**MAINE HEALTH CARE INNOVATION MODEL: DRIVERS FOR BETTER EXPERIENCE OF CARE**

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|  | **ACTIONS** |  |  |  | **SECONDARY DRIVERS** |  | **PRIMARY DRIVER** |  | **TRIPLE AIM GOALS** |
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|  | Blue Button Pilot: Provide Maine patients with access to their statewide HIE record through provider portals leveraging the “Blue Button” standards promoted by the Office of the National Coordinator for HIT (ONC)Use of shared decision making/patient decision aid toolsMedia Campaign on patient engagement and optimal health care utilizationBroaden participation of consumers in all SIM workgroupsConsumer Engagement forums and education regarding Payment and System Delivery ReformPublic reporting of common metrics by provider via the work of the ACI workgroup, the VBID workgroup, the Health Care Cost workgroups and Pathways to Excellence processAlignment of clinical and population outcomes with publicly reported Public Health performance measuresExpansion of patient advisors to Patient Centered Medical Home (PCMH) practices |  | **Health Information for Consumers** |  | **Consumer Education/ Access to Information** |  | **INFORMED CONSUMER ENGAGEMENT**  |  | *By 2017, Maine will improve targeted practice patient experience scores by 2%  from baseline for participating practices that participated in the 2012 baseline survey (using CG-CAHPS survey tool)**By 2017, Maine will increase from 50% to 66% the number of practices reporting on patient experience of care using CG-CAHPs* |
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|  | Real-time notifications from the Health Information Exchange (HIE) expansion to include MaineCare and provider care/case managers when MaineCare members are admitted or discharged from inpatient and emergency room settingsExpansion of HIE access to behavioral health providersPrimary Care access to patient utilization claims dataPractice reports reflecting practice performance on outcome measuresClinical Dashboard for MaineCare to monitor population healthMaineCare Discrete Medication Data Capture for HIE |  | **Health Information to Manage Care, Plan Provider and Patient-level Interventions** |  | **Improved Continuum of Care** |  |  |
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|  | Primary Care Providers* Leadership Training
* Community Health Worker Pilot
* PCMH/ Health Hmes Learning Collaboratives and technical assistance
* Training for primary care providers in behavioral health and developmental disabilities
* Shared decision making/Patient decision aids training
* National Diabetes Prevention Program

Behavioral Health providers* Training for Behavioral Health direct service workers in physical health integration
* Behavioral Health Home (BHH) Learning Collaborative and technical assistance

Community Care Teams Learning Collaborative and technical assistanceTraining of Blue Button Pilot Site personnel on use of technology with patients |  | **Workforce Education and Development** |  | **Patient/Family Centeredness of Care** |  |  |