indicators related to the management of diabetes are designed to illustrate both the increasing magnitude of diabetes-related illness in Maine, and the importance of evidence-based treatment for chronic disease in general.

Population-based Indicators. The Council believes strongly that its work should reflect all Maine people, including those who have employer-based insurance, those who purchase their own insurance, those who receive coverage through public programs and those who lack insurance altogether. This goal has proven particularly challenging, as there is very little population-based “system” data available. Because the payor systems, private and governmental, are the means through which much data is collected, information regarding the cost and utilization of services for people who lack insurance or who pay for care out-of-pocket is usually excluded. The Council recognizes this problem; however, short of the development of a comprehensive data collection and analysis system in Maine, it has no alternative but to utilize for many of its indicators claims data that excludes the uninsured population.

Evidence-Based Practice. Many of the indicators attempt to measure the extent to which Maine providers are utilizing proven methods of best practice, or evidence-based practice, in their clinical practices. There have been several recent efforts at the national level to develop evidence-based guidelines for clinical decision-making; the Council has incorporated them into its state-level work.

The Connection Between Participation, Quality and Cost. Much of the current research addresses one or two of the goal areas, but very little ties all three together. While there is recognition that participation and quality affect cost, we could find little population-based data to support that assumption. The indicators were developed with the goal of tying the three factors together. For example, “costs associated with avoidable hospitalizations”, represent costs that could be avoided if patients and providers managed and treated ambulatory-sensitive conditions according to best practice.

Cost Shifting. The Council discussed cost-shifting at length. The complexities of our public and private health care financing systems make it extremely difficult to show the true cost of providing health care services. The Council has included several indicators that illustrate the different prices paid by payors for the same service, but the Council was not able to discern the actual cost of providing the service. This is an area that should be noted by policymakers when looking at cost data.

Patient-Based Decision-Making. The Council discussed the need for the indicators to reflect the availability of information upon which health care consumers can make well-informed decisions. With the demise of managed care as a means for controlling costs, health care payors, including employers and the government, are shifting their focus to helping patients make well-informed decisions about their own health care. Such decision-making requires information about quality, outcomes and costs of services, very little of which is currently available to the public. The Council has included several indicators to measure the availability of such information.