|  |  |
| --- | --- |
|  | ***SIM Steering Committee***  ***Wednesday, February 24, 2016***  ***9:00am-12:00pm***  ***MaineGeneral***  ***Conference Room 3*** |

**Attendance:**

Jay Yoe, PhD, DHHS – Continuous Quality Improvement (via phone)

Deb Wigand, DHHS – Maine CDC (via phone)

Kristine Ossenfort, Anthem (via phone)

Randy Chenard, SIM Program Director

Stefanie Nadeau, Director, OMS/DHHS (via phone)

Andrew Webber, CEO, MHMC

Jack Comart, Maine Equal Justice Partners (via phone)

Shaun Alfreds, COO, HIN

Noah Nesin, MD (via phone)

Penny Townsend, Wellness Manager, Cianbro (via phone)

Fran Jensen, CMMI (via phone)

Mary Pryblo, St. Joseph’s Hospital (via phone)

Rhonda Selvin, APRN

**Interested Parties:**

Lisa Tuttle, Maine Quality Counts

Lisa Nolan, MHMC

James Leonard, OMS

Kathy Woods, Lewin

Kathryn Pelletreau, MAHP (via phone)

Judiann Smith, Hanley (via phone)

Lyndsay Sanborn, MHMC (via phone)

Liz Miller, Maine Quality Counts

Lorrie Marquis, MHMC

Robin Allen, MHMC

Tim Hannon, MHMC

Amy Dix, OMS (via phone)

**Absence:**

Lynn Duby, CEO, Crisis and Counseling Centers (retired)

Eric Cioppa, Superintendent, Bureau of Insurance

Katie Fullam Harris, VP, Gov. and Emp. Relations, MaineHealth (excused)

Lisa Letourneau, MD, Maine Quality Counts (excused)

Sara Sylvester, Administrator, Genesis Healthcare Oak Grove Center (excused)

Dale Hamilton, Executive Director, Community Health and Counseling Services (excused)

Rose Strout, MaineCare Member

**All meeting documents available at:** [**http://www.maine.gov/dhhs/oms/sim/steering/index.shtml**](http://www.maine.gov/dhhs/oms/sim/steering/index.shtml)

| **Agenda** | **Discussion/Decisions** | **Next Steps** |
| --- | --- | --- |
| **1-Welcome – Minutes Review and Acceptance** | *Approve Steering Committee minutes from September Steering Committee meeting*  Meeting minutes approved. |  |
| |  | | --- | | **2 - SIM Objective Review-**  **HealthInfoNet** | | |  | | --- | | *Objective: Report back regarding SORT recommendations. Highlight process with on-boarding Behavioral Health Organizations and Blue Button outcomes.*  Randy reminded the Steering Committee of the request for more information from HIN stemming from the SORT process.Gloria will be sharing a copy of the HIN Powerpoint for those joined the meeting by phone and can’t connect to Gotomeeting Randy also informed the steering committee that the entire meeting would be recorded and available via the SIM Public Website.  Shaun started by sharing the results on the Blue Button project, which was a one year SIM pilot to understand opportunities to promote access to patient records from EHRs. He explained that they put out an RFI to the Health Systems and providers. For Meaningful Use, providers and systems are required to provide portal for patients if they had received those grant funds. Blue Button is movement of information from practice to patient, VA had promulgated it, getting patients their information, and veterans can access all information from anywhere they were served by VA hospitals, and it was huge success. The RFI application from EMHS shined, and they put some of their own resources toward the project. HIN has been connected to almost all providers in the Bangor area, so have a lot of information on those patients. HIE is a 12th grade reading level, and gets really complex, wanted a system that had clear messaging established for their patient portal. HIN is very grateful for their efforts, time, and resources; they experienced a lot of engagement.  Katie Sendze led project team that working on this, lot of prep work developing the strategy. They used three primary care practices that had established patient portals, and met with patient advisory councils, so there were nice layers of patient engagement. Katie demonstrated the view of the Blue Button on the EMHS portal, and explained that patients could download a PDF file with their most up-to-date patient records. They created lots of marketing materials like brochures and posters; and educated staff to promote participation. Katie demonstrated the data around patient downloads and also discussed the survey results of feedback from patients on how they would use the data, what was most useful. Also had asked what information they would want to see going forward, they want to see Doctors notes.  There was a discussion about the difference between doctor notes and care plans. Shaun said there is no definition of what a care plan is, which is one of the challenges they face, the terminology is not well adopted, like in an EMR patient goals may not be a field to fill in. Patients what to see what their plan of care is and use that to better interact with their providers.  Katie explained that while the pilot was successful and they had more participants than expected, this is not the time to continue to do this work until next wave of innovation. There is a large amount of confusion for patients on how data is shared across a health system and then more broadly across the state. The interest is there, but work is still needed.  Shaun stated that people want to have access to their patient records, but policy framework makes it very difficult. Systems and practices have to pay to protect patient privacy; there are a lot of complexities that haven’t been dealt with yet. The technologies are there, the policy challenges need to be addressed.  Shaun and Katie moved on to discuss the HIN SIM objective of getting 20 behavioral health organizations connected to the HIE to share data and. There were no behavioral health organizations connected to HIN before this started. Maine is the first SIM state that provided incentives to adopt HIE connections, and $1.4 million went out to these organizations to help them do this. They had to train the staff to use HIE. An RFP was released, and there was particular focus on BHHs, but not all the organizations are BHHOs. The project kicked off May 2014, 75 sites from York county to Northern Maine. It was explained what behavioral health data is shared, they are working on trying to use the same language between behavioral and physical health providers. Behavioral health EMRs were not able to capture Encounter/Visit History, which had to be built in and there was no standard for capturing adverse reactions/allergies. This was a heavy lift for HIN and the agencies.  It was asked what data they aren’t able to share.  Shaun explained that Substance Use treatment data is the biggest challenge, there are huge barriers, but for care coordination it is huge and vital. He said that there has been some guidance with more flexible interpretation of the “to whom” concept as it relates to patient consent of CFR 42, but still going to be a challenge from due to organizational history.  Shaun was asked to provide more detail on the more flexible interpretation of CFR 42.  Stefanie stated that CFR 42, part two is open for comment, and recommended that the SIM Steering Committee create a comment for it, and Fran supported that recommendation.  Katie continued with details about onboarding of the 20 that are participating. Greatest hurdle was just proving that they have the foundational components, and dealing with those technological barriers. Six organizations haven’t tested data yet due to EMR vendor limitations. It was explained that they start by getting the agencies access to HIN records, while they work toward the capacity to share data. Katie gave details around the breakdown of the incentive payments.  Randy asked if there was concern that the six agencies were not going to get to the point where they can share data.  Shaun said that there are two vendors that are really challenging; Maine has some influence because it is SIM state. He is meeting with couple of the vendors next week to push this forward. Strategically working on this, and it’s not like no work is happening but some work is stalled while they make programmatic adjustments.  Katie said that they start with phased approach. In BHH, Nurse Care managers use this tool the most and then in others ACT teams. They then had to bring in experts that understood both worlds and demonstrate how they can use this physical health information. It has been a great success. Katie discussed volume of usage, population impact data as staff access patient records, and summarized value of using HIE in Mental health orgs, shared clinical benefits realized in the organizations. She then shared positive feedback from staff and the impact access to this information has had on their clients. HIN will be measuring change in ED utilization over 6 month period for clients of the organizations that are connected.  Shaun discussed ongoing challenges of sustaining this work, which is essentially lack of financial support. The agencies are given new work flows, the cost of IT systems are expensive, takes a lot of staff time, and if they don’t get help to fund this post-SIM they will drop out. It’s not that they don’t see the value of HIE connectivity, but they won’t be able to afford it. He highlighted the financial barriers in place from the EHRs and said that one vendor that operates in six of the agencies in Maine wants to charge them per sharing transaction. Katie also pointed out that they haven’t been able to afford to do scientific studies on workflow changes that have come along with HIE connectivity, still in “implementation mode”.  It was pointed out that if ED utilization has reduced then that could/should free up dollars that could be rerouted to maintaining HIE connectivity.  Katie said she hoped that the presentation met the ask of the SORT process and if additional information was needed people can follow up with her. | | For those that would like additional information on HIN activities, they can follow up with Katie Sendze. |
| |  | | --- | | **3- SIM Focus Areas- MHMC** | | |  | | --- | | *Objective: refined work plans for objectives that in include plans to address the new focus areas.* |   Andy began reviewing the MHMC presentation on revisions to work plans based on new SIM focuses. He reviewed the SORT feedback on the VBID workgroup, Measure Alignment, PTE Behavioral Health, and the practice reports. He said the Coalition has been thinking a lot about the feedback stemming from the SORT process and how they will change focus in SIM year 3.  VBID  Robin Allen agreed that initial plan was quite ambitious, so they did go back and look at what is realistic to accomplish in the last year. They feel that it is possible develop a framework and put forth recommendations that health plans could utilize in VBID plan offerings. She covered the PowerPoint slide that detailed the plans for the template concept. She explained the piece about shared-decision making and why it is important with chronic condition care. She then reviewed the month-to-month work plan, which has been shared with VBID workgroup and they are comfortable with this being a realistic deliverable by the end of SIM.  Randy asked if they had looked at incorporating NDPP within the framework, and Robin said that is something they could loop into VBID and she will bring that back to the workgroup. Jim also recommended that they take a look at incorporating the ADEF program, as it has been an extremely effective approach for those with diabetes. Frank pointed out that ADEF is almost universally covered under commercial plans, but NDPP is more challenging due to needing to create reimbursement strategies to sustain it.  PTE- Behavioral Health  Patti reviewed the PTE BH Steering Committee PowerPoint slides. She explained that the world of Behavioral Health is incredibly complex, with varying types of providers and settings. The work has been challenging, but some good work has been accomplished. She explained the focus for the rest of 2016, and said they will try to develop a bridge from current measures to outcomes measures. By 2017, they plan to have measures on getbettermaine.org site for case management and med management.  Randy pointed out that he didn’t see a connection to the narrowed focus on diabetes, but Patti said that might come into play through a med management measure.  Measure Alignment  Frank discussed plans for Measure Alignment Workgroup in 2016. Frank will be revisiting set with group to work on further alignment with recently released CMS measure set. Anticipating quarterly meetings at first, then by end of SIM can present updated measure set to be endorsed and used by parties in 2017. Frank discussed the benchmarking process on claims based measures and survey data, he stated that they are proposing to invite health systems to participate in this. Next month they will get invitations out to decision makers about the process, how it has evolved, and then if they would like to participate. Gives providers ability to see where the leakages are outside their system, allows for people under commercial to compare against practices across the state.  Randy will hold some time for Frank to give updates on interest from health systems in participating in the benchmarking process at an upcoming Steering Committee.  Practice Reports  Tim Hannon reviewed the PowerPoint slides detailing plans for Practice Reports, said he had visited and talked to several health systems and providers on how these reports are useful and what can be improved, and what information already provides value. They really emphasized wanting more timely data. Working on improving processes to whittle down the timeframe that these are built on, so data isn’t a year old. Gave break down of activities on these reports based on quarters of 2016. He plans to continue to meet with health systems on these reports. There is also strong interest in creating a providing group to get feedback and address comments from providers around these reports.  Andy said that in answer to the SORT feedback about more provider input on design and content, they are creating a venue for providers to do just that. He stated that the Coalition is committed to these practice reports long term, and it’s in their best interest to make these as useful as possible for practices. He said they now have an enhanced connection with Quality Counts, and are hoping to be able to help QC identify practices that have more opportunities for improvement, can’t provide TA to everyone this will allow them to target specific practices.  Randy suggested that they work closely with MaineCare for identification of those that should be targeted. Jim stated that he would like to see MaineCare really involved in terms of alignment of other reports that are being produced to make sure everyone is on the same page. Andy said they will build that into work plan moving forward.  It was pointed out that fragmented care was not addressed by this work plan and whether there is any place to incorporate that measure into the reports. It was stated by the Coalition that they were under the impression that the measure did not make sense at a practice level. Lisa offered to discuss further with Lewin. | Frank will to give update on interest of systems in benchmarking the measures from the Measure Alignment work group.  MHMC will engage MaineCare on topic of data and other reports that are produced to better align. |
| |  | | --- | | **4- SIM Focus Areas – Quality Counts Report Back** | | |  | | --- | | *Objective: Review of Learning Collaborative Agenda and refined work plans for objectives that in include plans to address the new focus areas* |   Lisa Tuttle said that what is being presented today is generalized information on the learning collaborative activities, essentially an overview of much more detailed project plans. She stated that Quality Counts really needs data visibility on how HHs and BHHs are performing on the focus measures in order to best focus on low performing practices. Randy said that they are actively in discussion about what data will be available and when for that exact purpose.  The MaineCare team will give the PCMH/HH and BHH project teams a presentation on the DHHS VMS Portal so they can start brainstorming how they can most effectively use that data, and they are working with the Coalition around the data on the practice reports. She said that Quality Counts’ role is to influence, recommend, and support what the practices are doing in quality improvement, but they cannot mandate, so there is a need for top down endorsement on making movement on some of these measures. They have less than eight months to work on focus areas, so getting timely data is imperative, as is getting buy in at leadership level. She said the next two learning sessions on June 3rd and the Sept 29th, will be combined with HH, CCTs, and BHHs.  Liz stated that the BHHOs can’t offer diabetes testing but they can get processes in place to highlight the importance through QI efforts. She furthered reviewed the plan to incorporate the new focus areas into the Learning Collaborative activities. Lisa reminded the Steering Committee that last summer they were asked by the state to focus on reducing readmissions, so that remains a large focus. This they had webinar on Empanelment: How to Improve Care Coordination and Reduce Fragmentation, so those efforts are already underway.  Liz said that they held the Health Home Learning Session on February 5th, and had over 300 attendees. They tried to provide more peer learning opportunities and more content on readmissions and care transitions. They received positive feedback on peer learning, and heard that the networking was invaluable. Liz the presented draft planning agenda for June to the Steering Committee and explained that it will be regional, provided in six different areas across the state. They are looking at exemplifying the P3 pilot success stories for the Consumer Voice segment, and working with MaineCare staff to organize a presentation on the Quality Dashboard, and printing out quality measure data so the practices have their own in front of them as they discuss how that information is most useful in providing care. Then they will cut virtual cord and have regions focus on what is happening locally. For breakout sessions they will have one on diabetes testing and one on coordinated care, once they have the practice level data they will be able to better refine these. She said the agenda isn’t set in stone and they welcome feedback from Steering Committee on content and direction. Lisa furthered explained that the structure for this Learning Session models the one from last June, and had heard positive feedback about going to them in their medical neighborhoods. Portland session is live and the other 5 regions are connected virtually, for the first part. There are onsite trained facilitators. In the afternoon breakouts, they plan to provide content and support for practices that also allows them to drill down into specific populations.  Randy asked how the practice level data they are looking for comes into play. Lisa explained that they want to see how practices are performing across these measures, which will allow them to tailor discussions. They can then prep lead admin through webinars and QIS support and guide them to specialized sessions in the Learning Session and regional forums, maybe even have them work on action plans in the sessions. Randy said that this is an opportunity to work with MaineCare on how to convey specific messaging based on practice level data.  Rhonda pointed out that it’s crucial to have the data so the practices understand where their opportunities for their improvements are.  Lisa said that MaineCare has been involved in the planning committees for both Health Home and BHH Learning Sessions which has worked really well.  Shaun offered to collaborate if they see areas where HIN data would be useful. He said they are starting a pilot with Community Action Programs, like York to bring transportation and housing into the HIE discussion. Lisa said she would really like to get data on which Health Home practices are connected to the HIE, and if/how they are using the notification functions. Shaun said the major barrier to that is attribution, and that is something that needs to be worked through. |  |
| |  |  | | --- | --- | | |  | | --- | | **5- MaineCare assessment of generating clinical measures for eCQM reporting** | | | |  |  | | --- | --- | | |  | | --- | | *Objective: In preparation for the reporting of clinical data for Maine Care’s Value Based Purchasing programs, an ad-hoc electronic clinical quality measure subcommittee will be convened to review options and findings from work to be undertaken in SIM year 3* | | |  | |  |   Jim informed the Steering Committee that MaineCare has been working with HIN for the last two months to develop an understanding around system capacity in Maine and the ability to produce a certain file QRDA required under Meaningful Use, produced by EHRs that will allow for reporting by providers on clinical data. There has been talk for a long time of using clinical data to better evaluate impact of VBP programs and on how to implement and strategized operations, on seeing if Accountable Care or Health Homes are impacting community. Starting with an a1C measure, initial strategies have been put aside due to difficulties and permissions necessary. Jim has worked with ONC, and held discussions with some experts and how collecting that data has gone in other states. Now looking at testing collection and analysis and reporting on a1C within the MaineCare Health Home program.  It was asked if the new CMS measures list impacts what has already been defined for quality measures for SIM.  Frank said that the measure set endorsed by SIM stakeholders and CMS consensus measures, there are some chronic illness clinical measures that CMS came out with that weren’t included in the SIM list but there is a lot of overlap and the goal is to align the two.  It was stated that the idea of a national core measure set has a huge impact, and it’s exciting for data management and will get vendors moving faster on updates and changes. The hope is that it will lead to more standardization of data collection and measures.  Fran suggested that the Steering Committee take a look at the MACRA 105, quality entity piece, because it is open for comment and the Steering Committee could provide valuable feedback.  Andy said the Coalition is working with Elizabeth Mitchell and others on a response to that. |  |
| |  | | --- | | **6- TCPI Work in Maine** | | |  | | --- | | *Objective: Review TCPI goals and objectives* |   Tabled |  |
| **6- Public Comment** | *Discuss health resource infrastructure review process*  Andy asked about next steps.  Randy said that the updates will be discussed with the MLT, which meets next Friday to see if there are comments or further actions to be taken and that will be communicated as soon as it is given. There may be additional SIM activities that may supplement these work plans. That will be coming out in weeks, not months. |  |

.