MAINE HEALTH CARE INNOVATION MODEL: DRIVERS FOR SUSTAINABLE REFORM

ACTIONS		SECONDARY DRIVERS	PRIMARY DRIVERS	TRIPLE AIM GOALS
Workforce Development (Training and Technical Assistance to Improve Competencies and to Implement Emerging Best Practices)	• Leadership Training • ACO Peer-to-Peer Support/Learning Collaborative • Community Health Worker Pilot • Primary Care Learning Collaboratives • Training for Primary Care Providers in Behavioral Health (ASD, DD) • Training for Behavioral Health Providers in Physical Health • Shared decision making/Patient decision aids training (roll out to begin with PCMH/HHs) • Diabetes Prevention			
Social and Financial Incentives (Motivations for Change in Provider, Patient, System Behavior)	Educate/Engage Public on Reform Efforts • Transparency through Reporting of Outcomes/Cost • Engagement: Employers and Payers, Consumers o broaden MHMC Employee Activation Group and other consumer education initiatives o Focus on MaineCare Population Expand Payment Mechanisms • Link Payment to Cost and Quality Outcomes • Enhanced payment for Health Home providers • ACO/Accountable Communities (Public) • Formation of Private Pay/Multi-payer ACOs • VBID (Value Based Insurance Design) • Alignment of State Level Policy Levers to Address sustainability • Cost Savings Study (Evaluation)	→ • **VBID: CONSUMER PORTION OF PAYMENT REFORM** • **PCMH HH (PMPM COST FEES)** → • **IMPLEMENTED ACOS/ACCOUNTABLE COMMUNITIES** • **PATIENT ENGAGEMENT** • **DATA** →	**PAYMENT REFORM**	Maine will transform health care to achieve the "Triple Aim" of improvement: advance population health, improve the experience of care, and reduce health care costs
System Processes (Shared Values, Alignment, Leveraging)	Align Priorities • Coordination of Public and Private Insurance Payers through common measures and payment strategies • Focus on Long Term Care (Medicaid Population) • Mindfulness of Underserved and Special Populations • Address Chronic Conditions/High Cost Procedures o Focus on: Care Transitions, ED Use, Avoidable Readmissions o Implement shared decision making tools (for certain populations or conditions?) o Examine Specialist Cost categories • Identify/address Barriers to integration of BH and Primary Care (incl. information exchange processes and competencies) • Maximize Allied Health Workforce (use of community resources) in support of health promotion o Ambulatory providers for homebound, at-risk-of-ED-use patients Leverage Existing Work (not complete list) • Balancing Incentives (OADS) • Health Care Cost Workgroup (adding BH subgroup) • ACI Workgroup • PCMH/HH Infrastructure (CCTs) • HMC Employee Activation Group and other consumer education initiatives	→ • **PCMH/HH MODEL** • **INTEGRATION OF BEHAVIORAL AND PHYSICAL HEALTH** • **PATIENT ENGAGEMENT** • **COORDINATION WITH PUBLIC HEALTH AND SOCIAL SERVICES** →	**SERVICE DELIVERY REFORM**	
Meaningful Data (Driving Decisions for Policy, Practice, and Payment)	Use Data for Practice Decisions • Primary Care Access to clinical data (HIE) and claims data (MCHC) • Community Care Team/Care Manager Access to HIN (admission, discharge, and ED notifications) for high risk patients • Statewide HIE access by ambulatory providers and PCMH • Blue Button Pilot for Patient Engagement • Practice Reports Use Data for Policy Decisions • Public Reporting of Cost, Care Quality, Health Outcomes (incl. Patient Experience of Care (CG-CAHPS) • HIN Clinical Dashboard for MaineCare on population health, utilization and clinical outcomes for Medicaid patients Monitor Project Progress • Public Private Governance Body • Evaluation of Model Test and Cost Savings • Common process and outcome measures across providers	→ • **DATA-INFORMED POLICY, PRACTICE, AND PAYMENT DECISIONS** → • **INTEGRATED, COMMUNITY BASED CARE MANAGEMENT** • **EDUCATED HEALTH CARE CONSUMERS** →	**REFORMED HEALTH CARE EXPERIENCES**	

DRAFT: Wednesday, July 10, 2013