
Leadership Maine – Class Project: Healthcare Perspective

1. Background

Red Square Team Members:

- Shannon Bonsey
- Charlie Dingman
- Peter Driscoll
- Alice Knapp
- Nicole Morin-Scribner
- Rosemary Presnar
- Bentley Snow Davis
- Tom Violette

Original Topic:

Health care costs: designing a system that supports lifestyle choices to impact on workforce potential, productivity and costs

Revised Topic-Sept:

Health care costs: designing a system of access to coverage of the costs of health care that has a positive impact on health status, workforce potential, productivity and the costs of living and doing business in Maine.

Revised Topic-Oct:

Health care cost containment: What can Maine learn and implement about controlling health care cost from other existing and proposed, evolving systems?

Areas of interest:

International systems – Tom/Peter/Rosemary

Maine/U.S. systems – Alice/Charlie

Maternal and child health – Shannon/Nicole

Objective:

Through research and interviews investigate economic and leadership perspectives associated with our topic within the areas of interest and how the lessons learned can be applied to desirable outcomes in Maine.

2. Introduction

Health care cost containment: What can Maine learn and implement about controlling health care cost from other existing and proposed, evolving systems?

Our approach is to try to open minds to other systems' policies and outcomes to change our way of thinking about healthcare in Maine and on a broader scale in the United States because states, especially Maine, cannot solve this issue alone.

We looked at other national systems as well as at the micro level on child and maternal health. We believe being proactive at this early stage can reduce overall long term costs.

Healthcare cannot be looked at in a vacuum; one must consider their culture and values and at times our own attitudes.

We found that viable systems do exist, but tradeoffs exist between costs, quality and access in these systems.

3. Economic and Leadership Perspectives

a. Healthcare Systems Comparisons

Our Project Team was in agreement that we should strive to provide healthcare coverage for all our citizens, but diverged on how to achieve that end point. We have learned from studying other systems that healthcare delivery can be done more efficiently with better outcomes. One thing is very clear: **Americans pay too much and get too little for their healthcare dollars.**

However, superimposing Universal Healthcare on our existing delivery system WILL NOT lower costs. In the shorter term, it would actually increase costs as the previously uninsured would be accessing services at a more rapid rate. While improved access to Primary Care Services is a positive element, long term improvement in a population' overall health status will ultimately be achieved thru reductions in unhealthy behaviors – not simply additional access to medical services.

The following key considerations become ever important during any healthcare discussion:

- Cost,
- Quality, and
- Access.

As a result of our research we did not find a healthcare system in which all three of these key indicators were simultaneously aligned – something has to give. Canadians have Universal Healthcare but the wait time in New Brunswick for most elective orthopedic procedures is 4-6 months and a non-urgent MRI can take up to 3 months. A transition to Universal Healthcare in the US would necessitate a major adjustment in consumer's expectations as access time for specialty care services will be less timely.

Some clear take-aways from our research:

- Canada, each citizen has their own individual health record which stays with them wherever/whenever they obtain services in the Country;
- Norway, each and every Primary Care Physician is electronically connected to a hospital; every citizen is assigned a Primary care Physician.

- Each Country we analyzed with a Central Single Payer System included financing mechanisms consisting of additional use taxes (Norway has a 23% tax on all goods/services, etc.).

The Table 1 exhibits our statistical findings.

Table 1. Comparison of International, US, and Maine Healthcare key statistics:

	Maine	United States	Canada	Norway	Denmark
Form of Government		Democratic Republic	Federal	Constitutional Monarchy / Parliamentary	Constitutional Monarchy / Parliamentary
Values	I Lead	Life, liberty, and the pursuit of happiness	Close to U.S.	Peace, Justice, Equality	Laid back, modern
Population	1.3 Million	301.1 Million	33.3 Million	4.4 Million	5.4 Million
Type of Healthcare System			Government (70%) Private (30%) Universal	Public Financed Single Payor	Government (82%) Private(18%) Universal Access
WHO Ranking	n/a	37th	30th	11th	34th
Healthcare %GDP		17%	9.8%	10%	8.6%
Healthcare per capita		\$7,600	\$3,326	\$3,616	\$2,780
How Financed?			Combination of Federal/ Provincial Taxes (GST/PST)	Corporate Tax(28%) Ind. Income Tax(0-13%) Payroll Tax(0-14%) Goods/Services Tax(24%)	Local Taxes
Female avg life Expectancy		83	82	83.3	80
Male avg life Expectancy		75	77	77.5	76
Infant mortality Rates per 1,000 live births		7.1 deaths	4.7 deaths	3.64 deaths	4.45 deaths

	Maine	United States	Canada	Norway	Denmark
Positive Aspects			--prescription drugs cost less than U.S. --medical marijuana is legal. - Universal Coverage	--Healthcare seen as a societal responsibility --Universal coverage --Rated as 'good' care --Common electronic medical records	--high patient satisfaction --accessible care 24/7
Challenges			-- Access/Waiting - No Outpatient RX Coverage	--High Taxes --The 'best'care or technology rarely available	--Waiting times --Aging Population --Lacking investment in efficiencies --little incentive for improved productivity/technology
Key Learning			-Each citizen has their own Individual Medical Record that follows them.	--Common electronic medical records. -Society' expectations are consistent with allocated resources.	--Decentralized services with local(county) control and planning

Healthcare Systems Comparisons, continued

Leadership - Norway “Revolution” Example

The construction of the Norwegian welfare state after 1945 under the leadership of the social-democratic Labour Party occasioned a radical reorientation of public health policy. Until his retirement in 1972 these changes were driven by the medical-political vision of the Health Director, Karl Evang, himself a physician, which derived from left-wing social medicine of the 1930s but also was inspired by British and American public-health practices that Evang had experienced during wartime exile. In this vision public health was an integral part of the welfare state. It was to be egalitarian and universal: all Norwegians, regardless of personal income and place of residence, would be guaranteed both good protection against disease and high-quality treatment of sickness and injury financed by the state. It would also be based on the expansive definition of good health adopted by the WHO in 1948: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Achievement of these goals required the expansion of preventive health care, which would be carried out by district medical officers (distriktsleger) assisted by specially trained public health nurses (helsesøstre) and supervised by county medical officers (fylkesleger). It also required the rationalization of the country's many small, local hospitals into a network of large, central hospitals with special care institutions for the chronically ill. To be effective, both reforms needed a sufficient supply of well-trained health specialists—physicians and nurses—as well as considerable monies for capital investment and day-to-day operations.

Despite the epochal organizational transformation, the health sector continued to expand strongly, driven by consumer demand, changes in lifestyle and population composition (for example, ageing), and medical technological advances. In 1980 public health services employed 181,000 persons, in 2000, 356,000. The cost to the public purse also doubled during the same period: from 36 milliard crowns (6.4 per cent of GNP) to over 70 milliard crowns (8.5 per cent of GNP). Neither did the 1982 law settle the issue of how high-quality health services could be provided equitably and cost-effectively. Controversy over the appropriate scope, quality, cost, and purveyance of public health services has become a fixture of the country's political discussion. In recent years “re-organization” has become a dreaded term for many public-health employees.

The most substantial change was carried out in 2002. Twenty years after the “revolution” of 1982, the state took over direct control of all hospitals in the country on the grounds of ensuring equality, improving quality, and reducing expenses. The consequences and permanence of this étatist move are still unclear; however, the simultaneous establishment of the country's first dedicated Ministry of Health underscores the central importance of public health in modern Norwegian society.

b. Maternal and Child Health Comparisons

There are plenty of unfavorable comparisons with other countries within the area of maternal and child health, but we decided to narrow our focus on an area that has little visibility but can have very high impact.

We (but most importantly, Shannon Bonsey) want people to remember is that our outcomes are bad...and that it is not about the delivery of poor health care but about the effects of poverty on individuals and our country's low value placed on family and children. (for example, family leave without pay, high incidence of child abuse. (Child abuse deaths are 3 times as high as Canada and 11 times as high as Italy).

We can be doing MUCH better! Below are details, information and findings for an area everyone can influence....breastfeeding.

The UN and World Health Organization (WHO) have developed indicators of best health practices. At the top of the list is establishing that breastfeeding should be the norm.

Who does it right?

Impressively, Norway has been listed as the best country in the United Nations Human Development Report every year since 2001. So how do they fare with breastfeeding as a practice? 97% of women breastfeed when leaving hospital, 80 per cent are breastfeeding at 3 months and 20 percent beyond 12 months.

How does Maine compare?

During 2003, 60% of the newborns screened at time of hospital discharge were exclusively breastfed. Unfortunately, the lowest rates of breastfeeding are associated with women whose infants are at highest risk of poor health and development. Women age 21 and younger, families that make less than \$15,000/year and those with less than a high school education have the lowest rates for breastfeeding.

Data from the 2003 Maine Pregnancy Risk Assessment Monitoring System (PRAMS) indicate that 78% of mothers surveyed initiated breastfeeding. Maine Women, Infants, and Children Nutrition Program (WIC) data for 2003 indicate that 52% of infants participating in the Program were ever breastfed, 25% of infants were breastfed at least six months, and 17% were breastfed at least one year.

Interview with WIC Director for Tri County Area (Androscoggin, Oxford, Franklin) as well as a case manager dealing with women in this geographic area.

Findings:

- Do you know people who have breastfed? NO. (typical answer when asked a client)
- Misconceptions: (If I breastfeed), NO one else will be able to feed my baby/Can never give any bottles/formula. In many cases, there are available alternatives to perceived barriers, if they know to ask for it. But lack of education and support systems, and the influence of Doctors, resort to the perceived easy out of bottle feeding.
- We live in a bottle feeding society... Why? Capitalism vs. positive pictures of breastfeeding. Marketing of artificial feeding is huge! Also huge lobbying in Washington DC, etc. by artificial feeding Pre-natal visits. Given info from formula companies. See formula as norm vs. breastfeeding. U.S. goes against WHO's strong statement that artificial feeding should not be marketed to women.
- Lots of free things (backpacks, etc) with their logo. At Doctors' office can sign a card for free stuff from formula companies. Norway doesn't have to deal with this.
- The need to return to workforce. In Norway can stay home with pay to breastfeed. Difficult to return to work. Misconception about ability to nurse in the morning and at night. Recommended but not all mothers have the education. Almost every hospital have lactation consultants...different hours and availability. Women typically need ongoing support.
- Need much more support, warm/hot lines. Maine doing fairly well in the country but U.S. is behind the time. Fewer family members who have breastfed in US vs. other countries where they get support as they had breastfed.
- Workforce area. Women can take FMLA, but not leave with pay & can't afford to for a full 12 weeks. Access to places to pump is an issue. In bathrooms (no privacy & yuck factor!) related doing it in closets! UNUM employs lactation consultant. In Norway it's the norm. Lack of universal health care.
- Lifestyle. "Babies operate on ancient time". Our lives are going, going, going and breastfeeding takes time for mothers, though, buying formula and preparing a bottle also takes time. Hard to remember to slow down.

So when we explore What can Maine learn and implement about controlling health care cost from other existing and proposed, evolving systems?...an obvious question is why can't we bring more focus on enabling moms to give their babies the most healthy (and cost effective!) nutrition available vs. spending lots of money on artificial baby formula?

...let's start with good health/nutrition right at the beginning!

The United Nations produces an annual Human Development Report which includes the Human Development Index. Norway has been the top of this list since ousting Canada in 2001.

What needs to be done/addressed/changed/improved so that all children grow well according to these standards?

A key characteristic of the new standards is that they explicitly identify breastfeeding as the biological norm and establish the breastfed child as the normative model for growth and development (WHO Multicentre Growth Reference Study Group, 2006b). Breastfeeding should be supported, protected, and promoted.

For the first 6 months, mothers need to be informed and empowered to practice exclusive breastfeeding. Children should be provided safe, wholesome, and nutritionally appropriate foods during the period of complementary feeding and after the second year when breastfeeding has ceased. Sound nutritional practices are important throughout childhood. Appropriate national guidelines should be developed to aid caregivers in choosing nutritious local foods in correct combinations and amounts to feed their children in order to maintain optimal growth in later childhood (the aim being to avoid both nutritional deficiencies and excesses).

Some background comparisons:

--Infant Mortality (deaths per 1,000 live births):

Maine (2002): 4.3 (#1 for US)

Norway (2000): 4 one of lowest in the world

--Percent of children with a medical home:

Maine (2003): 56.6%

Norway: 100%

--Immunizations:

Maine (2006): 83% of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Norway (1997): children up to one year of age were vaccinated against diphtheria, pertussis, and tetanus, 92%; polio, 92%; and measles, 93%. Tuberculosis tests are given on their time schedule from infancy onward. Children go through a comprehensive vaccination program and also receive psychotherapy and dental care throughout their nine years of basic school.

--Breastfeeding:

Norway: 97% of women breastfeed when leaving hospital, 80 per cent are breastfeeding at 3 months and 20 per cent beyond 12 months.

Maine: 40.6% of Maine mothers breastfeed their infants at 6 mos of age (State Goal for 2011 is 45%)

What is economic impact?

Without even taking into consideration all of the health related benefits (and therefore "saved" costs) of breastfeeding vs. formula feeding, consider this information taken from <http://www.fns.usda.gov/wic/WIC-Fact-Sheet.pdf>:

"Mothers participating in WIC are encouraged to breastfeed their infants if possible, but WIC State agencies provide infant formula for mothers who choose to use this feeding method. WIC State agencies are required by law to have competitively bid infant formula rebate contracts with infant formula manufacturers. This means WIC State agencies agree to provide one brand of infant formula and in return the manufacturer gives the State agency a rebate for each can of infant formula purchased by WIC participants. For FY2004, rebate savings were \$1.64 billion."

Hmm....so do the math. How much WAS spent (unnecessarily?) on artificial baby formula in the first place?!!!!

There is also an environmental impact with all those formula cans going into landfills, and that has a cost.

So, who is a leader on this issue?

We believe it's largely an invisible issue.

Of course, there certainly is some work being done by a number of agencies, WIC, La Leche League, and others. Examples follow:

There is an international "Baby Friendly" hospital designation (www.baby.friendlyusa.org) which recognizes hospitals who abide by the Ten Steps to Successful Breastfeeding. As of February 2008, there were 63 "Baby Friendly" Hospitals, four of which are in Maine (CMMC, Miles Healthcare, MaineGeneral and York). EMMC JUST SUBMITTED THEIR LETTER OF INTENT - May 2008

In many ways Maine is already a leader:

The legislature passed a law making it permissible to breastfeed in public areas and therefore mothers cannot be asked to leave that area (contrary to all situations we know when this in fact occurs) SO....speak out...It's the LAW

Karen Baldacci has stood up for breast feeding in many ways. She is a registered dietician and used to work for WIC in Bangor.

The Maine Centers for Disease Control (the old Bureau of Health) is also active in promoting breast feeding and is following work of the CDC at National level which has begun the slogan: PUBLIC HEALTH BEGINS WITH BREAST FEEDING

Some Public Health Coalitions are making breastfeeding a priority and linking it to obesity (the ability to decrease for new mothers and for children)

And the local and statewide breast feeding coalitions have developed a plan which includes:

- Social Marketing: Make it the popular thing to do
- More Baby Friendly Hospitals, work places, and other Businesses which attract customers. (stickers have been ordered and descriptions will be given to places of business that would like to transition and be recognized for their effort
- Increasing the number of peer and professional support groups (in Europe many communities have doulas that visit new mothers daily for free for several weeks)

4. Leadership Perspective – Examples of Maine Leaders

From our research and networking, the following are noteworthy examples of leadership in the healthcare arena in Maine.

a. Primary Care Provider (PCP) Office

"Best Practices" example of a Primary Care office. Achieving NCQA certification demonstrates a true commitment to patient quality and safety.

Husson Internal Medicine Achieves National Recognition for Quality Services

Husson Internal Medicine, part of EMMC, has recently become the only primary care office in Maine to have its physicians receive accreditation under all three modules of quality improvement through the National Committee on Quality Assurance. The designation by NCQA, the nation's leading authority on primary care quality assurance, amounts to "center of excellence" status for this primary care office.

Designations were achieved in diabetes management, heart/stroke, and physician practice connections. Physicians who achieve these recognitions show their peers, patients and others in the community that they are part of an elite group that is publicly recognized for its skill in providing the highest-level care. These designations reflect the commitment of the staff and providers at Husson Internal Medicine to utilize information technology, such as the Electronic Medical Record's ability to track quality indicators, to change practice process, and improve the quality of care provided to patients.

"We're proud that our clinicians are leading the quality charge in our state. Our patients should be reassured they are receiving the gold standard in care at Husson IM," comments Iyad Sabbagh, MD. "Our patients with diabetes, for example," Sabbagh continues, "receive routine checks at each visit on certain identified complication risk factors. Eye exams, foot checks, specific blood tests, etc. must happen routinely and consistently to minimize the occurrence of potentially dangerous complications."

EMMC brings the latest innovations and best practice standards in quality to its referral community. From groundbreaking clinical research to the latest robotic surgery techniques, EMMC is committed to be the best and offer the best. (Excerpt from April 2008 Bangor Daily News press release)

b. Employer

Hannaford Bros, the largest retail grocery chain in the northeast, is owned by Delhaize, an international business headquartered in Belgium. They are not impressed with the US position of being #1 healthcare cost, but 29 out of a 30 comparison group for healthcare outcomes. They posed the challenge to the Hannaford headquarters in Maine that they had to meet their employees' healthcare needs within a certain allotted budget.

Hannaford's response was to come up with a program that focused on health and wellness initiatives that resulted in their being one of the eight U.S. companies awarded the platinum recognition for promoting healthy lifestyles by the U.S. National Business Group on Health. Whereas the projected national trend for 2007-2009 is 26% increase in healthcare dividend costs, Hannaford is on target to meet ZERO percent increase without sacrificing quality or employee satisfaction in their health benefit program. In addition, Hannaford is taking a lead in encouraging members to receive lower cost treatment with high outcomes in Singapore!

Another significant way that Hannaford is playing a leadership role for healthcare in Maine is with its Guiding Stars Nutrition Navigation Program...

Nutritious shopping made simple. We all want a healthy lifestyle, but don't always have the time. Or the patience. Or the knowledge. The Guiding Stars program can help. Our unique, easy-to-use navigation system helps you find foods throughout Hannaford Supermarkets that give you the most nutrition for the calories.

Guiding Stars is the first, and only, program of its kind. We've developed this program to make it easy for shoppers to quickly identify and choose more nutritious foods. We gathered a panel of expert nutrition

scientists and asked them to develop criteria that reflect the most current scientific knowledge.

Each food at Hannaford Supermarkets is evaluated regardless of brand, price, or manufacturer with the same criteria, and all foods are rated, with the exception of five categories: bottled water, alcoholic beverages, coffee, tea, spices.

c. State Governor's Office (Gov. Baldacci)

Access to affordable, quality health care is the vision for investing in Maine people and creating a fair and stable business environment. All Maine people deserve quality affordable health care. My goal is to make Maine the healthiest state in the nation. I created the Governor's Office of Health Policy and Finance and established the comprehensive Dirigo Health Reform to address the needs of Maine families, workers and businesses.

- Dirigo Health is a landmark health care reform, provides affordable, accessible, quality health care.
- As of June 2006, more than 15,800 people and 2,300 businesses have coverage.
- Maine is one of seven states to reduce its uninsured population between 2000 and 2004.
- \$78 million of savings has been achieved in Maine's health care system in the last two years.
- The John F. Kennedy School of Government and partners named Dirigo one of the Top 18 Government Innovations for 2006.
- Our [State Health Plan](#) and [Maine Quality Forum](#) aim at improving public health and preventing disease.
- We led the effort that created the first of its kind tri-state state administered Medicaid supplemental drug rebate pool to help control the costs of prescription drugs.
- When the federal Medicare Part D program fell short of its promise to provide prescription drug coverage for Maine seniors, we provided assistance and funding to fill the gaps, ensuring Mainers were able to obtain lifesaving medications.
- We were recognized in 2006 by the American Lung Association for having achieved the first ever all-A report card of states on efforts to reduce tobacco use.

d. Federal Level – George Mitchell

Mitchell tackles U.S. health care

By Meg Haskell

Wednesday, May 07, 2008 - Bangor Daily News

If ever there were a time for high-level intervention in the debate over reforming the American health care system, former U.S. Sen. George Mitchell of Maine says, this is it.

Things have grown substantially worse since 1994, when, as Senate majority leader during the Clinton administration, he undertook an ill-fated effort to bring about serious change in the health care system, Mitchell said in a telephone interview Tuesday.

"We've had 14 more years of experience. More people are more aware of the problem, and there is a growing consensus that something must be done," he said.

One of four high-profile former majority leaders who established the Bipartisan Policy Center in 2007, Mitchell announced recently that the group would place national health care reform at the top of its agenda with a goal of making specific recommendations to the new president-elect and members of Congress before the end of the year.

At a press conference last month in Washington, Mitchell — who perhaps is best known as the man who brokered a peace deal in Northern Ireland after generations of violence — said, "I think we may have entered a period when, as to health care, the impossible may finally become possible."

At the press event, Mitchell said he had heard many personal stories during a national "listening tour" in the 1990s.

"We heard from families who couldn't afford health insurance and had spent down to poverty so they would be eligible for Medicaid to get care for their desperately sick children," he said. "If we took a similar listening tour today, we would hear the same sorts of stories, but there would be more of them, and they would be even more heart-wrenching, because the problems are so much worse."

All four of the policy center partners — the others are former Senate Majority Leaders Bob Dole, Republican of Kansas; Tom Daschle, Democrat of South Dakota; and Howard Baker, Republican of Tennessee — have strong, and differing, opinions about what needs to happen to fix American health care, Mitchell said Tuesday.

Co-directors of the policy center include Mark McClellan, who oversaw the Centers for Medicare and Medicaid Services and the Food and Drug Administration for President Bush, and Chris Jennings, a Clinton White House staff member and adviser to Sen. Hillary Rodham Clinton's presidential campaign.

The plan is to convene at least four meetings around the nation to hear from health care providers and consumers, insurers, the pharmaceutical industry and others engaged in the health care debate before attempting to craft a unified set of recommendations for policy change. The first meeting was held last month.

"We hope to deal with this important issue and demonstrate that bipartisanship is still possible," Mitchell said Tuesday. He underscored the need to keep an open mind in considering the compelling and often competing interests of health care stakeholders — including those who sometimes are vilified for their profit motives, politics or other characteristics.

"We shouldn't be too critical of people in health care," Mitchell said. "Everybody defines this issue through the prism of self-interest." The goal, he said, is to "make it possible [for groups] to accept change in the context of the larger interest in which they share."

And there is much to do. Reflecting the spiraling costs of new medicines and technologies, decreasing rates of insurance coverage, a growing disparity in the quality of care, and the power of entrenched industry groups, the U.S. health system ranked 37th in a 2000 World Health Organization survey of 190 nations. That ranking placed it just ahead of Slovenia, but behind Oman, Dominica, Chile, Saudi Arabia and many European nations.

A 2007 study by the Commonwealth Fund compared the U.S. with five other nations —Australia, Canada, Germany, New Zealand and the United Kingdom — and found the U.S. health care system ranked last or next to last on measures of quality, access, efficiency, equity and healthful lifestyles.

Trish Riley, architect of Maine's controversial Dirigo Health reforms for Gov. John Baldacci, said Tuesday that she is encouraged that Mitchell's group is taking on the gridlocked national health care debate.

The U.S. spends roughly twice as much per capita as other developed countries do on health care, Riley said.

"And we don't get any better coverage or better care," she said, speaking in a telephone interview Tuesday from a state health policy conference in Washington. "It's simply unacceptable."

Riley, who served as executive director for the National Institute for State Health Policy before joining the Baldacci administration, said many states, including Maine, Massachusetts and Vermont, have tried to achieve universal access to quality, affordable health care.

"But especially given the nature of our economy, a national solution is critically important," she said. That solution must include measures for improving health care quality and coverage as well as containing costs, she said. Cost-containment measures must be linked to quality and access, she said, and might include regulating hospital spending and a "reinvention of managed care" to limit how much people use the health care system.

Riley developed the Dirigo reforms in Maine after convening the same kind of meetings at the state level that Mitchell's policy center is holding on a national scale. She said she regrets not keeping participants engaged in an advisory capacity as the sometimes contentious reforms rolled out, because once the meetings stopped, many groups went back to protecting their turf.

"Dirigo's been under fire since Day One," she said.

The first of the national meetings took place April 24 in Washington and was chaired by Daschle. Mitchell said the next three meetings would be held in the home states of the other three majority leaders, including one in Maine, probably in the fall. Mitchell, who grew up in Waterville, now lives in New York but maintains a summer home on Mount Desert Island.

The group plans to develop its recommendations through the fall and will present its report after the November election but before the end of the year.

Mitchell said there is no assurance that the recommendations in the report will fall on receptive ears, but that some members of Congress already have communicated their interest and support for the project.

"It will be the quality of the report that carries it forward," he said.

For more about the policy center and its health care agenda, visit www.bipartisanpolicy.org.

e. Baby Friendly Hospitals

There is an international "Baby Friendly" hospital designation (www.baby.friendlyusa.org) which recognizes hospitals who abide by the Ten Steps to Successful Breastfeeding. As of February 2008, there were 63 "Baby Friendly" Hospitals, four of which are in Maine:

- Central Maine Medical Center
- Miles Healthcare
- MaineGeneral
- York

Despite the low rate of 17%, Maine has the highest rate in the country of infants born in breastfeeding friendly hospitals. Hooray for EMMC who just submitted their Letter of Intent to apply for this status.

Most agree that the hospital is the primary influence toward the success or failure of breast feeding mothers. Fact: 100% of all babies born at home and born at Ballard (s stand along birthing center in Portland) breast feed.

f. Maine Hospitals

The leaders of Maine's three largest healthcare delivery systems: EMHS, MaineGeneral Health (MGH), and MaineHealth (MH) announced a newly reached agreement. This Memorandum of Understanding sets broad guidelines regarding how the systems will collaborate in an increasingly challenged healthcare environment. This collaboration will work toward ensuring future statewide access to critical services, primary care services, and preventive services. It also recognizes that increasing quality and decreasing cost can only be accomplished by working together where possible, for the benefit of all the people of Maine.

This agreement marks the first time that these systems -that together span the entire state - have joined forces. In the next twelve months they already have agreed to explore ways to:

- Create seamless transfer of patient information between tertiary and community providers,
- Coordinate population health assessments and prevention strategies to address the epidemics of chronic disease, obesity, and substance abuse in Maine, and
- Comprehensively aggregate the purchasing power of the three organizations to further reduce the cost of supplies and equipment.

The agreement seeks to advance the goals and objectives of Maine's State Health Plan, and to preserve access to critical, primary, and preventive services. Maine hospitals are facing their highest ever demand for free care. Bad debt is at an all time high, and proposed cuts in federal Medicare payments could pose additional financial hardships. This comes at a time when a critical shortage of providers makes recruiting physicians, nurses, and other healthcare providers more difficult, while patients and providers alike expect the latest treatments and medications, and up-to-date techniques and technology.

MaineGeneral Health and MaineHealth have a long tradition of collaboration. While MGH is an independent nonprofit organization it has been an affiliate of the MH system since 1997. "Due to our unique geographic service area equidistant from Bangor and Portland it only makes sense to take the next step of working with EMHS, the second largest tertiary provider in Maine" stated Scott Bullock CEO of MGH. "Our patients and our

doctors are concerned with only one thing, where to get the best healthcare for their medical needs. We need to forge working relationships to make that easier and more cost effective.”

Bringing a fresh perspective and innovative solutions to these problems from other states, EMHS president and CEO Michelle Hood says anytime healthcare providers get together to study issues, look for solutions to problems, and share ideas and resources it benefits the people we serve. “Advances in medicine and technology have combined to offer more people more treatment options and new hope. However, Maine is a state of finite resources so it is more important than ever that healthcare providers work together to ensure that quality care and continuity of care is provided throughout the state,” Hood stated.

MaineHealth president Bill Caron expressed his delight with the opportunity to link the north and the south to create a united healthcare initiative for Maine bound together by the common values of individual and institutional responsibility, universal access, and commitment to the advancement of quality and resource stewardship. “Our system is founded on the premise of collaboration,” Caron says, “even with those with whom we might compete. Some issues, like the ones covered by this agreement, transcend competition and require us to work together for the greater good.” (Excerpts taken from March 2007 Bangor Daily News press release)

5. Lessons learned for Maine and to the Leadership Maine class

What can Maine learn and implement about controlling health care cost from other existing and proposed, evolving systems?

Big picture comments/other questions:

- Why isn't access to healthcare in US analogous to access to public education?
- The need to address administrative costs and current process inefficiencies
- State or federal legislation to limit or eliminate pharmaceutical TV advertisements (such as those imposed on the liquor and tobacco companies);
- Remember, despite our high costs, our outcomes rank very low compared with all other developing countries
- Universal coverage at **incremental** steps addressing access and high cost areas;
- Requires consideration of cultural change;
- States have limitations on what they can do in the U.S.
- Not just all about costs, it is about how we value individuals, particularly children and families living in poverty

Maine/Leadership Maine:

- Positive outcomes from Dirigo program are the State Health Policy and Maine Quality Forum; product does require continual improvement focus

Priorities/goals for Maine – children's health – what **WE** can do NOW:

- Breastfeeding should be supported, protected, and promoted. This is something everyone in our class and their associated companies can be aware of and educated on to address issue and have impact on healthcare costs within the state.
 - Greater awareness of our personal and cultural acceptance of breastfeeding
 - Promoting role models for this healthy practice
 - Promoting policies in our workplaces/businesses that provide greater support to breastfeeding moms.

6. **Project Team Interaction/Dynamics/Process**

- Roles were formed by “natural selection”, not by vote
- Became smarter on subject
- Very respectful

Reference List:

- Project Team Guidelines for Meetings & Team Charter, adopted Sept 2007
- Governor's Office of Health Policy and Finance website (www.dirigohealth.maine.gov)
- Governor's Advisory Council on Health Systems Development Data Book
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- Larry Widger MD, EMMC Medical Staff Anesthesiologist; practiced medicine in Norway for 5 years
- Nancy Morris, Maine Health Alliance, Director of Training; challenges of rural hospitals in Maine & end of life healthcare costs
- <http://www.healthymainepartnerships.org/>
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- Maine Kid's Count 2008; <http://www.mekids.org>
- Homeland Insecurity and Geography Matters, Michael Petit, President Every Child Matters; <http://www.everychildmatters.org>
- Andrew Sherwood MD, EMMC Medical Staff, Vascular Surgeon. Born/Raised/Practiced Medicine in Canada.

Team Charter (per CDingman email dated 10/16/08)

- All decisions will be made by consensus if practicable; if a consensus cannot be reached, an opportunity will be provided for divergent viewpoints.
- Whenever team members initiate action, each will inform the rest of the team and confirm that they are acting consistent with the team's chosen strategy or strategies.
- The team agrees to meet from time-to-time (physically or by telephone) and to be present and attentive to the project and other team members during these agreed times.
- We will review and adjust our focus on the project periodically, with the goal of accomplishing something strategic, i.e. producing a product that will be useful to policy makers or others engaged in addressing the problems that our project addresses.
- The team will pay attention to process, i.e.:
 - confer regarding process when a team member requests such a conversation;
 - allow everyone on the team to be heard with regard to questions of process; and
 - respect the contributions of every team member.
- All team members will come to team meetings prepared, i.e. having completed any agreed homework assignments.
- Each meeting will be guided by an agenda and will conclude with a discussion to determine the next agenda and a task list for work to be completed prior to the next meeting.