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MAINE'S STATE HEALTH PLAN

A ROAD MAP TO BETTER HEALTH

DirigoHealth
Working For Maine

GOVERNOR'S OFFICE OF HEALTH POLICY AND FINANCE

NOVEMBER 2005

This document is the **draft** biennial State Health Plan being proposed by the Governor's Office of Health Policy and Finance. It was prepared by the Office with the assistance of the Advisory Council on Health Systems Development and the input of hundreds of Maine citizens from around the state. Work on this Plan was supported, in part, by generous grants from the Maine Health Access Foundation and the Health Resources and Services Administration. The views expressed in this draft, however, do not necessarily represent those of our funders.

A final State Health Plan will be issued after comments received during the course of the public comment period are carefully considered. You may comment on this draft Plan at one of three public hearings:

Lewiston Hearing
November 21, 11 am – 2 pm
University of Southern Maine, Lewiston/Auburn Campus
51 Westminster Street
Lewiston

Brewer Hearing
November 21, 4-7 pm
Jeff's Catering Banquet & Convention Center
East West Industrial Park
5 Coffin Ave
Brewer

Portland Hearing
November 22, 11 am – 2 pm
Hannaford Hall/Abromson Building
University of Southern Maine
Portland

You may also submit comments in writing by sending them – **no later than December 2** – to:

Ellen Schneiter
GOHPF
15 SHS
Augusta, ME 04333-015

You can also submit comments by email to: ellen.schneiter@maine.gov

THE STATE HEALTH PLAN AS A ROADMAP

The State Health Plan is a roadmap, laying out a route to make Maine the healthiest state in the nation. It is a plan for Maine, of Maine, and by Maine – all of us have a role. As part of the Dirigo Health Reform Act, enacted in 2003, the Legislature asked the Governor to produce this roadmap, charting a comprehensive, coordinated approach to the way we manage our health resources and work toward improving health. (A copy of the statute governing the State Health Plan can be found in APPENDIX I.)

In July 2004, the Governor issued a one-year interim state health plan. Bound by a statutory deadline, there was insufficient time to cultivate broad public dialogue in developing this plan. Instead, this short term interim plan mapped, for the most part, only priorities already identified through the Dirigo Health Reform Act. This interim strategy was adopted with the explicit understanding that a more comprehensive planning process and a biennial plan would be developed over the coming year. The interim Plan laid the groundwork for this iteration of the State Health Plan; a brief status report on the interim State Health Plan is included in APPENDIX II at the end of this document.

IF YOU DON'T KNOW WHERE YOU'RE GOING, ANY ROAD WILL GET YOU THERE - PUBLIC ENGAGEMENT PROCESS TO CREATE THE ROADMAP

If the State Health Plan is to be a roadmap to improve the health of Maine, we need to set our course with a clear destination in mind and we won't succeed if some of us want to go to Dixmont while the rest of us prefer to go to Gorham. In order for the plan to be of Maine, for Maine and by Maine, we worked to engage the public in a discussion about priorities for the health and health care system of Maine -- where do we want to go together?

The Legislature's Joint Committee on Health and Human Services facilitated that work by amending the Dirigo Health Reform Act to allow us additional time to complete the State Health Plan and gain additional input. The state health planning process is also guided by the **Advisory Council on Health Systems Development** (ACHSD), an 11-person citizen board appointed by the Governor with review by the Legislature's Health and Human Services Committee, charged with advising the Governor's Office of Health Policy and Finance on the State Health Plan and conducting public hearings regarding it.

To assure that a broadly representative sample of Maine citizens had input into the State Health Plan, we conducted a number of different activities. First, with generous support from the Maine Health Access Foundation, Commonwealth Fund, the Robert Wood Johnson Foundation, Jane's Trust, the Wishcamper Group and the Betterment

Fund, we were able to conduct a unique community forum -- "**Tough Choices in Health Care**". Working with the University of Southern Maine's Muskie School of Public Service we developed a methodology to randomly select Maine citizens and invite them to participate in a daylong discussion of health priorities facilitated by the independent, nationally recognized organization, AmericaSpeaks. Outreach was facilitated by the University of Maine's Margaret Chase Smith School and Cooperative Extension to assure maximum independence and statewide reach. Twenty stakeholders in Maine assisted Governor's Office of Health Policy and Finance (GOHPF) in developing a primer for the Tough Choices campaign (available on our website www.dirigohealth.maine.gov. The primer provided basic information about Maine and Maine's health care system and walked participants through an exercise to balance often competing interests in cost, quality and access to health care.

On May 12th, over 300 citizens, selected through the random sample process, convened in Orono and Biddeford and participated in an interactive, facilitated review of choices. Citizens were asked to make choices based on information in the Primer and in small group discussions held that day. While "Tough Choices" was an exercise that only identified some choices we could make to reduce costs, improve access and improve quality of care and make us the healthiest state, it proved a challenging day. Indeed, often when participants had to make a tough choice balancing costs against access against quality it evoked the Yogi Berra expression, "When you come to a fork in the road, take it".

Participants discussed a series of choices and added several of their own. Of the 21 choices possible, only one won a majority. These were the highest ranked:

- *Quality*
  - More public health clinics for prevention – 51%
  - Establish best practices & create report cards on quality – 8%
- *System Level Change*
  - Single Payer - 48%
  - Combine Dirigo & MaineCare – 30%
  - Get out of private for profit paradigm – 8%
  - None of the above – 13%
- *Incremental Strategies & Improve Health*
  - Good food choices & exercise in schools – 13%
  - Require free preventive care in all health insurance plans – 16%
- *Contain Costs*
  - Re-evaluate insurance premiums – 6%
  - Cap costs on insurers/providers – 6%

A significant number of participants in "Tough Choices" felt that the exercise was too limited and did not provide adequate opportunity to explore other cost containment

strategies or explore methods to achieve universal access through a single-payer vehicle. Those individuals volunteered to participate in follow-up **focus groups** on August 18th in Portland and in Bangor.

The focus groups explored in greater detail what Maine should do about health care costs and whether a single payer option made sense and should be pursued. Participants reached no consensus on cost containment – some preferred market-based solutions and a loosening of regulations; others favored a more regulatory approach. In discussing single payer it become clear that a consensus definition of the term eluded the groups. A significant number of attendees felt a single payer could provide preventive and basic services but there would still be a role for private insurers in covering more costly or catastrophic care. The most popular "choice" for increasing the quality of the health of Maine people, and the most popular choice overall, was designated "strengthen the public health infrastructure." The exact meaning of this recommendation was not entirely clear at the time of the "Tough Choices" session. Upon review to transcribers' notes it became clear attendees were interested in having more clinics, but that recommendation was transcribed generally as "infrastructure."

Over the Summer and early Fall GOHPF and consultant, Eileen Griffin of the Muskie School conducted a series of **informal stakeholder interviews** to gain a better sense of concerns and priorities of key players in Maine. Discussions were held with: the Maine Hospital Association, the Maine Medical Association, the Maine Osteopathic Association, Maine State Nurses Association, Chamber of Commerce Board of Directors, Maine Healthcare Purchasing Collaborative Executive Committee, Community Health Coalitions, DHHS officials, the Bureau of Insurance, the Maine Quality Forum Advisory Committee, Dr. Erik Steele, Co-Chair of the Governor's Council on Physical Fitness, Sports, Health and Wellness, the Center for Public Health, the Maine Association of Health Plans, an employer focus group convened by the Androscoggin County Chamber of Commerce, the Office of the Long Term Care Ombudsman, the Brain Injury Association, the Eastern Area Agency on Aging, Disability Rights Center, the Advocacy Initiative Network of Maine and the Maine Association of Mental Health Services. A panel discussion at the Mane Public Health Association Annual Meeting provided additional input as did written documents submitted by citizens, Maine Health and Consumers for Affordable Health Care.

Making decisions about the top priorities for the State Health Plan required not just the input of engaged stakeholders and the general public but an analysis of the data as we know it. Using existing, credible data available for Maine, GOHPF issued "**The State of Maine's Health: A Regional Comparison**". That document divided the State into three sections to look at the State's diversity as well as its similarity. Specifically, the population of the State was evenly divided into three regions. Data was then synthesized comparing the three population regions of the State. The data book was released this Fall and was the foundation for a series of meetings with the public held during a "**Listening Tour**" in September. Over 260 Maine citizens participated in meetings in seven sites (Presque Isle, Brewer, Calais, Lewiston, Augusta, Saco and Portland). In addition, a **mini-survey** was shared with participants at the "Listening

Tour" to assure those who felt uncomfortable speaking publicly could have a vehicle for input and to allow additional comments for those who spoke as well.

The Listening Tour and mini-survey identified several themes.

The strongest theme, echoed at every site, was the importance of **prevention** and the need to improve education and wellness initiatives. Considerable discussion centered on the importance of supporting local, community efforts to improve health, and the strengthening of preventive activities. A similarly strong theme was the importance of **universal coverage**, though opinions of how best to achieve it varied with some strongly supporting DirigoChoice, others seeking single payer and still others favoring market based solutions. Others spoke of the importance of trained and available health professionals and clinics and the need to make health care more affordable.

When discussing priorities for public health and prevention activity, participants focused on **obesity/nutrition/exercise**, followed closely by concern about **substance abuse**, **tobacco use** and **mental health**.

Participants were explicit in defining health broadly -- articulating the importance of the economy on health noting that, as socio-economic status improves, so does health. They also stressed the critical importance of environmental health.

The public engagement process netted considerable input that reflected wide diversity of opinion but also identified the common themes that frame this State Health Plan.

The public engagement process will continue once the draft State Health Plan is complete. The Advisory Council on Health System Development will review the draft and provide on-going guidance to the staff. On November 21st & 22nd they will convene for **public hearings** for specific comments on the draft plan. On November 30th the State Health Plan will be reviewed by the **Joint Committee on Health and Human Services** for their comments. Based on these comments and on-going guidance from the ACHSD the final State Health Plan will be available by the end of December.

WE CAN GET THERE FROM HERE – GOALS OF THE PLAN/MAKING MAINE THE HEALTHIEST STATE

The public engagement process helped us understand disparate views about what it will take to make Maine the healthiest state in the nation. This goal points us in the right direction but we need more detail on our destination. What does it mean to be the healthiest state? Some people think of health as the absence of disease or infirmity. From this perspective, we might focus primarily on medical care as the pathway to health. Others think of health more broadly, to be a state of physical, mental, and social well-being. From this perspective, we might broaden our focus to include other factors that influence wellness such as healthy lifestyles, secure social relationships, or adequate income.

So are we trying to minimize illness or maximize wellness? Are we focusing on medical solutions or broader strategies?
On the Listening Tour, many of the ideas and suggestions made by stakeholders suggest a broad definition of health: many people focused on health promotion, the inter-relationship between physical health and mental health, and the need to place health within the context of broader community and state initiatives addressing employment, education, housing, transportation, the environment, and the economy. With this perspective in mind, this State Health Plan incorporates a broad view of what it means to be the healthiest state in the nation, and recognizes there are many.

FELLOW TRAVELERS ALONG THE ROAD

Obviously, community and public health organizations, medical professionals and health insurers play a significant role in promoting health. But many others, including each of us, our families, communities and employers play a role in moving Maine toward this goal.

With the State Health Plan reflecting diverse perspectives and providing direction, we need to make sure all of us are doing our part to move toward our goal.

GUIDEPOSTS

Just like any map, there are always choices about which road to take, where to get on and off the highway, whether to take a direct or scenic route. Every route has something to offer, and none should be rejected out of hand. The journey to making Maine the healthiest state will be full of such choices, so it is good to have some guideposts to help us keep to the right path. These guideposts – or guiding principles – should be checked often and certainly whenever a fork in the road appears, to make certain we are not going astray.

The following guideposts are what will lead us:

Accessibility

- Every person in Maine should have access to comprehensive, affordable health care coverage. This includes access to accurate, unbiased information that will allow each individual to make the best possible choices in taking steps toward better health;
- Needed health services should be reasonably located and available to all residents in a timely manner;
- Health begins in the community and is more than treatment – health begins in our homes and with prevention;
- Every Mainer should have the same opportunity to realize his or her potential. We must work to reduce disparities in health status that are associated with gender, education, age, culture and income.

Affordability

- The cost of care must lay within the reach of the resources we have to pay for it;
- In order to effectively manage costs, we have to understand what we are purchasing. The cost of care, coverage and its administration must be transparent to the public. Outcomes of care must be measurable, measured and publicly reported. Similarly, community and government services must be publicly accountable;
- Our investment in health must be sustainable over the long run. This means we must strive for the most efficient use of resources possible and to promote affordability over the long run.

Quality

- In Maine, the right care will be delivered at the right time and in the right place;
- Health care in Maine will be based on sound research and designed to maximize patient outcomes and patient safety;
- We will measure the quality of care provided in Maine and will continuously work to improve that care.

Some of the Signs Along the Way

Along every highway there are signs letting you know where you are and what direction you're headed in. While each leg of our journey has its own markers of progress, we can also mark our journey by taking a look down at the map from the tree top level – sometimes its easier to see from up there.

The following markers will be used to keep tabs on our journey to becoming the healthiest state:

Improving health outcomes by effectively integrating mental health and physical health, beginning with the issue of depression

Objectives: All children covered by MaineCare will be screened for depression using an evidence-based screening tool by 2007

Baseline data on the prevalence of depression will be collected by the State on a routine basis, through the BRFSS, by 2007

Assure that mental health counseling services are available and accessible to 90% of adolescents in Maine schools by 2008

Reduce emergency department visits for adults with a mental health problems as a primary diagnosis by 25% by 2008

Reducing the impact of substance abuse on health and health care costs

Objectives: Reduce the incidence of binge drinking by 18-24 year olds by 5% by 2007

Reduce the incidence of binge drinking among Maine high school students by 10% by 2007

Reduce 30-day alcohol use by Maine high school students by 10% by 2007

Increase the rate of treatment completion for substance abuse by 10% by 2008

Increase the rate of abstinence at discharge by 10% by 2008

Reducing the impact of tobacco-related diseases on health and health care costs

Objectives: Reduce cigarette smoking among Maine adolescents to 18% by 2008

Increase tobacco cessation during pregnancy to 90% by 2008

90% of people admitted to Maine hospitals for acute myocardial infarction who smoke are advised and assisted in quitting by 2008

Reduce hospitalization for asthma to 6.5/10,000 residents by 2008

Reducing the impact of overweight and obesity on health and health care costs

Objectives: Reduce the proportion of adolescents who are at an unhealthy weight to 5% by 2008

Increase the proportion of Maine adults with diabetes who have completed a diabetes management class to 80% by 2008

Reduce hospitalizations of Mainers for complications of diabetes by 10% by 2008

ASSESSING THE LANDSCAPE – THE CURRENT STATE OF HEALTH AND HEALTHCARE IN MAINE

There are many factors that impact our health: age, gender, race, culture, income, education, geography and just plain luck all play a role. In Maine, we face a number of factors that impede our progress toward becoming the healthiest state in the nation.

GEOGRAPHY

Maine is a very large state – more than 33 thousand square miles – almost the size of New Hampshire, Vermont, Massachusetts and Connecticut combined. Yet we have a population of just under1.3 million people – only a tiny fraction of the region's total population – spread across this vast geographic area. Our dispersed population presents a huge challenge as we work to ensure that every one living in our state has timely access to needed health care services.

Right now, resources are not equally distributed across the state.

AGE

Maine's population is somewhat older than that of the rest of the country. Our median age here is 38.6 years, compared to the median age of all Americans of 35.2 years. 14.4% of Mainers are 65 years of age or older; this compares to a nationwide figure of 12.4%. In just five short years, Maine is expected to have the 3rd largest share of residents 65 years of age or older, reaching 2nd place for that statistic by the year 2030. By then, it is projected that only 18.1% of Mainers will be under the age of 18.[i]

It would seem logical to conclude that the fact that Maine is "older" than other states is responsible for the fact that we spend much more on health care than other states do. However, this conclusion is not borne out by research, which finds that only 6-7% of growth in health care spending is attributable to the influence of aging.[ii] This is because the proportion of the population that is elderly is growing relatively slowly and, further, that spending on this sector of the population is increasing more slowly than is spending on younger people.

Although the research also shows that our longer life spans now reflect fewer years of disability (that is, we are living longer, generally healthier lives), the heavy burden of chronic illness in this state introduces some uncertainty into the equation for Maine.

HEALTH BEHAVIORS

The choices we make day to day about how we behave – whether we smoke, wear our seatbelts or helmets, whether we exercise, eat healthy, nutritious foods or use preventive medical care – do have an impact on our well being.
It is important that each of us take responsibility for our own actions and work to be as healthy as we can. By actively promoting our own health, we can reduce our risk of

sickness and death. At the same time, by working at being healthy, we help ourselves be as productive as possible.

It is also important that we all understand that it is not helpful to blame people for their health status. There are lots of reasons people engage in the behaviors they do and lots of reasons why they might find it difficult to alter those behaviors. Instead of finger pointing or punishing, we have to find ways of supporting and enabling better health behavior.

Socioeconomic Status

Taking all other demographic factors into account, income has, by far, the greatest impact on mortality. The influence on mortality of risky behaviors like smoking, drinking, lack of exercise or obesity pale in comparison to the influence of income.[iii] There are persistent gaps in health status between low income and higher income people – "inequality is a health hazard."[iv]

This is not to say that working to minimize risky health behavior is not a worthwhile endeavor. Nor does it imply that access to care is not important. But it does imply that in order to improve the disparities in health status that we have to pay attention to the issue of income.

Mainers have lower median household incomes than do Americans, generally[v] and, within Maine, there is variation in income. US Census data indicate that there are far fewer people living in poverty in the southern region of the state than there are in either the central or northeastern regions. This variation likely contributes to differences in health status and need across these regions of the state. Reaching our goal of becoming the healthiest state, then, parallels our economic development efforts. As our efforts to improve Maine's economy continue to succeed, our health will likely improve as well. We are on the right track – real (meaning the gain after taking inflation into account) per capita income in Maine increased 2.6% between 2003 and 2004.[vi]

Just as there are many factors that impact our health as individuals, so, too, are there factors that impact the performance of our health care system.

Health Status

Mainers bear a heavier burden of chronic illness than do most other Americans. This is partly because our population is somewhat older than the country as a whole, but it is also likely related to the fact that we are less likely to have a college education than Americans generally and tend to have lower incomes – and socioeconomic status does affect health. We also have the highest proportion of uninsured in the northeast and the lowest proportion of employer-sponsored insurance coverage. And we have high rates

of behaviors that influence disease, such as use of alcohol, tobacco, and sedentary lifestyles.

In addition to differences between Maine and the rest of the country, there are also differences *within* Maine. Part of the work we have to do to make Maine the healthiest state is to first recognize that differences exist across our state. The roads we travel down on our way to our goal may need more work in certain regions of the state than in others. The community that is Maine needs to reach across town lines, across cultural lines, across economic lines and see to it that every person – east, west, north and south – has access to an entry ramp onto this highway we are traveling down. This will be a hard trip and it may be a long one, but one well worth taking together.

THE HEALTHCARE MARKETPLACE

There are four major classes of players in our health care system. The first is purchasers, who buy care either through an arrangement with an insurance company or directly. Purchasers include employers who sponsor health insurance benefits for workers, individuals who pay all or a portion of their health care premium or the cost of services directly out of their own pockets, and governments – both state and local – which sponsor public programs like Medicare and Medicaid. Purchasers fuel the system by supplying funding. Insurers receive funds from purchasers and use it to reimburse health care providers for services delivered. Providers are health care professionals and organizations – including doctors, nurses, hospitals, pharmacies, etc. – who actually provide care. Suppliers, the fourth class of player, produce many of the "non-professional" inputs needed to supply care, including technological equipment, pharmaceuticals, bandages, lasers, and so on.[vii] Each of these players can and do impact the performance of the system in one way or another, their interactions forming a complex web where it is difficult to disentangle the impact of one player from that of another.

Many people advocate for more competition in health care as an answer to spiraling costs and sub-optimal outcomes of care. People advocating this position view health care as a traditional marketplace, susceptible to the traditional market pressures of supply and demand. The move toward health savings accounts and high deductible insurance plans is a market-based strategy in health care.

In order for a free market to work, though, patients would have to be responsible for a good portion of the cost of the care they were seeking to purchase *and* they would have to have information sufficient for them to make judgments regarding differences in the cost of care across providers. Providers, for their part, would have to compete for patients on the basis of price and quality.

Our market needs help to operate efficiently and effectively. Consumers need reliable ways to compare widely differing prices across providers. Although it is somewhat helpful to know standard or average prices, you just don't know when you go to the

doctor with a cough, whether you will end up paying $60 for an office visit and $6 for some over the counter cough medicine. Or, you might end up spending $6,000 for a chest scan and bronchoscopy. There really is no good way of predicting – and therefore, no good way of shopping around, especially for non-discretionary care. Comparing prices for routine care – like a simple office visit or blood test – is much simpler a task. However, when people need care – especially hospital care – it is often on an emergent basis, when emotions and anxiety are running high – situations not conducive to rational market behavior.

In Maine, our markets for hospital services, insurance coverage and many specialist physician services are highly concentrated. That is, there are just not a lot of "sellers" that consumers can choose from. Maine's 1.3 million people, predominance of very small business and vast geography make the state relatively unattractive for insurance companies; the administrative costs inherent in marketing and administering health care coverage in this setting are too high relative to earnings potential. Markets with few sellers and uninformed purchasers are not able to foster price competition, which is essential to a functional free market system.

Having health insurance coverage can insulate consumers from the any level of appreciation for the price of the health care services they seek and receive. This is because someone else – the insurer or Medicare or Medicaid – is paying the bill. Some people argue that if consumers share at least some financial risk for their care, they will be more discerning about how and when they seek care. This leads to recommendations for insurance policies with high deductibles. If you knew you were going to have to pay the first $5,000 of your health care every year, you would probably think twice before you went to the emergency room. The downside of these types of plans is that lower income people, or people who have higher health care needs, can end up putting off needed care until they are seriously and acutely ill, when care will be more costly and likely have poorer outcomes. We need to find a reasonable middle ground here, where consumers are incentivized to use care discriminatingly, but where everyone can appropriately access the care they need when they need it.

Health Care Costs

When looking at health care spending, it can be useful to examine what we are spending our money on and which medical conditions are driving increases in health care spending.

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.[viii] 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 just growth in the population.

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 $1.2 billion – nearly 37% of the $3.3 billion increase in health care spending over those 7 years – is attributable to the leading chronic illnesses: cardiovascular disease; cancer; chronic lung disease; and diabetes. Most importantly, these conditions are largely preventable.

Figure One: The rate of increase in health care spending, by driving factor

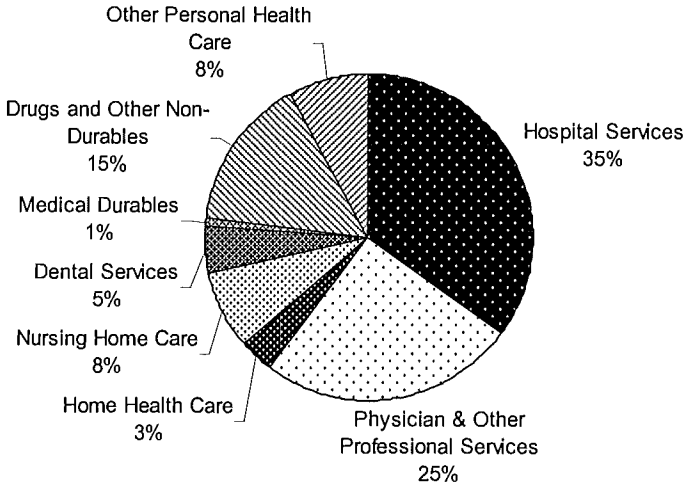
Maine	Portion of total increase attributable to this condition		Portion of this increase attributable to:					
			Increases in the cost of treatment		Increases in the diagnosis and treatment of the condition		Increased population	
Heart disease	8.1%	$0.26	83%	$0.22	1%	$0.004	16%	$0.04
Pulmonary conditions	5.6%	$0.18	42%	$0.08	47%	$0.09	11%	$0.02
Mental disorders	7.4%	$0.24	24%	$0.06	66%	$0.16	10%	$0.02
Cancer	5.4%	$0.18	51%	$0.09	33%	$0.06	16%	$0.03
Hypertension	4.2%	$0.14	67%	$0.09	21%	$0.03	11%	$0.02
Cerebrovascular disease	3.5%	$0.12	23%	$0.03	67%	$0.08	10%	$0.01
Diabetes	2.4%	$0.08	28%	$0.02	58%	$0.04	14%	$0.01
Total	36.6%	$1.201	49%	$0.585	38%	$0.462	13%	$0.154

What Mainers spend their health care dollars on is similar to that seen across the nation; below is a breakdown of Maine health care spending by categories of spending.

It is projected that, in 2005, there will be a 7.5% increase in our health care spending in Maine. This includes spending by consumers, insurers, business, and government. An overview of projected increases in spending, by category of expenditure, appears in Figure Two on page 15.

As noted elsewhere in this Plan, Maine's health care spending is higher than the median expenditures for the nation. In turn, the US spends more than other developed countries around the world. At the same time, our overall health attainment ranks only 24th among developed nations. The return on investment in that equation raises serious issues.

Unquestionably, Mainers enjoy some of the best health care available anywhere, hands down. Our hospitals, doctors and other health care professionals and facilities are world class. That we don't have access to quality care is not the issue. There is, however, a great deal of variation in the utilization and outcomes of care across our state. People are hospitalized much more often in some Maine communities than in others. So, where you happen to live can have a lot to do with the care you receive and what the outcomes of that care may be.



Cardiology, digestive and respiratory conditions account for the vast majority of the admissions to hospitals that show the most variation in rates from one community to the next.[ix] These are the categories for the most common chronic disease conditions. The rates of admission associated with these conditions vary from almost 20% below the state median to 40% above that median. While there is some difference from one town to the next with regard to the prevalence of these disease conditions, those variances are small when compared to the variation in hospitalization rates for the conditions.

There are many factors at work in generating these differences. The most important thing to note, though, is that these variations represent a significant opportunity to improve the quality and outcomes of our care and, consequently, ensure that the investments we are making in our health care are appropriate. Right now, we are unable to make that claim.

Figure Two: Personal Health Care Expenditures ($billions)		1998	Nat'l Chg 98-99	1999 est	Nat'l Chg 99-00	2000 est	Nat'l Chg 00-01
Hospital Services		$1.867	3.9%	$1.940	5.0%	$2.038	8.1%
Physician & Other Professional Services		$1.270	5.2%	$1.336	7.0%	$1.429	8.7%
Home Health Care		$0.187	-3.9%	$0.180	-2.2%	$0.176	6.6%
Nursing Home Care		$0.482	1.3%	$0.488	5.1%	$0.513	6.2%
Dental Services		$0.240	6.0%	$0.254	7.6%	$0.274	8.1%
Medical Durables		$0.060	1.8%	$0.061	2.9%	$0.063	4.0%
Drugs and Other Non-Durables		$0.559	16.2%	$0.649	13.0%	$0.734	12.8%
Other Personal Health Care		$0.343	11.6%	$0.383	8.9%	$0.417	12.0%
TOTAL ($billions)		$5.008	5.7%	$5.293	6.6%	$5.644	8.9%
Gross State Product ($billions)		$31.922	5.0%	$33.519	6.4%	$35.662	4.0%
% of GSP		15.7%		15.8%		15.8%	
Population		1,260,053	0.6%	1,268,097	0.8%	1,278,244	0.6%
Per Capita Personal Health Care Spending ($)		$3,974	5.0%	$4,174	5.8%	$4,415	8.2%

	2001 est	Nat'l Chg 01-02	2002 est	Nat'l Chg 02-03	2003 est	Nat'l Chg 03-04	2004 est	Nat'l Chg 04-05	2005 est
Hospital Services	$2.202	8.5%	$2.388	6.5%	$2.545	7.0%	$2.722	6.7%	$2.903
Physician & Other Professional Services	$1.554	8.2%	$1.681	8.1%	$1.817	7.5%	$1.953	7.1%	$2.091
Home Health Care	$0.188	8.3%	$0.203	9.6%	$0.223	13.0%	$0.252	10.6%	$0.278
Nursing Home Care	$0.545	5.3%	$0.574	3.9%	$0.597	4.2%	$0.621	4.9%	$0.652
Dental Services	$0.296	8.1%	$0.320	4.8%	$0.335	6.5%	$0.357	6.3%	$0.379
Medical Durables	$0.065	6.5%	$0.070	4.1%	$0.072	3.9%	$0.075	2.4%	$0.077
Drugs and Other Non-Durables	$0.828	12.6%	$0.932	9.7%	$1.023	10.6%	$1.132	10.5%	$1.250
Other Personal Health Care	$0.467	10.2%	$0.515	9.3%	$0.562	6.7%	$0.600	10.2%	$0.661
TOTAL ($billions)	$6.144	8.8%	$6.683	7.4%	$7.174	7.5%	$7.711	7.5%	$8.292
Gross State Product ($billions)	$37.094	5.2%	$39.027	4.6%	$40.829	6.1%	$43.336	3.3%	$44.775
% of GSP	16.6%		17.1%		17.6%		17.8%		18.5%
Population	1,286,000	0.8%	1,296,364	0.8%	1,307,000	0.7%	1,316,000	0.8%	1,326,000
Per Capita Personal Health Care Spending ($)	$4,778	7.9%	$5,155	6.5%	$5,489	6.8%	$5,859	6.7%	$6,254

A recently published study by the University of Southern Maine's Muskie School examines the experience of a group of more than 100,000 privately insured Mainers over a six-year time period spanning from 1995-2001.[x] These individuals were all members of group health plans sponsored by some of the state's largest employers, all of whom participated in the Maine Health Management Coalition over the course of the study period. The population in this study primarily comprised working people (or dependents of workers); in that sense, the findings associated with this population are not generally applicable to Mainers as a whole. However, a working population associated with large groups – such as the people employed by business members of the Maine Health Management Coalition – are generally viewed by insurance carriers as lower risks than folks working in smaller businesses or those not attached to the workforce, the theory being partially predicated on the assumption that if you are sick, you won't last long in large business' competitive marketplace. To the extent this perspective is accurate, the study population might be expected to be healthier than the general Maine population. This implies that the health care use and cost findings of this study may actually underestimate what goes on statewide.

The study's key findings are as follows:

- From 1995-2001, average age-adjusted per person costs in this insured group of more than 100,000 people rose 34%;
- Inpatient hospital care use changed modestly, but the rise in the average cost per discharge was far above the national average;
- While the increase in the use of physician services by this group exceeded the national average, the use of such services remained below the national benchmark;
- Outpatient costs – both hospital and non-hospital – rose substantially. Hospital outpatient costs were the most significant contributor to the overall increase, rising by more than 90%, and outpacing the national experience;
- Use of services across all health care delivery settings (not just hospitals) grew substantially. Increases in the use of advanced imaging, for instance, was striking. National data indicated that Maine's MRI capacity ranks among the highest in the US – 8 times higher than that of New Hampshire.

The cost of care is rising at a pace that outstrips the improvements in our economy. Continuation of this trend will mean that health care will comprise an ever-growing portion of our spending. If you accept the fact that Mainers do not have unlimited resources, this means we will have an ever-declining pot of money, then, to spend on other things that are important to us.

The fact that the median income in Maine is relatively low means that our residents likely require more health care services than do residents of wealthier states. Still, if we fail to balance health care spending with our ability to pay, our economy will suffer, which will not help raise the standard of living for all of our citizens. It is in this spirit that the Plan recommends the investment priorities described later in this document.

ARE WE THERE YET?

No. Making Maine the healthiest state is an ambitious goal; "getting there" will take time and significant energy across all sectors – communities, insurers, employers, state government, local governments and each and every one of us has a role to play in getting us to our goal. And – first things first – we have to agree on our destination and our route.

Maine does have many of the attributes of a healthy state. For instance, we've made tremendous progress in the area of infant mortality. Two decades ago, Maine had the highest rate of infant mortality in the country. By pulling together and with a lot of hard work Maine, today, is a national leader in reducing infant mortality.

Mainers have also done a great job in reducing the rate of teen smoking and we have improved the smoking quit rates among adults. These achievements are undoubtedly due, in part, to focused efforts on the part of health providers and advocates, State government, the Maine legislature, schools, store owners, employers and communities who have come together to make tobacco cessation a priority in our state.

But we still have a long way to go.

HOW DO WE RANK NOW?

These measures show how we rank now on measures for the 3 Cs and 2 Ds, plus measures for obesity/overweight, exercise, and children's well being.

These measures are posted at the Kaiser Family Foundation and the Annie E. Casey Foundation websites and are for the most part updated once every one or two years, allowing us to track our progress over time.

Importantly, the data for cancer and heart disease are "adjusted for age," which means that it shows differences between Maine and other states *after* taking into consideration that some states have older populations. This means that the differences shown here are *not* driven by the fact that Maine has an older population.

The data show that, relative to the rest of the country, we have high rates of cancer and asthma – i.e., the fact that we are "first or second highest" means that we have more cancer and asthma than other states – but that for the other measures, we are nearer the middle of the pack.

For all of these measures, there is considerable room for improvement, which will both improve quality of life for countless Mainers and bring significant savings in health care costs.

	Measure	US	ME	ME rank
Cancer	Cancer Incidence per 100,000, 2001, age-adjusted [xi]	461.6	515.0	2nd highest
COPD	Prevalence of Asthma in Adults, 2003 [xii]	7.7%	9.9%	1st highest
	Percent of Adults Who Are Smokers, 2004 [xiii]	20.6%	20.9%	24th highest
Cardiac	Heart Disease Death Rate per 100,000, 2002, age-adjusted [xiv]	240.8	209.0	37th highest
Diabetes	Prevalence of Diagnosed Diabetes in Adults, 2003 [xv]	7.2%	7.4%	19th highest
Depression	Prevalence of Poor Mental Health in Adults, 2004 [xvi]	33.9%	33.8%	26th highest
Weight	Rate of Overweight and Obesity in Adults, 2002 [xvii]	56.0%	55.9%	25th highest
Exercise	% of Adults at Recom. Level of Physical Activity, 2001 [xviii]	45%	50%	14th highest
Children	Percent of Children Age 19-35 Months Who Are Immunized, 2002-2003 [xix]	78%	78%	26th highest
	Binge alcohol drinking among youths, Age 12-17: Percent: 2002 [xx]	11%	11%	19th lowest
	Cigarette use in the past month, Age 12-17: Percent: 2002 [xxi]	13%	13%	14th lowest

Source: www.statehealthfacts.kff.org, except last two, from Kids Count Data Book, The Annie E. Casey Foundation , www.aecf.org/kidscount/sld/index.jsp. See Appendix __ for more information.

STARTING THE TRIP
"BE FIT FOR MAINE'S FUTURE" – AN INDIVIDUAL CONTRACT FOR HEALTH

To start this important journey of making Maine the healthiest state in the nation, we take the first step where health begins – with each of us individually, considering how to improve our own health within the context of our families and communities.

The 2006-2008 State Health Plan launches the "**Be Fit for Maine's Future**" campaign. A healthier state means a more productive citizenry and businesses, lower health care costs and a commitment to a high quality of life. Each of us can do something more to improve our health. Working with state, community and local public health organizations, health professionals, worksite wellness programs, private insurers, the Governor's Council on Physical Fitness, Sports, Health and Wellness, the Maine Center for Public Health and others, the Governor's Office of Health Policy and Finance will lead the development of a tool and strategy to stimulate individual action for better health.

The foundation of the "Be Fit for Maine's Future" campaign will be the creation of a Contract for Better Health. Unlike the well-intended but quickly forgotten New Year's resolution, research tells us that when we make a written commitment to another party, we are more likely to take that pledge to action seriously.[xxii]

The contracts will be developed by a work group convened jointly by GOHPF and DHHS Public Health and will incorporate existing efforts now underway in Maine like DirigoChoice's Healthy Maine Rewards program and other health risk assessment protocols. For example, the Keep Maine Healthy "5-2-1-0" tool created by the Maine Center for Public Health and the Maine Chapter of the American Academy of Pediatrics provides an example of a simple to understand, measurable tool to help children improve their health by eating 5 servings of fruits and vegetables, limiting screen time to 2 hours, exercising for 1 hour and avoiding soda each day.

The Be Fit for Maine's Future contract will be a similar checklist identifying areas for health improvement. The checklist will be signed by an individual and another party such as one's physician, a family member or a member of the Healthy Maine Partnership or Healthy Community Coalition. Unlike a full health risk assessment, the checklist will identify specific interventions (lose weight, exercise more, stop smoking, see a mental health counselor), set specific goals (10lbs, walk a mile each day, call the Maine quit line, make a counseling appointment) and set timelines (within 6 months, every day for a year, be smoke free for a year by my birthday, 2007) for individual action that are achievable. Some individuals may choose to make an individual contract; others might choose a family contract that could enhance the health of everyone in their family. Each contract will be completely confidential in the same way all other medical information is confidential. Compliance with the contract will be assessed by the

individual and the person with whom the contract is signed. This voluntary program will be well publicized and will allow individuals to elect with whom they wish to contract. The goal of the initiative is to drive home the message that a healthier Maine begins with each of us in collaboration with all those we look to for support and advice as we strive to take charge of our own health.

TASKS/WHO'S RESPONSIBLE/DUE DATE

- Convene public-private workgroup to review current related activities, design the contract & dissemination strategies & means to measure progress
  GOHPF/DHHS Public Health, 02/06

- Complete contract
  Public Health Work Group/GOHPF/DHHS Public Health, 03/06

- Complete dissemination strategy to reach maximum number of Mainers
  Public Health Work Group, 04/06

- Launch the "Be Fit for Maine's Future" contract initiative
  GOHPF/DHHS Public Health, 05/06

- Work with local public health organizations, MaineCare, providers to encourage participation in the program
  GOHPF/DHHS Public Health, on-going

- Add question to Maine BRFSS to assess progress in engaging public in Be Fit For Maine contracting effort
  DHHS Public Health, 2007

- Assure 30% of Maine people over the age of 10 have completed the contract by Dec. 31, 2006
  DHHS Public Health, 12/06

- Set a new goal for 2007-2008 by February 14, 2007
  GOHPF/DHHS Public Health

BUILDING THE NEEDED INFRASTRUCTURE - A PUBLIC HEALTH INFRASTRUCTURE FOR MAINE

Taking the long journey to make Maine the healthiest state requires an organized infrastructure that is strategic and reliable across Maine. For many years, through informal processes as well as through formal initiatives such as the Turning Points project, the public health community has discussed how to organize a public health system for Maine. Although much has been achieved, barriers such as limited resources, lack of consensus, and competing priorities have hindered Maine's ability to achieve this goal.

Maine's public health strengths lie in the dedicated people – paid professionals and volunteers – across the state working tirelessly to improve the health of their communities. Some of those who are dedicated to public health work as part of a local organization such as a hospital, school, Healthy Maine Partnership or healthy community coalition, while others work as part of a statewide organization such as the Coalition on Smoking or Health, the American Lung Association of Maine, or the American Cancer Society. Maine's commitment to spend its share of the National Tobacco Settlement (Fund for a Healthy Maine) on tobacco prevention and other public health strategies reflects the strength of Maine's commitment to public health and its dedicated public health community. As a result of these and other prior efforts, Maine has made marked progress in reducing youth smoking, infant mortality, and teen pregnancy.

Despite these commendable achievements, the State can do more to assure a more organized statewide system of public health. Currently, the State distributes public health funding in many streams, according to the specific content area the funds are intended to address. This is often in response to Federal funding requirements. As a result, Maine DHHS distributes over 550 separate grants to sub-state organizations for public health activities. These grants each require administrative and reporting capacity to assure accountability. And, there is little funding specifically for core activities. However, recently the public health community across the state has been working to identify ways to use these funding streams to build a more coordinated system for public health. The Legislature's Joint Committee on Health and Human Services has also expressed its support for strengthening the system of community health coalitions.

To expand Maine's public health infrastructure, we will have to build upon the strengths of Maine's public health community, within the limits of available financial resources. To discern the best path forward, the Governor's Office of Health Policy and Finance and the Maine Network of Healthy Communities with the Maine Department of Health and Human Services Offices of Public Health and Substance Abuse, formed the Public Health Work Group. The Public Health Work Group comprises 26 members including representatives from the Governor's Advisory Council on Health Systems Development, The Maine Public Health Association, the Maine Association of Substance Abuse Providers, Maine Network of Healthy Communities, Community Partnerships for a Healthy Maine, the Cities of Portland and Bangor, Communities for Children and Youth,

Maine Center for Public Health, University of New England, the Maine Hospital Association, Maine Primary Care Association, The Heart, Lung and Cancer Associations, Healthy Maine Partnerships, the Maine Municipal Association, the Department of Education and representatives of the Legislature's Health and Human Services Committee.

The Plan incorporates the recommendations emerging from this collaborative process, including a set of recommendations designed to improve coordination of existing fiscal resources, to use the strengths in Maine's existing network of public health organizations and community coalitions in order to build a statewide system of organizations and comprehensive community coalitions. Like an effective transportation system, this system will build upon existing local roads to assure their interconnectivity and access to major highways.

Additionally, the Public Health Work Group proposes a process using state, regional, and local public health infrastructure to identify and assure the delivery of all ten essential public health services in each area of the state. This step will be pivotal to Maine's achieving its goal of having an identifiable statewide public health infrastructure that has capacity to address a myriad of current and future threats to the public's health. The ten essential public health services include:[xxiii]

- Monitoring health status to identify community health problems;
- Diagnosis and investigation of health problems and health hazards in the community;
- To inform, educate and empower people about health issues;
- Mobilizing community partnerships to identify and resolve health problems;
- Developing policies and plans that support individual and community health efforts;
- Enforcing laws and rules that protect health and ensure safety;
- Linking people to needed personal health services and assuring the provision of health care when it is otherwise unavailable;
- Assuring a competent public health and health care work force;
- Evaluating the effectiveness, accessibility and quality of personal and population-based health services; and
- Researching for new insights and innovative solutions to health challenges.

GOALS FOR EXPANDING MAINE'S PUBLIC HEALTH INFRASTRUCTURE

- **Implement a Statewide Community-Based Public Health Infrastructure that Works Hand-in-Hand with the Personal Healthcare System**
  Maine will develop a system with community coalitions and sub-state health departments that results in effective partnerships with local and State organizations to assure delivery of the 10 essential public health services. This will include evaluation of organizations and coalitions against performance standards as well as coordinated State contracting and State oversight.

- **Assure Coordinated Funding for Sub-State and Local Entities**
  Maine DHHS will issue funds that braid public health resources together that will provide incentives to meaningful community-level collaboration to most effectively reach highest-risk populations, that will provide for more efficient program administration and help assure all essential services of public health are delivered across the State.

- **Streamline Reporting Requirements for Maine HHS Grantees**
  Maine HHS Public Health and OSA will establish one-stop web-based reporting tools to simplify data and administrative reporting requirements for grantees.

- **Improve Sub-State and Local Public Health Assistance**
  Maine HHS technical assistance for community-based organizations will be more mutually-beneficial.

- **Develop a Conduit for the State Health Plan**
  The community-based public health infrastructure will determine the flow of information and resources pertaining to the State Health Plan.

- **Initiate Action with Federal Agencies and National Foundations to Improve and Increase Funding for Public Health in Maine**
  We will invite federal agencies to discuss how they can assist us in achieving Maine's goals, including streamlining complex processes at the federal level. We will seek additional support from national foundations.

- **Improve Public Health Workforce Capacity**
  Accessible education programs will be developed that lead to a standardized credentialing for community health and prevention specialists.

BENCHMARKS/WHO'S RESPONSIBLE/DATES

- Public Health Workgroup will make recommendations for developing a performance standards system for organizations to assure the delivery of the 10 essential public health services for all areas of the State. The on-going role and support by Maine HHS will be addressed as well.
  June 2006

- Joint Healthy Maine Partnership (HMP) - Office of Substance Abuse (OSA) request for proposals released and contracts awarded for tobacco, obesity, and substance abuse programs. Statewide community-based public health infrastructure is improved through the integration of these funds.
  June 2006

- Collaboration strategies for communities and state agencies are developed for upcoming WIC, HIV/STD, substance abuse, and home visiting requests for proposals to assure continued improvements in public health infrastructure and coordination.
  June 2006

- Joint reporting requirements and system in place for OSA and HMP grantees.
  June 2006

- Maine HHS will work with the Public Health Workgroup to determine how State public health technical assistance for community-based organizations can be more mutually beneficial.
  June 2006

- Regional epidemiologists are co-located with Public Health Nurses and Health Inspectors.
  June 2006

- Linkages to University System are built for enhanced resources availability.
  June 2006

- Public Health Workgroup will develop and implement plans for conduits for the multi-directional flow of information, resources, and feedback regarding the State Health Plan.
  June 2006

- Governor's Office will convene a meeting with Federal agencies to include Maine public health leaders (Public Health Workgroup plus State leaders) -- to discuss how they can work together to achieve Maine's goals.
  September 2006

- Additional meetings will be convened with national foundations to support specific initiatives identified by the workgroup.
  December 2006

- Workforce Development Sub-Work Group will meet and make recommendations for developing and implementing a training and education program leading to community health and prevention specialist credentialing.
  June 2006

- A statewide community-based public health infrastructure is being implemented, with several organizations serving as pilots for a 10 essential public health services performance standards system.
  June 2008

- Maine HHS public health assistance is more mutually-beneficial and fully implemented.
  June 2008

- Educational and training program for community health and prevention specialists is implemented.
  June 2008

THERE'S MORE THAT CAN BE DONE... EMPLOYERS AND HEALTH PROMOTION/DISEASE PREVENTION

Every single one of us has a role in helping Maine become the healthiest state. In the Plan, we call on individuals to be fit for Maine's future. We lay out roles for state government, local community organizations and health care professionals. We call on payers to help move us toward our goal. And there's a role for business.

As health care costs have grown employers have taken an active role in efforts to promote health and prevent illness among their employees. Research demonstrates that 5-10% of the "effective workforce is lost due to health problems."[xxiv] Poor health affects productivity and that impacts a company's bottom line. Moreover, studies document that participation in health promotion intervention significantly decrease health care utilization. While the literature is not as robust about the cost effectiveness of worksite health promotion activities, employees have embraced such initiatives to retain and support employees and as a measure to reduce cost growth.

Maine employers have actively initiated such efforts. Cianbro, L.L.Bean and BIW and many others have long standing programs. Worksite wellness programs have blossomed in smaller companies as well, although there are often fewer resources to support such initiatives.

To acknowledge employer based leadership in worksite wellness, to help document "what works" and to help incentivize further deployment of these programs throughout Maine, the Governor's Office of Health Policy and Finance, Maine Health and Human Services Public Health and the Department of Economic and Community Development, and the Department of Labor will develop the Employee Wellness Challenge in cooperation with Maine's business, labor and public health communities.

TASKS/WHO'S RESPONSIBLE/DATES

- The Public Purchasers Steering Committee will expand its annual report to document worksite wellness initiatives now underway, the number of employees served and documented cost savings, if any.
  Public Purchasers Steering Committee, January 2007

- The Governor will appoint a private/public Employee Wellness Challenge Task Force to design a program to reward excellence in health promotion in large, medium and small firms in Maine.
  Governor, Governor's Office of Health Policy and Finance, February 2006

- Governor's Office of Health Policy and Finance, the Department of Economic and Community Development and the Department of Labor will develop staffing support to assist the Task Force in its work.
  GOHPF, DECD, DOL, February 2006

- The Task Force will establish criteria for the excellence award including scope of program, documented cost effectiveness and innovation and potential for replication and a simple process to identify or solicit nominees.
  Task Force, May 2006

- The Task Force will work with business and labor groups to promote the Challenge and encourage application and nomination.
  Task Force, May-September 2006

- The Task Force will appoint an independent panel of experts to review applications and nominations.
  Task Force, September 2006

- The Governor will make awards
  November 2006

TUNING UP FOR THE BIG TRIP – CHARTING A COURSE TO ADDRESS CHRONIC ILLNESS

Before any road trip, it's a good idea to check out the car to assess what work may need to be done. When setting out on the trek towards making Maine the healthiest state, we need to take stock of what's under our own hoods. And we need to address our most serious problems – the growing burden of chronic illness.

There are two types of illness: acute and chronic. An acute illness is one which has a sudden onset and is short in duration. It usually goes away on its own and often responds to treatment. The flu is an example of an acute illness. In contrast, a chronic illness like asthma or diabetes is long lasting, sometimes spanning over the course of a lifetime. Often, these illnesses are manageable, but not curable. These conditions are typically attributable to more than one factor, including genetics, environment and personal behaviors.

Examples of common chronic illness are familiar to all of us. They include the heart disease, cancer, chronic obstructive lung disease (including asthma), diabetes and depression – the leading causes of death in Maine. Arthritis is a chronic illness, as is Alzheimer's disease, Parkinson's, and cerebrovascular disease, which causes stroke.

These conditions impact many individuals and families in Maine, degrading quality of life, impacting the productivity of our workforce and generating hundreds of millions of dollars in health care costs. In Maine almost 40% of the $3.3 billion increase in health care spending from 1998 - 2005 is attributable to the leading chronic illnesses: cardiovascular disease; cancer; chronic lung disease; and diabetes. As medicine gets better at diagnosing and treating these disease conditions, and we live longer and longer, these types of conditions will become more prevalent.

Maine's experience with chronic illness can be summed up as follows:

- In 2001, heart disease and cancer accounted for 51% of the deaths in Maine. Maine's death due to heart disease is lower than the national rate. Although the prevalence of heart disease is similar wherever you go in Maine, death due to heart disease is significantly lower in southern Maine than in other parts of the state.[xxv]

- Maine's cancer death rate is higher than the national rate and is the same across all regions of Maine.[xxvi] However, the incidence of cancer is lower in southern Maine than it is in northeastern or central Maine. This is likely due, in part, because the population of central and northeastern Maine is "older" than that of southern Maine – and older age is highly correlated with cancer. It is also die to the relatively high rates of tobacco use that have existed for many years in the northern and central portions of the state, as compared to southern Maine; many cancers – not just lung cancer – are triggered by tobacco use. The prevalence of

coronary heart disease and related conditions such as high blood pressure and high cholesterol is similar in all areas of the state.

- Almost 10% of Maine adults report that they currently have asthma; this is significantly higher than the 7.7% reported by adults nationally.[xxvii]

- Death due to stroke is highest in the northeastern reaches of Maine.[xxviii] This may be attributable to the fact that the population in this region is older, has a higher rate of heart disease and is more likely to have multiple chronic conditions, making it more difficult for persons suffering a stroke to survive that event.

- While the prevalence of diabetes in Maine and across the nation is almost identical,[xxix] the percentage of Maine citizens with diabetes doubled between 1994 and 2002, with 7% of Mainers now having diabetes. Virtually all of the increase is in Type 2 diabetes and is largely due to greater prevalence of overweight[xxx] and inactivity and the aging of Maine's population. The prevalence of diabetes is about 58% higher in northeastern and central Maine than in southern Maine.

- According to a 2004 Maine Health Information Center study, 15% of MaineCare members had a diagnosis of depression and accounted for 36% ($315 million) of total claims payments.

At the same time:

- Maine's rates of overweight are slightly higher than that for the nation as a whole, although a smaller percentage of Mainers are obese.[xxxi] Mainers living In the central region of the state face the greatest challenge with regard to obesity.[xxxii]

- Based on the most recent Adult Tobacco survey performed by the Bureau of Health, 42% of adult MaineCare members smoke.

- Maine's rates of smoking and physical inactivity among adults are higher than the national rates. Nearly 24% of adults in Maine smoke, and nearly 26% have no leisure-time physical activity. Vigorous activity levels are highest in southern Maine and lowest in the northeastern region.[xxxiii]

- Unfortunately, many of the same problems that plague adults are also affecting the next generation of Mainers. The spring 2005 Maine Youth Risk Behavior study (YRBS) of 9th through 12th graders reveals that over 90% did not attend a physical education class on a daily basis, more than 10% are overweight and more than 37% do not participate in vigorous physical activity on a regular basis.[xxxiv]

Changing the health care system from one that serves predominantly acute illness to one better equipped to meet the needs of persons with chronic illness is like the difference between a road trip through Maine and an around the world voyage. For the former, a well running, well equipped car will get us there. For the latter, we'll need cars, planes and maybe boats, too! We'll need to navigate different languages and cultures and will probably need help coordinating the trip.

Just as a car can't get you around the world, chronic illnesses are not well served by the delivery system's acute care orientation. Our health care system has grown up around the need to respond in a rapid, "quick strike" fashion to acute illness and injury – getting a quick and decisive diagnosis and initiating intervention. The providers play the dominant role in this equation, with a less important role for self-management (and determination) by the patient. This model made perfect sense in a world where infectious disease and acute episodes of illness were the major medical challenges. Acute illnesses are addressed primarily by physician and hospital care; chronic illnesses require a broader range of social and environmental supports (for example, assistance with home monitoring of conditions and community based exercise programs). Hospitals are often the most costly point of care – we need to build alternatives to serve our different health care needs.

Over time, we have witnessed huge progress in the battle against acute illness, allowing us to live longer; although it is clear that acute illnesses continue to be a matter of concern – witness the challenges that will be posed by Pandemic Influenza. As we have reined in the impact of acute illness, chronic conditions have become the leading cause of illness, death and disability, impacting about half of all Americans and most of the health care spending.[xxxv] Patients with chronic illnesses like heart disease, lung disease, diabetes, cancer and mental illness live in the community; a health system that utilizes an acute model, silo-like framework – even managed and integrated care systems[xxxvi] – simply cannot efficiently or effectively meet the needs of those with chronic illness.

Even though chronic illness is a huge problem for us, we haven't developed very good systems or approaches to caring for persons with chronically illness in ways that ensure them the best quality of life possible. At the same time we need to ensure that the approach we adopt fosters quality, efficiency and cost effectiveness.

Improving the care of Maine citizens with chronic conditions will benefit the care consumer, the care provider, and our entire society. To improve this care, the evidence strongly suggests the need for a new model of care, one where planned regular interactions between patients and their families and formal caregivers focus on maintaining a citizen's health. The "care model" – which was discussed in the Interim State Health Plan – is intended to satisfy all of these criteria.

As called for in the Interim Plan, folks across Maine have been working to develop a variation of the care model for Maine and have been moving forward. MaineCare has recently issued a call for proposals for a new initiative designed to better meet the

needs of members who are high cost – most of whom are chronically ill. This early step is part of the state's effort to reinforce the care model in Maine.

The work of Quality Counts! – a statewide collaborative of private clinicians and businesses – has continued over the past year. The fledgling group now has an organizational "home" and is planning a third annual meeting this coming December.

The Executive Committee of *Quality Counts!* has been involved in the development of the MaineCare initiative and the work of the Chronic Care Work Group, established in accordance with recommendations of the Interim Plan. This group comprises representatives from both within and without state government, focusing on developing strategies to disseminate the care model in Maine.

Where We Need to Head

Improving the care of Maine residents living with chronic conditions will benefit individuals, families, care providers, payers, business and our entire society. To improve outcomes for persons with chronic illnesses, the evidence strongly suggests the need for a new model of care, one where planned regular interactions between patients, their families and their caregivers **focus on maintaining the patient's health.** Everyone – the consumer, the provider, the payer, policymakers and communities – have a role in the care model.

Throughout the past several years various Maine stakeholders have undertaken a wide range of chronic disease prevention and improvement efforts. Examples include:

- Over 60 physician practices across the state have voluntarily participated in year-long structured "learning collaboratives" led by the Maine Network for Health and MaineHealth to make systemic improvements in care and outcomes for patients with diabetes, depression, chronic obstructive pulmonary disease, and asthma. A number of health centers have participated in national "learning collaboratives" sponsored by the Bureau of Primary Health Care to improve care for patients with diabetes, depression, and cardiovascular disease.
- More than 50 physician practice groups and provider networks have invested in nurse care management programs to provide clinical management and active coordination of health care services for patients in need of support;
- More than 150 Maine physician practices are using electronic medical records; still others are using some form of disease registry to track outcomes and provide better population-based care in the communities they serve;
- Many Maine hospitals participate in MECares, offering community-based care support programs for patients with heart failure and coronary heart disease, focusing on education and support for patients ready to change unhealthy behaviors that are known risk factors for the progression of their disease;
- MaineCare is partnering with providers and launching a new initiative to provide care management to its most costly members;

- Maine providers from across the state have joined together to form *Quality Counts!*, focused on prevention and improving the quality of care provided to persons living with chronic illness through peer education and support; and
- Governor Baldacci has endorsed the implementation of the "Care Model" as the principal strategy for strengthening chronic disease prevention and management.

All of these efforts are to be applauded and encouraged, but we need to do more. Specifically, it is recommended:

- Governor's Office of Health Policy and Finance continues to work in collaboration with *Quality Counts!* and the Maine Quality Forum to advance the implementation of the Care Model throughout Maine
- GOHPF, *Quality Counts*, Maine Quality Forum – on-going

- Develop and implement a communications plan to spread endorsement of the Care Model to important non-governmental organizations such as members of the business community, community organizations (including non-health care related organizations such as Y's, Lions, Rotary Clubs), provider organizations and associations
- Governor's Office of Health Policy and Finance/Maine Quality Forum/*Quality Counts* – plans to be completed by June 2006

A Lens for Viewing Health Care Challenges

Importantly, facing up to chronic illness will take a comprehensive and sustained effort. This isn't a problem that can be solved overnight. Not only do we have to develop a new vision of caring for people, we have to be certain to view our health care challenges through a lens that may feel somewhat different to you.
There are multiple aspects to approaching health. These include: prevention, early detection, and treatment/rehabilitation. Within each of these aspects, there are interventions and actions that involve our entire community, from each of us as individuals and neighbors to local town officials, to employers and insurers, health care providers, and state policy makers.

The Governor's Advisory Council for Health Systems Development has assisted in developing a model for conveying a visual representation of this approach. That model is shown on the following pages. Before proceeding to this presentation, though, it's important to understand that this model may be applied to *any* class of health issues or conditions. If the condition you are most concerned about isn't shown here, that doesn't mean we consider it unimportant. While we use the model here to examine some of the state's leading chronic conditions, it can be just as easily applied to, for example, lyme disease, suicide, oral health or any other health issue you can think of. Each of the aspects of the model apply to all health issues – that's why it is so useful in thinking through how we might tackle an issue.

CARDIOVASCULAR DISEASE, CANCER, CHRONIC LUNG DISEASE, DIABETES		
Prevention	**Early Detection**	**Treatment/Rehabilitation**
Modifiable Risk Factors	***Modifiable Risk Factors***	***Modifiable Risk Factors***
Smoking High blood pressure Low HDL/high triglycerides Stress Overuse of alcohol Lack of physical activity Poor nutrition – high BMI Poor air quality Presence of comorbidities Depression, other mental illness	Blood pressure, cholesterol levels, weight, smoking status, presence of co-morbid conditions, depression	- Variations in medical utilization and outcomes - Noncompliance with therapeutic regimen; noncompliance with routine care protocols
Interventions	***Interventions***	***Interventions***
- Broad based educational campaigns healthy lifestyles -- smoking cessation -- exercise programs -- school based programs -- nutrition campaign - individualized education that is personally relevant - appropriate screening for risk factors - Individualized treatment plans that focus on modifiable risk factors such as HBP, depression hyperlipidemia, etc. - Tailoring of policy agenda to support healthy lifestyles, health education, screening, early intervention; need to exploit opportunities to address modifiable risk factors -- public education campaigns -- public health infrastructure & care model -- payment policy for MaineCare and state employees	-Additional education efforts (focused) -care management infrastructure, referrals -monitoring by PCP for modifiable risk factors: blood pressure, digital rectal exam, occult blood testing, LDL/triglycerides, smoking status, depression, comorbidities, history -supportive assistance for patients and their families who indicate a readiness for change to improve lifestyles -supportive assistance for providers who are ready to implement population-based care model into practice (and inclusion of depression as essential element in implementation of care model) - Assistance for schools engaging in early identification of risk factors in children and their parents for the purposes of targeting interventions	- Focus on patients at highest risk for on-going, intensive education and support - Broad based implementation of care model to ensure appropriate support of the patient - reduce unwanted variations in medical care through provider education, consumer involvement in care decision making - Ensure that system capacity (with regard to full range – ambulatory and hospital) of services is appropriate and available to patients
Settings	***Settings***	***Settings***
State government Workplace Schools Community Providers	Providers Schools Communities Workplaces Government	Providers/Health systems Communities Government Workplace
Providers	***Providers***	***Providers***
- Primary care providers, specialists, school based providers, care managers in systems, practices and payer settings, hospitals and nurses: screening, education, 5 "A's" (ask, advise, assess, assist, arrange),	- Use of registries in PCP practices to track population with risk factors and to provide on-going monitoring of "vital" signs - Implementation of care model in primary care practices to ensure that	- "enrollment" of high need patients in care model system of delivering care - accessible office hours to encourage ambulatory care when appropriate, avoid hospitalizations

provider activation (involvement in community partnerships, policy setting, public education, etc.)	high risk patients are followed regularly and supported in monitoring of their risk factors	- work to understand etiology of unwanted variation in the use of medical care for high-variation conditions - Incorporate use of best practices and evidence based care - incorporate patient into the decision making process
Community	***Community***	***Community***
-Schools: early education re: healthy lifestyles; family education; healthy food choices in cafeteria; exercise programs; school based health centers -Workplace: access to appropriate health benefits; smoke free workplaces; healthy indoor air quality; exercise opportunities; living wage Community partners/advocates: support for local partnerships programs; support for phys ed in schools as well as healthful menu in school cafes; walking trails and sidewalks planned for; support for local Ys; religious organizations walking programs, exercise programs; health advocacy (e.g. Healthy Futures program	- Community screening events with feedback loop to PCP offices - Implementation of comprehensive model of tracking community residents at risk – e.g. Farmington initiative - workplace wellness programs pay special attention to employees with risk factors; encouraging regular monitoring via health plan communications; coverage of routine "vital" sign checks	- Full participant in the care model; ensure patients are connected to supportive community services to aid their compliance with treatment and their full recovery. This can and will include non-traditional resources/non-health care resources such as Ys, religious organizations, financial institutions, etc. - workplaces provide meaningful health benefits
Consumers	***Consumers***	***Consumers***
- Enter into a "Be Fit for Maine's Future" contract - Get regular check ups – ask questions! -Know your personal and family health history - Practice healthy lifestyles Weight & nutrition mgt Exercise Smoking cessation -Informed consumer -Productive interactions w/ health care provider -Model healthy behaviors for children	- Consumers to encourage family members at risk to secure regular monitoring services - Ask for support in monitoring your risk factors – know your values! Know signs and symptoms	Be active participants in your own care Ask questions, ask for support Know and consider your options
State Government	***State Government***	***State Government***
Model healthy behaviors: support exercise programs; insure healthy indoor air quality; provide healthy food choices in cafes -Implement appropriate incentives and care management for publicly insured populations -Implement policy that supports the care model	- State to engage high risk MaineCare members in a care model system, so as to ensure encouragement of on-going monitoring of members at risk for an event in the near future	Encourage dissemination and implementation of "best practices" Educate providers and consumers about variation in medical care and work to reduce that variation Provide incentives for appropriate location of needed health services

-Implement policies that support access to care and coverage as well as promote high quality care - Employ strategies that align or braid resources to support the care model down to the local level -Promote supportive environmental policy Develop bandwith capability to permit telemedicine connectivity across the state (still have pockets with no access)		
Outcomes	***Outcomes***	***Outcomes***
Reduced incidence and prevalence of risk factors -reductions in BMI – reduce the proportion of adolescents who are at an unhealthy weight to 5% by 2008 -increases in numbers of people exercising regularly -reduction in the number of new smokers and in the number of quitters - Increase tobacco cessation during pregnancy to 90% by 2008 -improvements in indoor air quality at work and outdoors	Reduce cigarette smoking among Maine adolescents to 18% by 2008 Increase tobacco cessation among pregnant women to 90% by 2008 Reduce hospitalizations for asthma to 6.5/10,000 residents by 2008 Reduce hospitalizations of Mainers for complications of diabetes who have completed a diabetes management class to 80% by 2008	Reduced mortality rates for heart disease, lung disease, cancer and diabetes Reduced disability from these conditions/improved patient outcomes Cost of care is more appropriate

DEPRESSION		
Prevention	**Early Detection**	**Treatment/Rehabilitation**
Modifiable Risk Factors	***Modifiable Risk Factors***	***Modifiable Risk Factors***
General: Economic, social, interpersonal stress; Physical disability, Co-occurring medical issues; Emotional/physical abuse and other trauma; Lack of social supports; Isolation; Rx interactions/side effects; Substance abuse; Major life changes; **Children:** Mental illness/substance abuse in parent, family economic or marital stress, caregiver disorganization, academic difficulties, learning disabilities **Teens and young adults**: Difficulties fitting in with peer group; learning, attentional, cognitive, academic issues, school environment that supports bullying, exclusion; lack of community opportunities for healthy social, recreational activities **Elderly:** Cognitive decline, failing health, loss of independence, loss of home, death of partners, friends, increased sensitivity to med side effects	Lack of awareness of early signs Lack of information about high risk groups across the general population	Lack of social supports; Unrecognized PTSD; Abusive setting/situation; Co-occurring morbidity from physical illness(includes substance abuse; Discontinuation of prescribed medication; Unacknowledged impact of major life change Stigma; lack of access (lack of provider capacity, transportation, insurance etc)
Interventions	***Interventions***	***Interventions***
Education re depression and principles of good mental health for all; Identification and development of mental health promotion, mental illness prevention strategies (learning from public health and from substance abuse prevention) (a field in its infancy) Importance of social networks and social support **Stigma Reduction**: Reduce stigma associated with depression (MI) through media campaign of well known people talking about their experience with depression; Effect recommendations of SAMSHA on reducing stigma; integration of depression screening as routine part of primary care; statewide campaign promoting concept that	Routine screening for Depression by pediatricians, NPs, PCPs; Routine screening for Substance Abuse; Public education for all re signs and symptoms of depression, (akin to campaigns to have public identify signs of a heart attack or a stroke) I; Routine depression screenings in schools, community and nonbehavioral health settings; Parenting "classes" and support groups in nonbehavioral health settings; Early identification and referral of academically struggling, withdrawn and aggressive children by pediatricians, teachers, coaches, group activity leaders (scouting);	Accurate Diagnosis and Functional Assessment; Medication; Hospitalization; Counseling/therapy; Protective Intervention by public safety, social services personnel; Construction of network of social supports including family as appropriate; Goal Setting and measurement of achievement; Education re illness and health maintenance (nutrition/exercise/smoking cessation)

mental health is part of health and important for optimal functioning of all citizens. Early identification of at risk babies/ new parents; Parenting "classes" and support groups in nonbehavioral health settings; Identification of high risk family units/parents in community settings; early identification and support for children at risk academically or socially. Early identification of vulnerable children by pediatricians, teachers, coaches, group activity leaders (scouting); Resiliency training for vulnerable kids; Special training for teachers re bullying intervention and reduction; Routine depression screening as part of health check-up for all ages; routine screen for postpartum depression Trainings and discussions with local public safety and legal/judicial players to identify kids(and adults) in trouble early in their contact with these systems ; Community opportunities for teens and young adults for skill building social, recreational, vocational activities. Trainings and materials for workplace supervisors re creating healthy workplace Outreach for disabled persons, shut ins, elderly.	Trainings and discussions with local public safety and legal/judicial players to identify depressed kids(and adults)early in their contact with these systems ; Trainings, materials, and referral resource databases for human resource professionals and workplace supervisors	
Settings	***Settings***	***Settings***
State government, Schools; PCPs'/NPs' offices; Senior Centers; Workplace; Health care settings; Community settings	Schools; after school activities settings; Places of worship; Health care settings Senior Centers	Outpatient mental health provider (s); PCP/NP office; inpatient
Providers	***Providers***	***Providers***
- Support for integration of mental health competency, screening and treatment in healthcare settings (including school health clinics) across the state - Education curricula for primary care providers, office staff. Development of psychiatric consultation teams to support/educate primary care providers. - Telemedicine support for psychiatric education and	Training on evidence based screening tools and interventions supported by payers, state agencies, medical societies, mental health specialists and public health educators; registry of depressed patients in each practice; Inclusion of mental health/substance abuse assessment fields in EMR. Integration of mental health services in school health clinics. Identification and referral of	PCP/NP ; Mental health professionals using co management model (produces best outcomes); Continuity of care and communication between hospital, psychiatric consultant, mental health provider and health care provider. Use of protocols, algorithms for psychopharmacology. Use of outcome measures to guide treatment decisions. Support for evidence based practices.

consultation. Creation of educational materials for provider offices. - Education for providers on screening for trauma (of all varieties), assessment of stress disorder, psychological first aid for stress reduction.	vulnerable/depressed kids and adults performed by teachers, clergy, after school activity leaders, PCPs/NPs, public safety personnel	Community health agency Screening for PTSD, Substance abuse
Community	***Community***	***Community***
DV providers; schools; HMPs; community education Departments of hospitals; identification of and check-in with vulnerable kids and adults performed by teachers, clergy, after school activity leaders, PCPs/NPs, public safety personnel Education on trauma awareness and principles of psychological first aid for public safety, teachers and other community members. Workplace: Engaging employers in supporting parity in insurance, pay for performance for depression screening, EAP programs that are accessible, anti-stigma campaigns in the workplace, recognition of link between depression and decreased, productivity, absenteeism	Hospital Depression Screening days Employer support for depression screening through the workplace Employer support for insurance support/pay for performance for depression screening (Pay for PHQ-9 as for glucose tolerance test) and for care model for depression	Social support groups sponsored by places of worship, senior centers; hospital health education programs Employment/employer support. Transportation. Safe housing options. Equal access to recreational, social opportunities Anti stigma campaigns
Consumers	***Consumers***	***Consumers***
Productive discussions with health care provider; Healthy lifestyles; Informed consumer re family history, personal vulnerabilities, and signs and symptoms of depression and its relationship to physical illness	Productive discussion with PCP/NP; Healthy lifestyle; Identification and utilization of natural supports; Recognition of "red flags"	Active participant in treatment planning process; Active participant in goal setting process; Goals for recovery – re-engagement in community, family, work. Active engagement in treatment; Self-Management of maintenance regimen; Recognition of "red flags" and action steps to take; Medication compliance
State Government		
Consider adoption of Massachusetts model for pooling state, payor contributions to support dedicated psychiatric team to consult to primary care providers for all children (?adults) (17 cents per child per month from insurers, covers 1.5 million children Include depression and mental illness in advocacy/policies/public funding for care model, integrated care, quality indicators for depression Anti-stigma campaign: everyone has mental health		

Training for state agency work force in awareness of impact of depression in clients they serve, in non behavioral health settings (Education, Corrections, Elderly, Child Protective, Mental Retardation) Creation of statewide, web based training materials Promotion of EMR and Personal Health record (MHINT) in Maine that includes mental health information. Include mental health issues in integrated data systems and data analysis of existing data sources to identify high risk populations and co-morbidity; relation to high medical costs, substance abuse, smoking, obesity, cardiovascular health Staff to provide linkage from mental health to public health to provide technical assistance and support to public health programs (e.g. STD's, maternal and child health, primary care, suicide prevention, emergency preparedness etc.) Support for identification and development of strategies for mental health promotion/mental illness prevention		
Outcomes	***Outcomes***	***Outcomes***
Public awareness of factors contributing to good mental health; Community efforts to reduce environmental risk factors for ; Early identification of vulnerable kids and adults	Early diagnosis and referral to appropriate treatment as much as possible within the primary care system; Early resolution of depressive symptoms; Return to usual activities	Recovery from illness Return to usual activities Risk factor reduction; Relapse plan;

SUBSTANCE ABUSE		
Prevention	**Early Detection**	**Treatment/Rehabilitation**
Modifiable Risk Factors	***Modifiable Risk Factors***	***Modifiable Risk Factors***
Availability of drugs (incl. tobacco/alcohol); Laws/norms accepting of drug/ alcohol use; Chaotic home environments and ineffective parenting; School failure; Poor peer relationships; Poor coping skills; Behavioral disorders; Youth oriented marketing by alcohol and prescription drug companies	Recreational use of drugs and alcohol; Lack of knowledge of lifestyle risk factors; Lack of knowledge of physiological risk factors	High risk behaviors Disengagement from social supports; Physical illness due to substance use Stigma of being identified as an addict
Interventions	***Interventions***	***Interventions***
Law enforcement re: sales to minors and social access (furnishing and underage possession) Evidence-based prevention programs targeting community based risk and protective factors as described above; Screening and brief intervention; Environmental strategies that address marketing and public perception of norms; Responsible retailing; Parent education and support	PCP/NP screening during routine and brief intervention when appropriate; Peer, parent, counselor discussion about substance use; Referral for assessment/evaluation Effective education through court/school/workplace diversion programs; Consistent effort to address early signs of misuse—policy and law violations	Comprehensive assessment; Accurate diagnosis; Detox; residential treatment with varying lengths of stay; Intensive Out-patient treatment; Outpatient treatment; Medication assisted treatment; Coordinated with primary and other specialty care for people with co-occurring disorders; Self-help
Settings	***Settings***	***Settings***
Schools/colleges Families Community Workplace Health care settings Religious institutions	Schools; Athletic activity settings; Community Home; Health care provider setting; Workplace	SA programs; PCP community
Providers	***Providers***	***Providers***
PCPs/NPs Youth workers/social service agencies Law enforcement Community Volunteers/coalitions School and college personnel Parents EAPs/wellness teams Clergy Learning from tobacco cessation: the importance of provider screening and discussion to move person with	Peers; SA counselors; PCP/NP; Law enforcement School/college personnel Parents Employers	SA professionals; MD, NP Peers abuse

substance abuse issues from pre-contemplation to cessation. Development of SA screening tools and brief interventions for primary care providers.		
Community	***Community***	***Community***
Business community School systems Public safety and criminal justice Retail liquor stores	Peers; SA counselors; PCP/NP; Law enforcement School/college personnel Parents Employers	Public safety personnel; Teachers; Employers; Support groups Recovery community
Consumers	***Consumers***	***Consumers***
Parents discuss substance abuse issues including setting clear rules with their kids; parents monitor and enforce rules Kids participate in discussions about risk taking behaviors; Assess personal risk factors including family history	Productive discussions with PCP, family members, educators, peers, counselors; Commitment to healthy lifestyle	Commitment to treatment program; Commitment to recovery; Relapse plan; Engagement in goal setting
State Government	***State Government***	***State Government***
Identify targets/goals Provide funding support and guidance		
Outcomes	***Outcomes***	***Outcomes***
Increase % of youth who remain alcohol/drug free Increase age of first use from baseline to target (different for different drugs); Reduce high risk drinking, alcohol related injury; and personal problems due to alcohol consumption (see targets attachment at end); Reduce fetal alcohol syndrome by reducing use by pregnant women	Reduction of risk taking behavior, i.e. binge drinking, pharming Reduce recidivism among first time offenders 5% reduction in binge drinking for adolescents 10% reduction in binge drinking for young adults	Recovery; System of formal and informal supports for consumer Increase in treatment recruitment and retention; i.e. shorter waits for treatment and reduced treatment drop-out rates Specifically: reduce wait times by 10% and increase treatment completion rates by 10%

DESTINATION: EFFECTIVE INTEGRATION OF MENTAL HEALTH INTO PHYSICAL HEALTH

There's no getting around it – mental health is inextricably intertwined with our physical health. Our mental health (or lack thereof) impacts on our ability to function well at work and school, to interact with our family and our ability to handle our social roles. Poor mental health is known to impact on morbidity and mortality associated with heart disease, stroke, diabetes, and physical disabilities. It is also a known risk factor for smoking, substance abuse, suicide and injury, and commonly co-occurs with other behavioral health conditions such as substance abuse.

The World Health Organization has found that more than 26% of Americans have a mental health disorder during a 12-month period.[xxxvii] The lifetime prevalence of depression is 20-25%. Still, most people in need of mental health treatment do not seek care.[xxxviii] This is probably due in large measure to the stigma associated with mental illness, a lack of understanding about mental health and illness among consumers and, sometimes, providers, and other barriers. Such barriers include mental health care workforce shortages, a lack of integration of mental health into our primary care delivery system, the historic isolation of mental health from major changes in the health care delivery system, reimbursement policy, an evidence base that is weaker than that which exists for general health care and a tendency to focus on major or severe mental illness as opposed to common ailments.

WHICH WAY FROM HERE?

We have mapped out several stops along the way toward our destination. The first stop is a place where Maine citizens will understand the signs and symptoms of depression, from childhood to older age, as well as they do the signs and symptoms of an ear infection, heart attack or stroke. Aiding our trek will be the availability of early depression screening by primary care providers, in schools and in the workplace. And we need to be certain that all of us have timely access to quality, evidence-based care for depression.

Starting this journey with depression makes sense. It is a common ailment that affects almost a quarter of us at some point in our lives. Moreover, there is good evidence base for depression care and relative agreement on quality standards for that care. Valid tools for screening and follow up for this condition are widely available, as are algorithms for the use of prescription medications for treatment.

THE FIRST STEPS

This trip is going to be a long one, but even "a journey of a thousand miles begins with a single step."[xxxix] One of the first things we must do to increase awareness, educate people about depression and reduce the stigma associated with this condition is to

consistently monitor the prevalence of depression in both the general population as well as in special populations, such as persons with substance abuse, disability, chronic disease, post-partum, and parents of at risk children. Specifically, over the coming biennium the following steps will be taken:

PREVENTION

We need to use existing epidemiological and other data sources to monitor the prevalence of depression in the general population as well as in special populations. There are many sources of these data including the Behavioral Risk Factor Surveillance Survey, MaineCare data and data from the Office of Substance Abuse, all administered by the Maine Department of Health and Human Services, and the all payer/all claims database administered by the Maine Health Data Organization. Private businesses and insurers also have important information and data to contribute to this effort as well. This includes those employers participating in the Maine Health Management Coalition as well as Anthem Blue Cross and Blue Shield of Maine, Harvard Pilgrim, Aetna and Cigna and businesses that are self-insured. We call on these private sector interests to establish their own monitoring function and to share aggregate findings with the state, through the physician leaders within the Department of Health and Human Services who are focusing on this task.

The Maine Department of Health and Human Services will convene a work group charged with the development of programming to increase public awareness of the signs and symptoms of depression across a person's lifespan. This work must be coordinated with existing public health, health education and education programs. The group will comprise representatives from the DHHS Behavioral and Developmental Services, the Maine Center for Disease Control and Prevention, MaineCare, the Office of Minority Health, the Office of Primary Care, the Department of Education, the Children's Cabinet and appropriate representatives of consumer advocacy groups as well as provider associations. The group will be convened by the Deputy Commissioner for Integrated Services of the Department of Health and Human Services.

The Maine Quality Forum will ensure that its activities related to the dissemination of Electronic Medical Records technology include mental health services settings.

EARLY DETECTION

The public health/behavioral health work group discussed above will identify preferred screening instruments for depression, appropriate to the different phases of lifespan, working toward the development and adoption of policy for promotion of the use of a universal screening tool across a range of non-mental health DHHS activities including substance abuse activities, public health activities, school health activities, elder services activities and so on.

Importantly, there already exists a robust body of literature on screening tools for depression that can be put to effective use in any of these settings. The crux of the issue is identifying strategies to ensure that the screening tool(s) are put into consistent use in primary care, educational and social service settings.

Until a universal tool is identified, MaineCare will continue to require age-appropriate screening for depression through its Bright Futures/Preventive Health Program.

Best practices adopted by Maine health care practitioners will include a screening for depression as part of routine screening and screening for diabetes, heart disease and so on.

The public health/behavioral health work group will develop and implement a plan to increase screening for depression in at least two communities, non-behavioral health settings: senior centers, workplaces, schools, community coalitions, etc.

TREATMENT

The Maine Quality Forum will work with the public health/behavioral health work group to identify and adopt uniform standards for measuring the quality of care for depression. This collaborative group will work with commercial insurers to encourage the adoption of incentives for evidence-based quality depression care.

MAKING SURE EVERYONE IS IN THE CAR – ACCESS TO HEALTH CARE

Preventing disease and promoting health are critically important long term strategies, but they will not eliminate illness and disability. Access to health care for all Mainers remains an essential goal of Dirigo Health and Maine's State Health Plan.

The ultimate destination on the health care access highway is affordable, quality health care for every Mainer. But access is directly related to affordability -- the health care cost crisis here and across the Nation complicates Dirigo's goal of universal coverage.

As we noted in last year's State Health Plan, when the cost of care increases, insurance premiums also rise. Increases in insurance premiums put a strain on businesses, which eventually pass on some of the cost to their employees, in the form of increased premiums paid by the employee. Some businesses attempt to stem the rate of increase in premiums by requiring increased cost-sharing – in the form of higher deductibles and/or higher co-payments – by employees.[xl] The following measures reflect the impact this phenomenon has had on Maine families in recent years:

- Thirty-eight percent of Maine's insured population pays more than 5 percent of their total household income toward health insurance premiums. One in twenty pays more than 20 percent. People who have to buy non-group coverage pay over $4,000 a year for coverage.[xli]
- The median deductible in Maine in 2002 was over $4,000.[xlii]
- Because of rising premiums and out-of-pocket requirements, on average Americans spent 18.2% of their income in 2001 on medical care, more than they spent on food, housing, and transportation.[xliii] Maine families likely spent a higher share of their income on health care, since health care expenditures per person in Maine are higher and income is lower than the national average.

As families become increasingly unable to afford these cost increases, some families lose insurance altogether, and many simply put off accessing care. Maine has the highest rate of uninsured citizens in New England.[xliv] About 136,000 (17%) of non-elderly Maine residents spent part of 2002 uninsured, and on any given day, roughly 1 in 8 non-elderly Mainers were uninsured. 80% of the uninsured work -- of those who do work 73% work in small businesses or are self-employed. 52% of the uninsured are below 200% FPL or $30,500/year, for a family of three.[xlv]

Lack of insurance and access to timely, adequate care impacts both the lives of those without access as well as the health system as a whole:

- The uninsured tend to be more costly to the health care system because they are less likely than the insured to receive preventive care, are diagnosed at more advanced disease stages, and are more likely than the insured to be hospitalized for preventable conditions like pneumonia and uncontrolled diabetes.

- Death rates for uninsured women with breast cancer are significantly higher than for insured women.[xlvi] Health insurance would reduce mortality rates for the uninsured and could improve their annual earnings by 10-30%.[xlvii]
- In Maine, over 11 percent of the population reports not visiting a physician because of cost.[xlviii] Forty-two percent of families with uninsured children report delaying needed care for their children due to costs. This rate is seven times that seen in insured families.[xlix]
- In 2003 Maine's hospitals reported $108 million in bad debt and $42 million in charity care costs caring for the uninsured.[l] These costs are then passed on to insurance companies, who in turn raise premiums for businesses and individuals causing the ranks of the uninsured to continue to grow.

The DirigoChoice plan is making important progress, enrolling 8,500 Mainers and over 700 small businesses already with its comprehensive, affordable coverage. A waiting list of 3,000 individuals will be addressed when the program reopens to individuals and sole proprietors January 2006. DirigoChoice has spurred re-invigorated competition from other insurers in the small group market. And, Dirigo's initiative to expand access to parents with incomes between 150% and 200% of the federal poverty level through MaineCare has already increased coverage to nearly 4,000people.

Dirigo exists in a costly marketplace. Original projections for the DirigoChoice product were made using 2002 data; premium costs have grown significantly since then, although they dropped markedly in Dirigo's first year of operation:

Year	Avg. small group premium increase
2003	**16%**
2004	**6%**
2005	**13%**

Source: Maine Bureau of Insurance

Assumptions about how much employers could pay and about what insurance companies would charge had to be re-visited and expenditures increased to address concerns raised by insurers about the potential risk -- and associated costs -- of serving an uninsured population. Planned expansion of MaineCare's waiver that provided coverage for Maine's childless adults below 125% FPL were stalled when the program reached budget limits set by the Federal government. Importantly, a changing Maine economy and health care marketplace brought in an unexpectedly high number of low wage workers eligible for the program's deepest discounts and revealed the growing problem of under-insurance in our State. A recent study by the Muskie School at USM found that among DirigoChoice enrollees who switched from other coverage, 40 percent had deductibles in excess of $2,500. High deductibles were disproportionately concentrated in the lowest income families for whom out-of-pocket costs can represent a severe hardship. For example, among DirigoChoice enrollees with family incomes less than $23,500 (about 40 percent of enrollees) a $2500 deductible is more than 10

percent of household income. The survey confirmed that those who had been paying high deductibles were more likely to report doing without health care during an illness due to costs. The growth of the under-insured in Maine likely explains the fact that nearly 1/3rd of bad debt being provided by Maine's hospitals is incurred by persons with health insurance.

Some continue to support the establishment of high risk pools as a means to increase access. But such pools operate only in the individual market and have no impact on the small and large groups where the majority of Mainers are insured. DirigoChoice provides individuals an opportunity to purchase a lower cost, higher value group health plan and provides subsidies to help make it affordable.

Dirigo Choice is not intended to be a solitary vehicle to expand access to all the uninsured; MaineCare plays a crucial role as does private-employer-based coverage. DirigoChoice integrates with both and recognizes that to sustain employer based coverage requires affordable options in addition to the subsidized DirigoChoice product.

The road to universal coverage converges with the road for cost containment -- it's a long uphill drive but Dirigo Health continues to make progress. For that progress to continue, the State Health Plan calls for specific actions:

TASKS/WHO'S RESPONSIBLE/DATES

- Participate with The Commonwealth Fund in its initiative to conduct an independent evaluation of progress to date in Dirigo Health, to identify key successes and areas requiring improvement
  Governor's Office of Health Policy and Finance/Dirigo Health Agency – Spring 2006 and on-going

- Develop and implement with Anthem BCBS a comprehensive marketing and outreach plan to reach the uninsured and expand DirigoChoice uninsured enrollment by at least 100%
  Dirigo Health Agency – January 2006

- Complete the redesign of the MaineCare waiver for childless adults to ensure compliance with federal spending limits and with an eye toward re-opening the program to childless adults
  Maine Department of Health and Human Services – ongoing

- Work collaboratively to review the effectiveness of Dirigo Health Reform's requirement for 78% loss ratio in small group market in making coverage more affordable in that market, as well as insurance regulation and its impact on premium costs
  Governor's Office of Health Policy and Finance/Maine Bureau of Insurance – March 2006

- Analyze the effectiveness of the DirigoChoice High Risk Pool
  Dirigo Health Agency and Maine Bureau of Insurance – October 2007

- Establish the Health Policy Leadership Forum, representing business, insurers, providers, consumers, and government, to assure ongoing communication and strategy to access affordable coverage.
  Governor's Office of Health Policy and Finance – February 2006

- With funding and support from The Robert Wood Johnson Foundation's State Coverage Initiatives, and in collaboration with the Muskie School of Public Service and others, conduct three public educational sessions to explore issues identified by the Forum related to health care coverage.
  Governor's Office of Health Policy and Finance and Forum – March 2006, September 2006 and February 2007

QUALITY

The quality of health care is of paramount importance. If care is of poor quality, patient outcomes will be poor, we will have misspent our health care resources and our communities and economy will suffer. The Institute of Medicine defines **high quality care** as care that is:

- **Safe** - avoiding injuries to patients from the care that is intended to help them
- **Effective** - providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding under use and overuse, respectively)
- **Patient-centered** – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions
- **Timely** – reducing waits and sometimes harmful delays for both those who receive and those who give care
- **Efficient** – avoiding waste, including waste of equipment, supplies, ideas, and energy; and
- **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

The Maine Quality Forum was created as part of Dirigo Health reform. Its mission is to advocate for high quality health care and help each Maine citizen make informed health care choices. To achieve its mission, the Forum serves as a clearinghouse of best practices and information to improve health, and acts as an informational resource for health care providers and consumers. Efforts undertaken by the Maine Quality Forum include sharing best medical practices with providers and consumers, as well as wellness, health promotion and disease prevention initiatives. Additionally, the Forum – supported by a broad based advisory committee - creates quality standards and assesses needs for new medical technologies throughout the state.

EDUCATING AND ENCOURAGING ADOPTION OF BEST PRACTICES IN HEALTH CARE

A "**best practice**" in health care delivery is the consensus opinion of what should be done in a specific clinical situation. The National Quality Forum, a public-private collaborative comprising consumers, payers, employers, health care professionals, health systems, accrediting bodies, unions and researchers, works to promote the development and use of common approaches to measuring quality and fostering capacity for quality improvement. The Maine Quality Forum and the Maine Quality Forum Advisory Council have worked to promote awareness of the NQF 30 best safe practices among Maine providers and consumers through the development of the **Safety Star** recognition program. This program will identify hospitals that lead the way

in patient safety, using the NQF safe practices as a basis for certification. The program was launched in September 2005, with the first award anticipated in January 2006.

The Maine Quality Forum has begun to collect clinical information from providers measuring their compliance with best practices in the care of heart attack, heart failure, pneumonia, and surgical infection reduction. These data will be analyzed and made available to the public in early summer 2006.

The Maine Quality Forum is also collecting data about nursing resources, hours and skill levels as well as other nurse-sensitive indicators, to establish best practices in nursing care for the state of Maine.

Using its website and distribution of print materials, newspaper advertisements and outreach to and collaboration with groups in the workplace, the Maine Quality Forum continues to promote public understanding of the concept of best practice and to raise expectations of provider performance.

Variations in Medical Care

Marked variation in the use of medical care for the same clinical problem from one geographic area to the next is a hallmark of the current state of health care. Where patients live frequently determines whether or not they will be hospitalized or have surgery for conditions that can be treated in different ways.

Variation in the frequency with which surgery is chosen as the route for care is driven by surgeon preference, custom and training. The Maine Quality Forum has publicized extreme variations in the state in rates of lumbar fusion, carotid endarterectomy and hysterectomy for non-cancerous conditions of the uterus, and has provided "feedback" information to those communities that have shown an interest in reducing their apparent over-use of these modes of care.

Variation in the use of inpatient care and the use of specialty medical services is related to the supply of those services. When there is more capacity in the system to provide the care, more care is provided, even if there is no evidence that there is an underlying need for such care. Further, there is evidence that more is not better when the utilization of services falls significantly outside average rates.[lii]

Improving the Care of Patients With Acute Myocardial Infarction

As noted elsewhere in this Plan, the leading cause of death in Maine and the U.S. is acute myocardial infraction (AMI or heart attack). The care of patients with acute myocardial infarction is challenged by rapid technological change responsible for marked improvement of outcomes by saving heart muscle from damage caused by lack of blood flow.

Myocardial infarction occurs when the cardiac muscle is deprived of oxygen because of obstruction of a nourishing artery or coronary artery. When a vessel is suddenly obstructed, the heart muscle is at risk of cellular death. If the obstructed vessel can be reopened prior to cellular death then the heart muscle can be saved from damage. Presently, there is consensus among clinicians that reopening the blood vessel must occur within 90-120 minutes of the onset of symptoms.

Thrombolytics or clot busting drugs have been used in an attempt to reopen obstructed blood vessels; these medications must be given within a short time frame of approximately 30 minutes after patient arrival in the emergency department.

Primary angioplasty, where a catheter with a small balloon is inserted through the groin to reopen the cardiac blood vessel appears to be more effective than thrombolytics in reopening clogged vessels. Primary angioplasty is only performed in hospitals that have a cardiac catheterization laboratory. The procedure should be started within two hours of patient arrival. Therefore, the challenge is to move a patient to a facility with a cardiac catheterization laboratory within 90-120 minutes of the onset of symptoms. Research shows, though, that hospitals across the country are challenged to provide this type of intervention within the needed time frame, particularly when a patient arrives at the hospital outside of normal daytime business hours.[lii]

This combination of limitations – treatments that must be delivered within a critical time frame, treatments that may be available only at a distance from the patient, and challenges within a hospital to provide rapid response during night time hours- presents a statewide challenge for co-ordination of care. In Maine geography is destiny. The challenge is to offer effective primary angioplasty to as many citizens of the State of Maine as possible. Given the time limitations, the process has to be time efficient from the first 911 call until the balloon is inflated within the obstructed vessel. Quality care of patients with acute myocardial infraction requires that each and every patient receives appropriate treatment within the time frame recommended by heart experts.

Addressing the Challenge

A process indicator is a measurement that represents the efficiency of the process without specific measurement of the actual outcome. In the present situation, it is proposed that measurement of the critical process variable of time from first call to reopening of the obstructed vessel by angioplasty is the indicator of success of the entire process.

Several groups in the state are presently attempting to improve the process. It is time to step back and look at the problem from a statewide perspective. The Maine Quality Forum will serve as the facilitator and resource for bringing together and supporting the stakeholders in a collaborative effort to provide consensus care of acute MI to the largest number of citizens possible.

The objectives of this effort will be as follows and will serve as yardsticks for success:

- All patients presenting to a hospital in Maine are treated according to a consensus treatment map that takes into account best medical practices and the realities of time and distance in Maine
- Clot busting drugs are given within 30 minutes of arrival at all Maine acute care hospitals for appropriate patients
- Patients with AMI that are appropriate for PCI receive their treatment within 120 minutes of arrival at the treating hospital

All participants in this effort realize that the care of acute myocardial infarction will continue to evolve. However, we as a group are determined to use the best knowledge and resources at hand to care for our citizens with myocardial infarction, always ready to change our treatment protocols as knowledge evolves.

TASKS/WHO'S RESPONSIBLE/DATES

The Maine Quality Forum, through the MQF Advisory Council, will convene a statewide group consisting of representatives of the continuum of care of patients with acute MI, from the call to first responders to hospital discharge. This *ad hoc* group will be responsible for establishing a treatment map for patients with acute MI. The treatment map will include metrics of performance such as time to thrombolytic, time to PCI and other metrics the group identifies as appropriate. The Maine Quality Forum will use the MQF Advisory Council as a public forum to present and discuss the progress of the effort, based on its agreed upon metrics.

- Ad hoc group is convened
  Maine Quality Forum/MQF Advisory Council, January 2006

- Care map is in place and data of agreed upon metrics is being collected
  Acute MI work group, Maine Quality Forum, January 2007

- MQF Advisory Council discusses and publicizes Maine performance based on predetermined metrics, July 2007

RESOURCE ALLOCATION

Making Maine the healthiest state requires allocating resources to prevention and to efforts to address chronic illness. It requires changes to the system of care and the re-direction of resources to incentivize wellness while continuing investment in the essential services of our current care system.

Among the purposes of the State Health Plan are the charges to assist in the determination of the level of capital investment Maine will make in health care each year and to guide the approval of applications for Certificates of Need by the Department of Health and Human Services, as well as lending decisions made by the Maine Health and Higher Education Facilities Authority. Specifically, the law requires that a Certificate of Need application or request for public financing cannot be provided unless the project meets the goals explicitly outlined in the State Health Plan.[liii]

CAPITAL INVESTMENT FUND

Certificate of Need is a regulatory program that reviews and either approves or denies certain types of projects undertaken by health care providers. In Maine, Certificate of Need 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.

In this state, only about 26% of all capital investments made by health care providers (and hospitals are the type of provider most often impacted by CON requirements) fall under CON scrutiny.[liv] Those projects that do require review, however, are evaluated by the Department of Health and Human Services, which assesses the proposals against a variety of quality, cost and access considerations.

One of the constraints the law puts on Certificate of Need is an annual limit on the dollar value of the projects approved by the Department of Health and Human Services, which are allowed to go ahead with implementation. This limit is called the Capital Investment Fund (CIF) and is set by the Governor's Office following guidelines approved by the Legislature. The intent of the CIF 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.

Depending on the number and the cost of proposed projects up for review, the Capital Investment Fund (or "CIF") may or may not be large enough to accommodate approval all of the pending applications. For instance, if the CIF is set at $6 million and projects for which review is sought total up to a combined 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. In that situation, proposals will compete with

one another, with those deemed by the Department of Health and Human Services to be the best applications being approved; the remaining proposals will be turned down.

CONSIDERATIONS IN SETTING THE CAPITAL INVESTMENT FUND

The law 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.

Available data on this topic are restricted to hospitals; no comparable data (in the public domain) are available for the health care system as a whole. According to *The 2005 Almanac of Hospital Financial & Operating Indicators,*[lv] the average age of plant in Maine in 2003 was 9.63 years, as shown in Figure Three. Of the 47 states for which data are available, Maine ranks 20th in terms of average age of plant.

Figure Three: Average Age of Plant

	1999	2000	2001	2002	2003
ME	9.5	9.71	9.77	9.32	9.63
NH	7.55	8.28	8.21	7.89	7.74
VT	8.92	9.62	9.97	9.92	9.22
MA	10.34	9.56	9.56	9.67	10.6
CT	9.49	9.49	10.54	10.27	10.6
NJ	9.63	9.93	10.59	11.14	10.65
NY	10.48	10.16	11.66	11.84	11.42
PA	10.48	10.43	11.32	11.88	11.65
RI	9.12	9.91	10.33	11.47	11.8
NE	9.95	9.82	10.46	10.83	10.65
Rural	9.45	9.71	9.92	10.03	9.96
All	9.22	9.39	9.61	9.76	9.83

While our plant has aged slightly over the past 5 years, Maine has a lower average age of plant than the entire northeast region and tracks the age of plant for both rural hospitals and for all hospitals, as a group. This suggests that the condition of capital in this state tracks that of the nation and is, on balance, similar to that found in our neighboring states, the exception being New Hampshire, which has tracked far below the regional and national averages for several years.

This is not to say that there are no arguably comparable states with an average age of plant less than that of Maine's. Nor is it intended to imply that there is no difference among Maine hospitals with regard to age of plant. Data from the Maine Hospital Association taken from hospital financial income statements[lvi] show Maine's largest

hospitals having a 2003 age of plant of 7.4 years, medium sized hospitals having an average plant age of 9.78 years and small hospitals 10.34 years. Again, this compares to the average age of plant, nationally, of 9.83 years and, in the Northeast, 10.65 years.[lvii] Certainly, hospitals in each state exhibit a range of plant ages; Maine is no exception. Still, in terms of benchmarking our own state against the region and the country, our hospital community bears up well.

The Almanac provides some other interesting benchmarks for consideration. One is the dollar value of capital costs per discharge, adjusted for differences in wage rates and case mix (Figure Four). "Capital" is the cost of bricks and mortar – or buildings – as well as equipment. Available data indicate the gap between Maine's capital cost per adjusted discharge and that of New Hampshire has been narrowing. While there are no data available for Vermont, Maine has consistently had a higher capital costs per discharge than Massachusetts, as it has compared to the Northeastern region, the nation as a whole, and rural hospitals, generally. This means that Maine's investment in hospital capital (buildings and equipment) is at or above that in other New England states, which, in this regard, serve as reasonable benchmarks for our health care system.

Another measure available is the rate of growth in capital expenditures, which reflects the addition of capital assets (property, plant and equipment) that is added in a single year; a higher value in this measure indicates a more active program of capital investment in additions and replacement of facilities.

Figure Four: Capital Costs per Discharge (Adjusted for Wage Index & Case Mix), 1999-2003

	1999	2000	2001	2002	2003
ME	$404.87	$414.14	$506.33	$468.29	$469.90
NH	$449.09	$445.07	$545.62	$431.54	N/A
VT	N/A	N/A	N/A	N/A	N/A
MA	$262.46	$161.32	$150.69	$172.73	$144.06
CT	N/A	N/A	N/A	$369.20	N/A
NJ	$409.18	$423.16	$392.20	$463.75	N/A
NY	$328.97	$358.17	$384.17	$310.13	$356.44
PA	$358.41	$321.77	$344.64	$361.99	$393.02
RI	$259.44	$280.30	$255.88	$274.01	$288.43
NE	$355.09	$281.22	$295.41	$309.46	$279.55
Rural	$386.86	$406.72	$397.20	$409.13	$423.77
All	$423.93	$400.40	$395.29	$412.62	$397.67

Data for Maine and benchmarks are shown below in Figure Five. While our rate of growth has been declining, Maine's rate of growth is higher than Vermont's, Massachusetts's, and Connecticut's, the Northeast's, rural hospitals' and the US's with regard to this measure.[lviii] This implies that we are investing in hospital capital at a faster rate than is generally observed in the benchmark areas.

Figure Five: Capital Expenditure Growth Rates, 1999-2003

	1999	2000	2001	2002	2003
ME	8.4%	11.0%	8.0%	6.9%	6.5%
NH	8.6%	5.3%	8.8%	7.3%	7.2%
VT	6.7%	6.0%	6.3%	6.5%	5.7%
MA	6.0%	5.5%	4.7%	6.3%	5.8%
CT	6.3%	4.3%	3.8%	5.2%	4.8%
NJ	6.1%	4.0%	4.8%	5.3%	7.2%
NY	6.2%	4.7%	4.0%	4.4%	5.3%
PA	5.8%	5.5%	4.8%	6.0%	5.4%
RI	6.9%	6.7%	5.8%	9.9%	8.3%
NE	6.4%	5.5%	5.2%	5.5%	5.7%
Rural	6.6%	6.1%	6.0%	5.7%	5.8%
All	7.1%	6.4%	6.2%	6.2%	6.4%

These data provide little evidence that we should speed up our rate of investment in facilities at the present time. To the contrary, the data show Maine's overall health care costs are high relative to other parts of the nation, indicating, perhaps, that we should slow our rate of investment or focus investment in projects that result in a decrease in operating costs.

Other Considerations

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 value of the Capital Investment Fund is the subject of a rulemaking proceeding and is not part of the State Health Plan. However, the Maine Quality Forum did not identify any technological developments that would necessitate special adjustments to the CIF.

This consideration 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.

Strategies

In evaluating and prioritizing projects submitted in accordance with Maine's CON statute, the Department of Health and Human Services should be guided by these priorities. Insofar as the statute at 22 MRSA §335, sub-§1 directs the Commissioner of

the Department of Health and Human Services to approve an application for a CON if the project is, among other things, consistent with the State Health Plan, it is important that this Plan clearly lay out criteria for projects.

In doing so, we must recognize the limitations of Certificate of Need. Between 1997 and 2002, only 26% of hospital capital expenditures were related to approved CON projects; the remaining 74% were not subject to CON review.[lix] We must therefore, strive to maximize the usefulness of this planning 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.

The Department of Health and Human Services is currently recruiting for a new Director of Certificate of Need and is planning to move the office into the Commissioner's office. This "relocation" signals the level of importance the CON function plays in Maine's health care landscape and will ensure that the Commissioner has ready access to the information and resources needed to arrive at sound decisions regarding the approval or denial of application requests.

PRIORITIES FOR CERTIFICATE OF NEED

What's needed where?
There is great interest in having the State Health Plan provide guidance regarding how many of which kinds of services Maine needs where. That is a difficult charge to carry out.

In 2003, Maine's level of community hospital beds[lx] per 100,000 residents was the highest in northern New England, including Massachusetts.[lxi] Maine, along with 10 other states, formed the middle tier of bed "density" in the nation, all having 260 – 305 beds per 100,000 residents, compared to a national figure of 280 beds for every 100,000 residents.[lxii] At the same time, Maine is one of the least densely populated states. That is part of what drives our relatively high bed count – the fact that our population is dispersed over a very large geographic area contributes to the fact that we have more hospitals and more beds than you might otherwise expect.

Research has shown that the supply of hospital beds influences the rate of use of those beds; that is, the more beds there are available, the more often they tend to be used.[lxiii] For instance, about half of the variation in rates of discharge for patients hospitalized for any medical condition can be explained by the supply of acute care beds.[lxiv]

In light of the documented tendency for supply-induced utilization and given the already high bed count in this state and the fact that patient care is continuing its "migration" away from the inpatient setting, and the average length of stay is declining, we do not believe new community beds are needed in Maine at the present time.

Providing guidance for other types of services is more difficult. The rate at which basic science moves forward and the rate at which new technologies are developed and moved into the marketplace will continue to outpace researchers' abilities to rigorously test them for their impact on outcomes of care or, for that matter, the quality and appropriateness of their use. It is difficult to rely on health care market forces alone to assure quality and appropriateness; the consumer reaction to managed care's attempts to exercise this type of influence demonstrates a public distaste for this type of "intrusion" of external forces into the patient/physician relationship.

As noted above, there is ample evidence of the reality of supply-induced demand, most especially with regard to services for which there are few documented clinical guidelines. Many of these "supply-sensitive" services are used in treating patients with chronic illness[lxv] - and chronic illness is one of Maine's major health challenges. These services include, but are not limited to, imaging procedures and diagnostics, but also include use of intensive care units and hospitalizations. Use of these services is influenced, in part, by an underlying premise that "more is better." Yet we know that isn't true. The United States – and Maine - spends more per capita on health care than any other industrialized nation,[lxvi] yet our level of health attainment falls 24th among such nations.[lxvii] Finally, those areas demonstrating high levels of supply sensitive services have higher levels of health care spending, which is associated with lower quality, poorer access to care and lower patient satisfaction, along with a somewhat higher risk of death.[lxviii]

There are many examples of this phenomenon in Maine. The variation in the rate of hospitalization for adult medical conditions is one such example, with the rate ranging from 19% below the median to more than 40% above the median. The rate of hospitalization for chronic lung disease is significantly lower in the southern region of the state than it is anywhere else in Maine. For other examples, see the website of the Maine Quality Forum (www.dirigohealth.maine.gov) or *The State of Maine's Health,* published by the Governor's Office of Health Policy and Finance and also available at the Dirigo website.

There is a balance, to be struck between our ability to afford to support certain services in our "backyard" and the value the services may provide to patient care. Clearly, we cannot afford to establish services on this order in every community in the state, nor would that foster high quality services and good outcomes, but Mainers need to have reasonable access to such care.

Invasive cardiology and cardiac surgery are services that undoubtedly save lives and enhance the quality of life for many patients. They also carry with them relatively high price tags and generate costly claims. In a 2000 report commissioned by the Maine Department of Human Services, Public Health Resource Group provides recommendations regarding how cardiac services in Maine should be developed.[lxix] These recommendations lay out thoughtful guidance, supported by clinical literature, regarding minimum volumes for diagnostic cardiology services, angioplasty and open heart surgical programs, as well as suggestions for where such services should be

located. This report cautions against the development of excess capacity, noting that at the time the report was prepared, such capacity existed in certain parts of the state, because of the danger and cost associated with overuse.

- **This report should be updated and used as guidance to set future priorities for CON approvals. The Department of Health and Human Services will commission such an update, to be completed by January 2007.**

There is also a continual challenge in the shifting boundaries between invasive cardiology and cardiac surgery, which is part of the evolution of cardiovascular care. The distinction between these two types of care is growing more difficult to discern. This situation is not confined to cardiovascular services. Gamma knives, for instance, may present similar "problems," blurring the line between old and new services – what is subject to CON review and what is not, how to balance cost and quality against the promise of a technological advance.

The Maine Quality Forum has been established, in part, to examine these types of questions. It is intended to serve as a forum for clinicians, payers and consumers to discuss the implications of new technologies and how Maine might best address the questions raised by them. The Maine Quality Forum represents a valuable resource for the Department of Health and Human Services as it works to assess CON applications and issues related to Certificate of Need, as it is a mechanism for bringing clinical and epidemiological expertise to bear on these issues.

The Department is currently considering entering into a Memorandum of Understanding with the Quality Forum to formalize a relationship for just such a purpose.

- **The Department of Health and Human Services will move ahead with that Agreement in as expeditious a manner as possible, with the Agreement fully functioning prior to the January 2006 competitive review proposal evaluations.**

Specific Priorities

As noted above, under Maine's regulatory system, proposals requiring CON review may sometimes find themselves competing with one another for approval. Similarly, there are times when there are two or more applications pending for review that seek to implement the same type of project – a new cardiac surgery program, perhaps, or surgical center.

The Department of Health and Human Services' CON program has adopted rules that govern the manner in which the application review process will be conducted. Those rules rely heavily on guidance provided in the State Health Plan, which by statute, must set out criteria to allow for the prioritization of applications submitted to the Certificate of

Need Program for review and approval. This is important in situations where there are competing proposals. However, the priorities are helpful even when there are no competing proposals. A lack of competition does not mean that a proposal should necessarily be summarily approved. The priorities for CON set out in the State Health Plan are intended to guide decisions regarding approval, regardless of the competitive posture of any application.

The most recently completed review cycle was the state's first experience reviewing CON applications under the new provisions of the Dirigo law. Four hospital applications were received and all were recommended for approval by the CON review staff; each was subsequently finally approved by the DHHS Commissioner. During the course of the review process, the CON unit received – as required by statute – input from both the Bureau of Insurance and the Bureau of Health regarding each application. This input was to be factored into the Department's evaluation of an application. The Department, however, found it lacked clear guidance regarding how that input should be factored into its overall assessment. For instance, it is not clear what the outcome of a review should be if one of the two Bureau's provides a negative finding regarding the application.

The law sets out the considerations that are to guide the Commissioner of Health and Human Services in decisions regarding the approval or denial of CON applications. These factors range from the ability of an applicant to actually provide the proposed service in accordance with relevant standards of care, to a demonstrated public need for the project and its impact on health status and health care spending. The Bureau of Public Health and the Bureau of Insurance are called upon to provide written assessments of the likely impact of each proposal on the health of the population and on insurance premiums locally and statewide.

Importantly, the law does not give more weight to one of these factors over another; by default, they are all assigned equal importance.

- This means that the Commissioner – and, by extension, Department staff preparing recommendations for the Commissioner regarding CON proposals – **should give equal weight to the input from both the Bureaus of Public Health and Insurance, as they do to the record established by the applicant.** Responsible parties: Commissioner, DHHS and Acting Director, Certificate of Need Unit; to be accomplished by January 2006.

- The Commissioner must work with the Bureau of Public Health to ensure that the input provided by that Office is provided in a form and manner that is useful to the application evaluation process.
  Responsible parties: Commissioner, DHHS and Director, DHHSPH; to be accomplished by January, 2006.

The experience of the first round of competitive review has also revealed a lack of clarity around the "tightness" of the connection between an application for CON and the priorities in the State Health Plan. While the Interim Plan was crafted in a way that was

thought to be clear that applications – as opposed to applicants – had to satisfy one or more of the priority criteria, as a practical matter, applicants relied on organization-wide activities as evidence of satisfying priority criteria as opposed to making a case for the project itself meeting criteria.

This situation is not what was in the Interim Plan. Therefore, in this iteration of the State Health Plan, the intent is once again articulated, in a manner meant to be clear, concise and without ambiguity. That is the intent of this section of the State Health Plan.

A minimum requirement for approval under Maine's Certificate of Need law is that the project – *not the applicant, but the project submitted for review* – is consistent with the State Health Plan. This includes priorities established in this Plan for such projects; these priorities are articulated below.

Priority: Projects that protect public health and safety are of utmost importance.
Projects that directly and unambiguously protect the public's health and safety are assigned the highest priority in the current environment, where resources are constrained. Examples of such projects include:

- Projects that have as a primary, overriding objective the elimination of specific threats to patient safety;
- Projects that center on a redirection of resources and focus toward population-based health and prevention; such efforts address our state's greatest area of need. 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 and depression; Projects that specifically incorporate as a primary component of the initiative for which approval is being sought, a comprehensive scope of concern including prevention, early detection, treatment and rehabilitation of chronic conditions, especially cardiovascular disease, cancer, lung disease, diabetes, and depression. Such efforts will contribute to efforts to implement the care model across our communities and will encourage appropriate utilization of resources and maximize patient outcomes. At a minimum, priority projects will devote 1% of the total "value" or cost of the project to new investment in a related public health effort that is aimed at reducing the demand for the service proposed under the application at the population level. Projects demonstrating additional new investment in such public health initiatives should receive a higher priority ranking;

    - **The Department of Human Services will convene an advisory committee comprising representatives of Maine hospitals, ambulatory care centers, health care professionals and experts in public health to define for the Certificate of Need Program what types of investments called for in this priority**

will "qualify" a project as having satisfied this criteria. This committee will be convened no later than June 2006 and shall complete its work by September 2006, in advance of the deadline for CON letters of intent for the January 2007 review cycle

- Projects that incorporate best practices in building construction, renovation and operation to minimize environmental impact both internally and externally.

Projects that contribute to lower costs of care and increased efficiencies are also high priorities. The rate at which spending on health care is increasing in this state is unsustainable, given current economic constraints. 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 should be given very high priority during the competitive review process. These types of projects may include:

- Projects that physically consolidate hospitals or services that serve all or part of the same area and that demonstrate an appropriate, cost effective use for the "abandoned" infrastructure, that do not result in increased costs to the health care system and that, in accordance with state policy as expressed in Maine's Growth Management Act,[lxx] do not contribute to sprawl; and
- Telemedicine projects that facilitate improvements and cost efficiencies in the quality of diagnosis and treatment especially in Maine's smaller, rural communities;

Projects that advance access to services and reflect a collaborative, evidence-based strategy for introducing new services and technologies are also priority projects. Advances in health care are introduced on what almost seems like a daily basis. Often, these advances carry many promises – enhanced diagnostic and treatment capability, for instance, or improved patient or provider convenience – but do not include the promise of lowering the rate of increase in the cost of care or of necessarily substantially improving the outcomes of care. We need to be very cognizant of the costs that accompany the introduction of this type of new technology; historically it has not led to moderations in spending increases. Instead, it has often led to duplication in capacity and in increased demand for services.

Importantly, this does not mean to say that Maine should shun adoption of new innovations in health care – that would be short-sighted. Instead, we need to step back from decisions to race to adopt the newest technologies and evaluate the costs and benefits of incorporating them into our health care system. This means asking ourselves if these advances represent interventions that have proven clinical effectiveness, improve patient outcomes and if they are cost effective.

Projects and/or applicants demonstrating certain attributes should be deemed higher priority ranking than those without those attributes. Importantly, this criterion relates to attributes of *either* the proposed project for which CON review is being sought or to the applicant requesting application review. This contrasts with the other criteria, which specifically relate to attributes of the proposed project, *not* the applicant.

There are certain activities and attributes that directly complement our efforts to make Maine the healthiest state and which relate to strategies laid out in this Plan. These "highest" priority assignments should be given in the following circumstances:

- Projects that include a complementary preventive component that will lead to a reduced need for services at the population level will receive the highest priority among all applications reviewed in a given review cycle. For instance, a cardiac surgical program application that includes a comprehensive preventive program promoting heart health should be given priority over a cardiac surgical program without such a prevention component. A proposal for construction that employs "green" building methods, thereby protecting and promoting good environmental health, should be given priority over another project that fails to have a preventive component.

  This priority assignment is not constrained to proposals for similar services or similar purposes (for instance, to two construction projects). In any particular review cycle there may be a range of dissimilar projects; such is often the case. All else being equal, those projects incorporating prevention as a significant portion of the proposed activity must be considered of higher priority than those that do not. *Investing in prevention is the key to the long term sustainability of our health and our health care system.*

- Projects and/or applicants that demonstrate a tangible, real (as opposed to in kind) investment in the MHINT project should be assigned a higher priority ranking than applicants failing to make such an investment. These investments must be for hardware, software or direct financial contribution to the MHINT project.

  Similarly, applicants and/or projects representing real investments in electronic medical records systems both in the hospital and in community medical practices will receive a higher priority ranking than those applicants failing to make such an investment. Qualifying investments will support clinical data exchange between separate data systems or applications using accredited standards for the exchange of data such as HL7.

- Projects that exercise less than a exercise 0.5% increase on regional insurance premiums shall be given priority consideration under the CON review process. Experts have recently testified in Maine that every 1% increase in insurance premiums nationally is associated with a reduction in the number of people with employer-sponsored coverage of approximately 300,000; in Maine, this equates to about 1,750 people.[lxxi lxxii]

Projects that do not reflect the priorities described above, shall not be considered priorities for approval by the DHHS Certificate of Need Program.

STRENGTHENING MAINE'S RURAL HEALTH SYSTEM

This Plan places a focus on strengthening Maine's local public health infrastructure. We must be particularly mindful of the state of the health system in our more rural communities. These considerations involve not only the infrastructure for health care delivery in these areas of Maine, but on the *systems* aimed at promoting and preserving health. These aren't exclusive of one another; instead, they are mutually dependent.

In examining shifts in utilization patterns and the continuing trend in the movement of many types of services off of the hospital campus and knowing that this trend is unlikely to reverse itself, the future of the small, rural hospital is in considerable flux. The impact of many of the changes already underway is being reflected in financial statements of many of these facilities. While Medicare and Medicaid payment policies at both the federal and state levels play a role in the financial health of small, rural institutions, the environment in which these organizations operate present the biggest challenge to their operating margins.

At the same time, these facilities often provide critical services to their communities, providing, for example, 24-hour emergency department availability and local access to lab and imaging services. Local access to such services is vital to the integrity of a robust community. As the health care system continues to evolve, though, these facilities will find themselves serving more and more difficult or acutely ill patients, as healthier patients (and those less costly to care for) are diverted off campus to other sites of care. Patient volume will continue to decline and the fixed costs of operating a hospital – which are considerable – are left to be spread over a shrinking number of patients, contributing to the upward spike in the cost of care and leading to an increasing likelihood of patients passing by the local hospital for less expensive delivery sites.

This "catch-22" and the potential impact it holds for our rural communities merits careful and measured consideration. As the role of the hospital evolves, as market pressures on small facilities continue to exercise themselves, as the health needs of communities change and as other components of the system of rural health shift in capacity and focus, our ability to ensure the all Mainers – including residents of our rural areas – may

be as healthy as possible. We must affirmatively and actively address this issue rather than waiting to react to a crisis.

Elsewhere in this Plan, we discuss efforts to develop and strengthen Maine's public health infrastructure, with an eye toward the roles played by local public health organizations. This is a vital aspect of ensuring we have a robust rural health system. We must consider, too, the issues of the rural hospital.

The Governor's Office of Health Policy and Finance, in collaboration with the Maine Department of Health and Human Services, the Maine Hospital Association, the Maine Medical Association, the Maine Osteopathic Association and the Maine Primary Care Association will convene a study group to develop policy recommendations for addressing the challenges faced by Maine's small and rural hospitals and the infrastructure that interacts with those facilities to form the backbone of the rural delivery system. Participants in this group must over-represent rural providers and consumers, although representatives of Maine's health care systems and insurers must also be included. The group will consider strategies that might be undertaken by communities, insurers, businesses, health systems, and health care professionals to meet the urgent and emergent health care needs of rural Mainers. Additionally, the group will develop recommendations regarding rural health policies, reimbursement policy, licensing policy and other related issues that might be undertaken by the state and/or federal governments with regard to this issue.

- Governor's Office of Health Policy and Finance will solicit cooperation from the above named organizations in forming the Rural Health Working Group by January 31, 2006
- The Governor's Office of Health Policy and Finance, with the collaborating organizations, shall convene a first meeting of the Rural Health Working Group no later than March 1, 2006; all collaborators shall cooperate in providing support to the work group.
- The Rural Health Working Group shall report out recommendations to the Governor no later than July 1, 2007.

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 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. These distances can prove particularly difficult for frailer or older individuals; bad roads or poor weather can make travel even more challenging.

Telemedicine also has the potential to alleviate the economic hardship of missing work for rural individuals who must take a day off – often without pay – to travel to the nearest large city to see a specialist. To the extent that appropriate access to necessary services is facilitated, the chance that needed care is delayed or forgone is minimized. Delayed or forgone need care can contribute to increased emergency department utilization and hospitalizations and poorer health outcomes

Telemedicine can also be extremely useful in the prevention, early detection, effective treatment and rehabilitation of chronic illnesses by providing: greater access to patients; increased participation by patients in their own care; and earlier identification of signs and symptoms and quicker treatment for these symptoms. Telehealth holds particular potential for those patients with chronic illnesses such as heart disease or diabetes and for enhancing access to mental health services through telepsychiatry.

Using funding from a variety of federal and private sources, the Maine Telemedicine Services (MTS) at Healthways Regional Medical Center of Lubec has been instrumental in helping to develop a robust telemedicine infrastructure in Maine, with equipment at numerous hospitals, clinics, and other facilities in all parts of the state.

However, there is evidence to suggest that in some communities, the current infrastructure is not being used to its full advantage. Barriers to telemedicine use have been cited to include:[lxxiii]

- **Licensing** – Some believe the state licensing process for telemedicine is cumbersome and might be streamlined to increase cost-efficiency for both the state and providers, while simultaneously improving quality.

- **Credentialing and Privileging** – Hospitals may not be comfortable accepting reciprocity for the credentials of visiting physicians, even those providing services solely by telemedicine. This can create a need for providers to become credentialed to work for a number of different institutions, which can be costly for the physician, and thus serve as an impediment to telemedicine use.

- **Reimbursement** - The use of telemedicine would be facilitated by payers' willingness to reimburse for telemedicine services, and by payers clearly articulating guidelines regarding the reimbursement for telemedicine use. Currently, Medicare pays for telemedicine services as if the visit is a face to face visit; MaineCare pays for telemedicine services if the provider has met certain standards for the provision of such care, including having appropriate equipment, a quality plan and if the patient has explicitly provided informed consent;[lxxiv] Anthem often pays for telemedicine services without knowing that this was how the provider cared for the patient; and Aetna will not pay for telemedicine services.

  Another reimbursement issue is how the total payment is allocated between (a) the provider being seen via telehealth, and (2) the "host" institution (where the

patient is physically and the telemedicine equipment are located); e.g., if a small rural hospital uses its telemedicine equipment to transmit to an urban provider, the small institution must have a mechanism to finance use of its infrastructure; however, if the financing results in lessening the reimbursement for the urban provider below the level they receive for seeing patients in person, there is a reduced incentive to accept rural telemedicine patients.

Over the coming year, GOHPF will work with stakeholders to ascertain the appropriate balance between any new expenses associated with additional dissemination of this type of care delivery and the effectiveness of the service, and to investigate ways to address the barriers cited above, with the goal of achieving an appropriately-developed and appropriately-utilized telemedicine infrastructure that serves the best interest of patients.

- The Maine Office of Primary Care (DHHS) in conjunction with the Governor's Office of Health Policy and Finance, will convene a work group on telehealth in Maine. The workgroup, which will comprise broad representation from the provider community, payer community and consumer advocacy groups, will be convened no later than February 28, 2006.
- This group will develop recommendations regarding the potential cost effectiveness of telehealth in Maine no later than September 2006.
- If the cost benefit analysis indicates investment in telehealth is affordable and will yield good outcomes, this group will develop recommendations regarding strategies to foster the dissemination and use of telehealth initiatives in Maine. Among the questions they will consider are:
  - Examples within Maine of the use of telehealth infrastructure to foster optimal capacity for certain health care services and the replicability of those models in other areas of the state;
  - Necessary safeguards to ensure the safety and quality of telemedicine for those patients relying on it;
  - Identification of evidenced-based guidelines upon which to base decisions regarding which health conditions, health services, and circumstances, and strategies to develop broad based consensus among providers and payers for widespread use of those guidelines;
  - The advisability of creating a single telemedicine entity to coordinate telemedicine policy and activity within the state; and
  - Alternatives for encouraging reimbursement of telehealth services.

- The Telehealth Work Group will report out its findings and recommendations to the Governor no later than December 31, 2006.

CHECKING THE MAP: KNOWING IF WE NEED COURSE CORRECTIONS

In any long journey it's important to check the map to determine our progress and identify obstacles and opportunities ahead. Bridge construction could cause unnecessary delay and require detours; a new by-pass could provide a more direct route to our destination. Indeed, sometimes we'll find ourselves in uncharted territory -- we'll all need to serve as cartographers to develop the way.

Because the State Health Plan is of Maine, for Maine and by Maine, we'll need a mechanism to check in with fellow travelers. Are we making progress? Do we need to re-think the route?

We propose a formalized, public process to review progress the State is making in reaching goals of the plan.

TASKS/WHO'S RESPONSIBLE/DATES

- Advisory Council on Health Systems Development (ACHSD) will review progress through hearings, ad hoc meetings and other evaluation activities to determine if state plan objectives are being met and issue reports to the Governor's Office of Health Policy and Finance (GOHPF) and identifying areas of concern.
  GOHPF/ACHSD, on-going

- GOHPF will share report with key stakeholders for their response
  GOHPF, July 2006, February 2007 and September 2007

- GOHPF will share reports and responses with the Governor and Jt. Committee on Health and Human Services.
  GOHPF, September 2006, April 2007, November 2007

APPENDIX I

STATE HEALTH PLAN STATUTE

Chapter 5: STATE HEALTH PLANNING

§101. Duties of Governor

1. Duties of the Governor. The Governor or the Governor's designee shall: [2005, c. 369, §1 (amd); c. 397, Pt. C, §1 (amd); §2 (aff).]

A. Develop and issue the biennial State Health Plan, referred to in this chapter as "the plan," pursuant to section 103 by December 1, 2005 and every 2 years thereafter;

[2005, c. 397, Pt. C, §1 (amd); §2 (aff).]

B. Make an annual report to the public assessing the progress toward meeting goals of the plan and provide any needed updates to the plan;

[2003, c. 469, Pt. B, §1 (new).]

C. Issue an annual statewide health expenditure budget report that must serve as the basis for establishing priorities within the plan; and

[2003, c. 469, Pt. B, §1 (new).]

D. Establish a limit for allocating resources under the certificate of need program described in Title 22, chapter 103-A, called the capital investment fund, for each year of the plan pursuant to section 102.

[2005, c. 369, §1 (amd).]

The Governor shall provide the reports specified in paragraphs B and C to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters. [2005, c. 369, §1 (amd); c. 397, Pt. C, §1 (amd); §2 (aff).]

§103. State Health Plan

1. Purpose. The plan issued pursuant to section 101, subsection 1, paragraph A must set forth a comprehensive, coordinated approach to the development of health care facilities and resources in the State based on statewide cost, quality and access goals and strategies to ensure access to affordable health care, maintain a rational system of health care and promote the development of the health care workforce. [2003, c. 469, Pt. B, §1 (new).]

2. Input. In developing the plan, the Governor shall, at a minimum, review the process for the development of the plan with the joint standing committee of the Legislature having jurisdiction over health and human services matters and seek input from the Advisory Council on Health Systems Development, pursuant to section 104; the Maine Quality Forum and the Maine Quality Forum Advisory Council, pursuant to Title 24-A, chapter 87, subchapter 2; a statewide health performance council; and other agencies and organizations. [2005, c. 369, §2 (amd).]

3. Requirements. The plan must: [2005, c. 369, §§3-5 (amd).]

A. Assess health care cost, quality and access in the State based on, but not limited to, demographic, health care service and health care cost data;

[2005, c. 369, §3 (amd).]

B. Develop benchmarks to measure cost, quality and access goals and report on progress toward meeting those goals;

[2003, c. 469, Pt. B, §1 (new).]

C. Establish and set annual priorities among health care cost, quality and access goals;

[2003, c. 469, Pt. B, §1 (new).]

D. Prioritize the capital investment needs of the health care system in the State within the capital investment fund, established under section 102;

[2003, c. 469, Pt. B, §1 (new).]

E. 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;

[2005, c. 369, §4 (amd).]

F. Provide recommendations to help purchasers and providers make decisions that improve public health and build an affordable, high-quality health care system; and

[2005, c. 369, §4 (amd).]

G. Be consistent with the requirements of the certificate of need program described in Title 22, chapter 103-A.

[2005, c. 369, §5 (new).]

3-A. Review. The plan must be reviewed by the joint standing committee of the Legislature having jurisdiction over health and human services matters prior to being finalized and issued by the Governor. [2005, c. 369, §6 (new).]

4. 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. [2003, c. 469, Pt. B, §1 (new).]

APPENDIX II

STATUS OF INTERIM STATE HEALTH PLAN

STATUS REPORT ON THE INTERIM PLAN

A one-year Interim State Health Plan was developed with the advice and guidance of the Governor's Advisory Council on Health Systems Development and charted a series of short-term objectives. Over the past year, Maine has made progress in achieving each of these objectives. That progress is documented below.

- *Develop strategies to reduce the use of emergency departments for Mainers experiencing a psychiatric crisis.* As lead for this objective, the Office of Adult Mental Health Services within the Maine Department of Health and Human Services:

  - launched a review of each of the 11 contracts it holds for the provision of crisis services; this work is now almost complete.
  - Is conducting a series of focus groups with representatives of the Mental Health Council of the Maine Hospital Association, as well as with ED physicians with the purpose of increasing understanding of others' views regarding the delivery of crisis services;
  - conducted 5 consumer forums focused on crisis services, facilitating an exchange of views, beliefs and expectations regarding crisis services;
  - solicited proposals for peer support services for persons presenting at emergency departments with a mental health crisis (the award of this contract, however, is currently under appeal);
  - created a Rapid Response Subcommittee to develop recommendations for responding quickly to the needs of persons with a mental health crisis, presenting at an ED and who are expected to remain there for at least 8 hours;
  - is working closely with the Maine Hospital Association to develop a good understanding of the resource needs generated by persons with mental illness, who seek care at Maine hospitals; and
  - is working with existing crisis stabilization units across Maine to ensure that use of such services is optimally effective as a short term alternative to emergency department services and psychiatric inpatient placement.

- *Develop strategies to improve outcomes and reduce costs of treatment of substance abuse and co-occurring disorders.* As lead for this objective, the Office of Substance Abuse (OSA),within the Department of Health and Human Services:

  - applied for and was awarded a multi-year, $3 million federal grant to improve treatment and improve administrative efficiencies for the provision of treatment of people with co-occurring disorders;
  - is streamlining licensing regulations to prevent conflict and redundancy between Mental Health Substance Abuse licensing and allow for the creation for dual licensing;
  - is conducting a cost study of co-occurring disorders, that will for people with co-occurring disorders; and

- reached agreement with 58 community agencies to alter policies and practices to make services more available to people with co-occurring disorders.

- *Convene Governor's working group on the health system and care model.* The Governor's Office of Health Policy and Finance has taken the lead for this objective. The GOHPF has:

  - convened a Care Model Working Group comprising representatives of the public health community, the physician community, legislators and a range of state officials involved in health, health care and quality improvement;
  - applied for and received a grant from the National Governors' Association to fund the early work around adapting the care model for Maine;
  - partnered with *Quality Counts!*, a statewide consortium of physicians, health care providers and payers working on the dissemination of the care model in Maine.

  In adition to these efforts, the MaineCare Program has recently issued an RFP for assistance in implementing care management techniques for the program's high cost members and DHHS' Office of Elder Services challenged area agencies on aging during the past year, to develop an agenda around early detection and prevention strategies for elders.

- *Work to ensure appropriate and quality care by identifying variations in practice patterns, utilization of services and outcomes of care.* The Maine Quality Forum was created as part of the Dirigo Health Reform Act to advocate for high quality health care. The Maine Quality Forum:

  - has posted geographic variations data for a range of surgical procedures and types of medical admission, highlighting the fact that people living in different communities – sometimes very close to one another – may receive very different care for the same medical condition. Increasing awareness of medical care variation stimulates discussion among providers to improve their practice and achieve better outcomes;
  - is currently conducting an analysis of the use of advanced imaging in this state and its impact on our healthcare system; and
  - has also completed rulemaking to establish criteria for "healthcare quality datasets." Beginning this summer, all health providers that treat patients with heart attack, congestive heart failure, pneumonia and surgical infection will be required to submit data that will document their success in complying with recognized best practices for these conditions. Similarly, hospitals will submit data regarding their success in preventing the incidence of pressure sores and the need for use of patient restraints. Inpatient facilities will report information related to nurse staffing levels.

- *Continue Maine's historic work to ensure our citizens have access to needed pharmaceuticals at reasonable and affordable prices.*

  - The GOHPF and the DHHS have developed a nulti-state purchasing collaborative to negotiate larger rebate agreements with drug companies;
  - GOHPF and DHHS are working to facilitate the transition of Maine seniors to Medicare's new Part D program;
  - GOHPF and DHHS have worked with the Legislature to develop wraparound benefits for some of Maine's most vulnerable citizens who may be adversely impacted by the introduction of the federal government's Medicare Part D program; and
  - GOHPF has worked with the Penobscot Indian Nation to implement PIN Rx, Maine's first pharmacy mail order distribution center. PIN Rx provides pharmacy mail order services to the State of Maine Pharmacy Program, which includes MaineCare, Drugs for the Elderly and Maine Rx Plus members; private groups and businesses will soon be able to purchase medications more cheaply through PIN Rx, as will beneficiaries of Medicare Part D.

- *Provide guidance for determining the level of future investment in health care services, the issuance of Certificates of Need and related lending decisions.* Two steps have been taken to address this objective:

  - GOHPF has established rules governing the Capital Investment Fund (CIF), which sets an annual limit on the aggregate dollar value of CON project approvals;
  - The Office of Elder Services within DHHS has been working to develop improved predictors of need for nursing facility care, to ensure our long term care capacity targets the most needed levels of care.

- *Strengthen Maine's Certificate of Need program by setting out criteria for prioritizing projects that are submitted for review and approval.* The Interim State Health Plan identified criteria for prioritizing Certificate of Need applications, giving:

  - high priority to projects that protect public health and safety; projects that contribute to lower costs of care and greater efficiencies; and projects that advance access to services and reflect a collaborative, evidence-based strategy for the introduction of new services and technologies;
  - high priority to projects submitted by applicants who demonstrate evidence of good faith efforts to meet the voluntary cost and price constraints set out in the Dirigo Health Reform legislation; and applicants demonstrating an investment in the use of electronic medical records; and
  - No priority to projects that result in a duplication of services or facilities; those that result in an increase in the number of inpatient beds; those that involve the construction of new hospital facilities; and those that involve major expansions of existing services and/or facilities.

- *Establish statewide health expenditure targets for Maine.*
  Broad expenditure estimates have been updated by GOHPF according to the most recent national data from the Center for Medicare and Medicaid Services, but the more detailed work contemplated in the State Health Plan under this task has not been completed. This is due, in part, to a decision to forego the strategy of employing regional health planning entities, which would have played a role in the development of expenditure targets. Nevertheless, GOHPF in September 2005 began work on a more detailed expenditure report, given the constraints cited below.

  The all payer/all provider database administered by the Maine Health Data Organization, which was supposed to have been available for public use in February 2005, remains as yet, unfinished; the Agency projects integration of MaineCare data to be completed in the near future. Issues related to integration of Medicare data remain a matter of negotiation between the Agency and the federal government.

- *Promote the concept of Paying for Performance to public purchasers.* "Paying for performance" means reimbursing providers for providing optimal care. Three public sector payers – the State Employees Health Insurance Program (SEHIP), the Maine Municipal Employees Health Trust (MMEHT) and the University of Maine System (UMS) – are working in conjunction with private sector businesses to establish a framework for pay for performance. MaineCare is also moving to incorporate certain aspects of pay for performance into its reimbursement policy. With the introduction of a new care management initiative for high cost members will come a structure of enhanced payment for those physician providers who meet certain performance criteria associated with the delivery of effective and efficient care for chronically ill MaineCare patients.

- *Improve Maine's data and information technology systems to facilitate improvements in the quality of care.* The Governor's Office of Health Policy and Finance has provided support to the Maine Health Data Organization in obtaining data submissions from both Medicare and MaineCare. Integration of MaineCare data is not yet completed. Although CMS has indicated a willingness to submit Medicare data, MHDO has not yet executed a Memorandum of Understanding with CMS to effectuate that submission. This means that, for the time being, we will not have data from the federal Agency that runs Medicare to augment the information in the all claims data base.

  The implementation of the Bureau of Health's Integrated Public Health Information System (IPHIS) system is running on time and on budget. This system will result in the implementation of a centralized, web-based integration capacity at the State level that will allow for the timely, accurate and secure exchange of public health information within the Bureau of Health and across organizations and agencies outside of state government working in the public health sector.

- *Develop framework for comprehensive integrated, patient-level data system.* This objective relates to the need to develop and implement the use of electronic medical records in all types of provider settings and to establish methods for providers to share clinical information electronically and confidentially. When such a system is in place, any provider in Maine will – with the patient's consent – be able to access personal clinical information quickly, easily and securely. This will cut down on unnecessary testing and the potential for dangerous drug interactions. It will also help providers deliver better care, since they will have a complete picture of a patient's clinical status.

  Representatives of state government and the private sector have been working collaboratively on the Maine Health Information Network Technology project (MHINT), with the goal of facilitating the timely, accurate and secure exchange of patient level clinical data between health care providers. The MHINT project is currently in its second phase, the feasibility study having been completed earlier this year. .

- *Reduce the number of uninsured by 31,000.* Unlike other goals in the Interim State Health Plan, this goal is not "modest" and will required sustained effort over many years. To date, efforts to reduce the numbers of un- and underinsured have included:

  - Launching DirigoChoice in January 2005, which now serves approximately 8,300 members all across the state;
  - As part of Dirigo health reform, expanding MaineCare eligibility for parents of children living in households with annual incomes between 150% and 200% of poverty (federal spending limits have prevented MaineCare from expanding coverage for childless adults). As of September 30, 2005, there were more than 3,700 parents receiving coverage who weren't previously eligible;
  - Support of employer based coverage by stimulating competition in Maine's small group insurance market with the introduction of DirigoChoice;
  - The Bureau of Insurance has implemented rules called for by the Dirigo Health Reform legislation that establish criteria for oversight of small group insurance rates and minimum loss ratios.

- *Preserve the fiscal and programmatic integrity of MaineCare as a safety net to cover Maine's lowest income citizens.* The Governor, the Governor's Office of Health Policy and Finance, and DHHS have worked to preserve MaineCare coverage through:

  - Advocacy in front of the Legislature and Congress; Active participation with a working group established by the National Governors' Association established to respond to the federal call for Medicaid reform;
  - Publication of "Understanding MaineCare: A Chartbook about Maine's Medicaid Program" which provides information about MaineCare, who it serves, what coverage it provides, how much it spends on what services. This book was disseminated widely, provided to all legislators as well as the press, and is available on the website of the Governor's Office of Health Policy & Finance;

- Interdepartmental meetings involving DHHS staff, the staff of the Department of Administrative and Financial Services and the Governor's office have been held on a regular, biweekly basis;
- eligibility expansions for parents of SCHIP children were implemented in the summer of 2005; work to bring spending under the childless adult waiver program into line with federal limits is on-going, with the objective of re-opening enrollment in that program as soon as possible.

- *Develop a resource inventory by region, documenting health, mental health, substance abuse, public health and long term care resources and workforce.* "The State of Maine's Health," published by the Governor's Office of Health Policy and Finance in August 2005, includes this resource inventory.

ENDNOTES

ENDNOTES

[i] www/census.gov/population/projections/PressTabs5.xls. May 9, 2004.

[ii] Bodenheimer T. "High and Rising Health Care Costs. Part 1: Seeking and Explanation." *Ann Intern Med.* 2005;142:847-854.

[iii] Lantz PM, House JS, Lepowski JM, Williams DR, Mero RP, Chen J. "Socioeconomic Factors, Health Behaviors, and Mortality." *Journal of the American Medical Association.* 279:1703-1708. 1998.

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[v] www.census.gov/population/projections/PressTabs5.xls. may 9, 2005.

[vi] Personal communication with Catherine Reilly, State Planning Office, November 3, 2005.

[vii] Bodenheimer T. "High and Rising Health Care Costs. Part 1: Seeking and Explanation." *Ann Intern Med.* 2005;142:847-854.

[viii] Thorpe KE, Florence CS, Joski P. "Which Medical Conditions Account For the Rise in Health Care Spending?" *Health Affairs Web Exclusive.* August 25, 2004. www.healthaffairs.org.

[ix] *See* the website of the Maine Quality Forum: http://www.mainequalityforum.gov/chart_08.html

[x] Kilbreth E., Ziller E., Payne S. *Trends in Health Services Costs and Utilization, 1995-2001: An Analysis of a Privately Insured Population in Maine.* University of Southern Maine Muskie School of Public Service. October 2005.

[xi] Cancer Incidence per 100,000, 2001. Notes: These figures are age-adjusted to the 2000 U.S. standard population. Excludes basal and squamous cell carcinomas of the skin except when these occur on the skin of the genital organs, and in situ cancers except urinary bladder. Sources: U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999-2001 Incidence and Mortality Web-based Report Version. Atlanta (GA): Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; 2004. Available at: www.cdc.gov/cancer/npcr/uscs.

[xii] Prevalence of Asthma in Adults, 2003. Sources: 2003 Behavioral Risk Factor Surveillance System (BRFSS), Table C1, analysis by Air Pollution and Respiratory Health Branch, National Center for Environmental Health Centers for Disease Control and Prevention, available at http://www.cdc.gov/asthma/brfss/03/brfssdata.htm.

[xiii] Percent of Adults Who Are Smokers, 2004. Notes: Data represent adults who reported that they currently smoke every day or some days and who have smoked at least 100 cigarettes in their lifetime. Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data (BRFSS), 2004, unpublished data. Information about the BRFSS is available at http://www.cdc.gov/brfss/index.htm.

[xiv] Heart Disease Death Rate per 100,000, 2002. Notes: These figures are age-adjusted to the total U.S. population in 2000. **Definitions:** Causes of death attributable to heart disease mortality include ICD-10 Codes I00-I09; I11; I13; I20-I51. Sources: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Compressed Mortality File (CMF) compiled from 1999-2002, Series 20, No. 2H 2004 on CDC WONDER On-line Database.

[xv] Prevalence of Diagnosed Diabetes in Adults, 2003. Sources: Behavioral Risk Factor Surveillance System, 2003; analysis by the National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition and Physical Activity, Centers for Disease Control and Prevention, available at http://apps.nccd.cdc.gov/brfss/list.asp?cat=DB&yr=2003&qkey=1364&state=All.

[xvi] Prevalence of Poor Mental Health, 2004. Notes: Data represent adults who reported having poor mental health between one and 30 days in the past 30 days. Percentages are weighted to reflect population characteristics. Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data (BRFSS), 2004, unpublished data. Information about the BRFSS is available at http://www.cdc.gov/brfss/index.htm.

[xvii] Rate of Overweight and Obesity, 2002. Notes: Overweight or obese is defined as having a body mass index greater than or equal to 25.0 kg/meters squared. Percentages are weighted to reflect population characteristics. Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Survey Data, 2002, unpublished data.

[xviii] % of Adults at Recom. Level of Physical Activity, 2001. Definitions: Recommended levels of physical activity according to 2001 criteria entail: 1) self-reported moderate-intensity activities for at least 30 minutes a day, 5 days a week or more (e.g., brisk walking, bicycling, vacuuming, gardening, or other activities that cause small increases in heart rate and breathing); or 2) vigorous-intensity activity for at least 20 minutes a day, 3 days a week or more (e.g., running, aerobics, heavy yard work or other activities that cause large increases in heart rate and breathing). Sources: Prevalence of Physical Activity, Including Lifestyle Activities Among Adults --- United States, 2000--2001, Mortality and Morbidity Weekly Report, Volume 52, Issue 32, August 15, 2003, Centers for Disease Control and Prevention.

[xix] Percent of Children Age 19-35 Months Who Are Immunized, 2002-2003. Notes: Data is self-reported by respondent. Children in the Q3/2002-Q2/2003 National Immunization Survey were born between August 1999 and November 2001. Margin of error is within 1% - 8% of stated figures. Definitions: For the purpose of this dataset, immunized children are those who receive 4:3:1:3:3, which is four or more doses of diphtheria, tetanus, and pertussis, three or more doses of poliovirus vaccine, one or more doses of any measles containing vaccine (MCV), three or more doses of Haemophilius Influenza type B (Hib), and three or more doses of hepatitis B vaccine (HepB). **Sources:** Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State -- U.S., National Immunization Survey, Q3/2002 - Q2/2003. National Immunization Program, Centers for Disease Control and Prevention. Available at http://www.cdc.gov/nip/coverage/NIS/02-03/toc-0203.htm .

[xx] Binge alcohol drinking among youths, Age 12-17: Percent: 2002. **Definition:** Binge alcohol drinking within the prior 30 days. Footnote: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the prior 30 days. The 2000 estimate is an annual average based on the 1999 and 2000 NHSDA. The 2001 estimate is an annual average based on the 2000 and 2001 NHSDAs. **Data Source:** Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. 1999 Data: "1999 National Household Survey on Drug Abuse State Tables of Model-Based Estimates," Table 7B. 2000 Data: "State Estimates of Substance Use from the 2000 National Household Survey on Drug Abuse: Volume I. Findings," Table A.16. 2001 Data: "State Estimates of Substance Use from the 2001 National Household Survey on Drug Abuse: Volume I. Findings," Table B.8. 2002 Data: "State Estimates of Substance Use from the 2002 National Survey on Drug Use and Health," Table A.8. Data available online at http://www.oas.samhsa.gov/

[xxi] Cigarette use in the past month, Age 12-17: Percent: 2002. **Footnote:** The 2000 estimate is an annual average based on the 1999 and 2000 NHSDA. The 2001 estimate is an annual average based on the 2000 and 2001 NHSDAs. Data Source: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. 1999 Data: "1999 National Household Survey on Drug Abuse State Tables of Model-Based Estimates," Table 9B. 2000 Data: "State Estimates of Substance Use from the 2000 National Household Survey on Drug Abuse: Volume I. Findings," Table A.22. 2001 Data: "State Estimates of Substance Use from the 2001 National Household Survey on Drug Abuse: Volume I. Findings," Table A.11. 2002 Data: "State Estimates of Substance Use

from the 2002 National Survey on Drug Use and Health," Table A.11. Data available online at http://www.oas.samhsa.gov/

[xxii] *See for example:* Haber D and Rhodes D. Health Contract With Sedentary Older Adults. *Gerontologist.* 44(6):827-835; _____. Behavioural counselling in general practice for the promotion of health behaviour among adults at increased risk of coronary heart disease: randomized trial. *British Medical Journal.* 1999, 319(7215):943-7; ____. Behavioral contracting as a tool to help patients achieve better health. *Family Practice.* 1991. 8(4):336-42.

[xxiii] Institute of Medicine. 1988.

[xxiv] The Economics of Integrating Injury & Illness Prevention & Health Promotion Programs, Seth Seabury et al, RAND, 2/05.

[xxv] Maine Department of Health and Human Services, 2001-2002.

[xxvi] Maine Department of Health and Human Services; Maine Health Data Organization UHDDS 2002, 2003.

[xxvii] BRFSS data set, 2002-2003.

[xxviii] Maine Department of Health and Human Services, 2001-2002

[xxix] BRFSS data set, 2002-2003

[xxx] There is a difference between "overweight" and obesity which is related to body mass index. The body mass index of a person who is overweight is lower than that of a person with obesity. In Maine, our rate of obesity is lower than the national average, but the prevalence of overweight is higher than the national average, putting more Mainers at risk of becoming obese.

[xxxi] BRFSS data set, 2002-2003

[xxxii] BRFSS data set, 2003-2003

[xxxiii] BRFSS data set, 2002-2003

[xxxiv] YRBS data set, 2005.

[xxxv] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21PPPstPPP Century.* National Academy Press. Washington DC. 2001.

[xxxvi] Wagner EH, Austin BT, Von Korff M. Improving outcomes in chronic illness. *Managed Care Q.* 1996 Spring; 4(2): 12-25.

[xxxvii] The World Health Organization World Mental Health Survey Consortium. "Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys." *JAMA.* 291(2):2581-2590.

[xxxviii] US Surgeon General. Mental Health: A Report of the Surgeon General. US Department of Health and Human Services. Washington DC. 1999.

[xxxix] Lao Tzu. *The way of Lao-tzu.*

[xl] Mercer Human Resource Consulting, "Surprise slow-down in US health benefit cost increase: Employers shift costs to employees, take steps to improve workforce health," December 8, 2003.

[xli] Muskie School of Public Service, University of Southern Maine. Data from household survey sponsored by Maine's HRSA planning grant. 2002.

[xlii] Muskie School of Public Service, University of Southern Maine. Data from household survey sponsored by Maine's HRSA planning grant. 2002.

[xliii] Uwe E. Reinhardt, Peter S. Hussey and Gerard F. Anderson. "U.S. Health Care Spending In An International Context." *Health Affairs*, Vol 23, Issue 3, 10-25.

[xliv]Kaiser Family Foundation, State Health Facts Online, www.statehealthfacts.kff.orgUUUTTT.

[xlv] Muskie School of Public Service, University of Southern Maine. Data from household survey sponsored by Maine's HRSA planning grant. 2002.

[xlvi] Kaiser Family Foundation, "Uninsured and Their Access to Health Care", Jan. 2003 Fact Sheet 1420-oy

[xlvii] Jack Hadley, Sicker and Poorer: The Consequences of Being Uninsured, the Urban Institute, Washington, D.C., May 2002.

[xlviii] AARP, *Reforming the Health Care System: State Profiles 2003.*

[xlix] Muskie School of Public Service, University of Southern Maine. Data from household survey sponsored by Maine's HRSA planning grant. 2002.

[l] Source: audited financial statements

[li] *See,* for instance, Wennberg DE and Wennberg JE. "Addressing Variations: Is There Hope For The Future?" *Health Affairs Web Exclusive.* W3-614; DOI 10.1377/hlthaff.W3.614. December 10, 2003. *See,* also: Wennberg JE and Cooper MM. *The Dartmouth Atlas of Health Care in the United States.* Dartmouth Medical School, Center for the Evaluative Clinical Sciences. 1996.

[lii] Magid DJ, Wang Y, Herrin J, McNamara RL, Bradley EH, Curtis JP, Pollack CV, French WJ, Blaney ME, Krumholz HM. "Relationship Between Time of Day, Day of Week, Timeliness of Reperfusion, and In-Hospital Mortality for Patients with Acute ST-Segment Elevation Myocardial Infarction. *Journal of the American Medical Association.* 2005;294:803-812.

[liii] 2 MRSA c. 5 §103

[liv] Kane N. Maine Hospital Financial Performance: 1993-2002. Presentation to Commission to Study Maine's Community Hospitals, June 21, 2004.

[lv]*2005 Almanac of Hospital Financial and Operating indicators.* Ingenix, 2004.

[lvi]From data presented by the Maine Hospital Association to the Commission to Study Maine's Community Hospitals, January 2004.

[lvii]*2005 Almanac of Hospital Financial and Operating indicators.* Ingenix, 2004.

[lviii]*2005 Almanac of Hospital Financial and Operating indicators.* Ingenix, 2004.

[lix]Kane N. Maine Hospital Financial Performance: 1993-2002. Presentation to Commission to Study Maine's Community Hospitals, June 21, 2004.

[lx] This excludes beds in psychiatric hospitals and in other types of specialty hospitals (such as rehabilitation facilities).

[lxi] In August 2005, the Governor's Office of Health Policy and Finance (GOHPF) published *The State of Maine's Health*, a data book examining aspects of Maine's health and health care system as compared to the nation as a whole and across regions within Maine. That booklet provides much useful baseline information on differences in health status and the burden of disease within Maine as well as information on the distribution of certain types of resources across the state.

[lxii] Kaiser Family Foundation. *Trends and Indicators in the Changing Healthcare Marketplace.* April 2004.

[lxiii] *See,* for instance, Wennberg DE and Wennberg JE. "Addressing Variations: Is There Hope For The Future?" *Health Affairs Web Exclusive.* W3-614; DOI 10.1377/hlthaff.W3.614. December 10, 2003. *See,* also: Wennberg JE and Cooper MM. *The Dartmouth Atlas of Health Care in the United States.* Dartmouth Medical School, Center for the Evaluative Clinical Sciences. 1996.

[lxiv] Wennberg JE and Cooper MM. *The Dartmouth Atlas of Health Care in the United States.* Dartmouth Medical School, Center for the Evaluative Clinical Sciences. 1996.

[lxv] U.S. General Accounting Office. Health Care: Unsustainable Trends Necessitate Comprehensive and Fundamental Reforms to Control Spending and Improve Value; Highlights of a GAO Forum. www.gao.gov/cgi-bin/getrpt?GAO-04-793SP.

[lxvi] Anderson GR, Hussey PS, Frogner BK, Waters HR. "Health Spending in the United States and the Rest of the Industrialized World." *Health Affairs.* 24(4). Maine figure calculated using data from the federal DHHS Centers for Medicare and Medicaid Services, Office of the Actuary.

[lxvii] World Health Organization. *The World Health Report 2000: Health Systems – Improving Performance.* Geneva, Switzerland. 2000.

[lxviii] *See*, for example: Fisher ES, Wennberg DE, Stukel TA Gottlieb DJ, Lucas FO and Pnder EL. The Implications of Regional Variations in Medicare Spending. Part1: The Content, Quality, and Accessibility of Care. *Ann Intern Med.* 2003;138:273-287. Fisher ES, Wennberg DE, Stukel TA Gottlieb DJ, Lucas FO and Pander EL. "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care." *Ann Intern Med.* 2003;138:288-298.

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[lxx] 30-A MRSA c. 187, §4312(3)(a)

[lxxi] Pre-filed expert testimony of John Shiels, Lewin Associates; filed in the matter: Review of Aggregate Measurable Cost Savings Determined by Dirigo Health for the First Assessment Year, Docket No. INS-05-700; page 15, line 11-18. October 2005.

[lxxii] Inclusion of this reference should in no way be construed as agreement by the State with the conclusion drawn from the data with regard to the matter of the Dirigo Savings Offset Payment; in that case, it is our view that the manner in which the expert applied the data referenced was erroneous.

[lxxiii] Minutes from April 5, 2005 meeting, "Enhancing Current Telemedicine Services," sponsored by the Maine Health Access Foundation.

[lxxiv] DHHS is currently reviewing MaineCare's telemedicine policy.