SIM

HEALTHCARE SYSTEM TRANSFORMATION

A Collaborative Partnership led by Maine DHHS

Paul R. LePage, Governor *Mary C. Mayhew, Commissioner*

Maine State Innovation Model Quarterly Report

July 1 - September 30, 2015



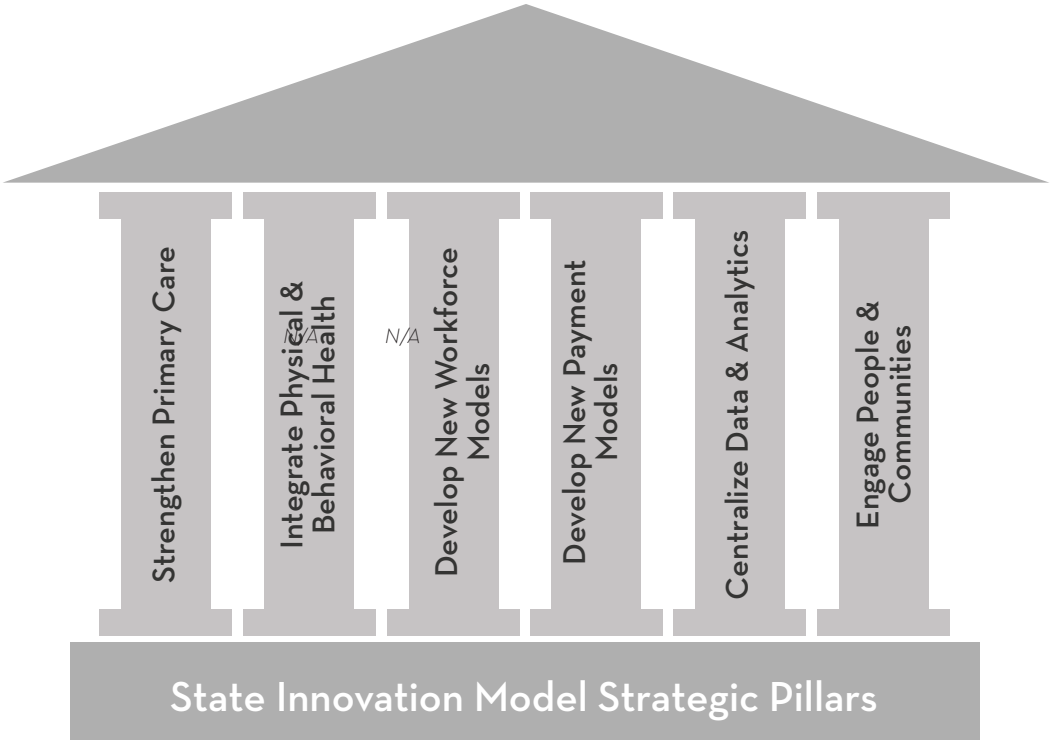
Maine State Innovation Model: Q4, 2015

OVERVIEW

Maine believes that its healthcare system can improve the health of Maine people, advance the quality and experiences of healthcare, and reduce healthcare costs by 2016. Over the course of three years, an unprecedented partnership among physical and behavioral health providers, public and private insurers, data and system analysts, purchasers, workforce developers, and Maine consumers will put this belief to the test through the Maine State Innovation Model (SIM).

The model has a foundation in emerging healthcare initiatives, promising community-based demonstration projects, and evidence-based strategies that empower consumers with long-term health conditions. The power of the innovation, however, comes from the concurrent application of existing efforts with enhanced investments, all within a shared commitment to accountability, transparency, and quality.

The six strategic pillars of the State Innovation Model (*below*) are each comprised of individual objectives that are aligned to effect meaningful change in our healthcare system. The following sections provide an overview of the work being undertaken in each pillar, and how it is progressing to date. For a detailed description of SIM objectives see page 9 or visit www.maine.gov/dhhs/sim.



SIM OUTCOMES: Results From the SIM Evaluation

Evaluation is a key component of Maine's SIM award. In the spirit of "that which gets measured gets improved," each delivery target across the SIM initiative will be examined to determine where we are succeeding, where we are falling short, and where we should be focusing our efforts going forward. This evaluation will be a greater focus of the SIM newsletter as we move towards the end of SIM work in Maine.

As Maine's State Innovation Model work closes out its second year, more focus continues to shift to measuring the impact of SIM work being done, and, more generally, healthcare transformation throughout the State. This work is being led by The Lewin Group, which has been meeting regularly with staff from the State's Office of Continuous Quality Improvement (OCQI) and SIM stakeholders to identify and refine measures for evaluation.

Over the last quarter The Lewin Group facilitated three Evaluation Subcommittee meetings where they presented on preliminary consumer, provider and key stakeholder findings, dashboard and data analysis development, and commercial/Medicare SIM benchmark activity. They also met separately with commercial health plans to review and discuss the approach for commercial target setting in September.

While evaluation efforts are proceeding smoothly and promise to offer important insights into the SIM work being done around the state, at this point the evaluation work is very much foundational. In the coming quarter we will begin to see the fruits of this labor, and the results of this ambitious healthcare transformation work. Public reporting of evaluation results under SIM will be available in December, both on the SIM public website (http://www.maine.gov/dhhs/sim/) and the MHDO website (https://mhdo.maine.gov).

PILLAR 1: Strengthen Primary Care

A strong primary care system is foundational to improving the quality and lowering the cost of healthcare in our state. Primary care doctors play a leading role in managing patients' health and coordinating their care with hospitals and specialists. When primary care doctors have the tools and resources to do their job effectively they are able to keep patients healthy and reduce the need for costly emergency care down the road.

State Innovation Model work to strengthen primary care continued to make progress this quarter. Notable advancement was made through Maine Quality Counts' (MQC) efforts to support practice transformation and sustainability through the Health Homes (HH) Learning Collaborative as final details were completed for an all-day integrated learning session on Oct 2, focusing on strengthening partnerships between primary care Health Homes, Community Care Teams (CCTs) and Behavioral Health Home Organizations (BHHs) in order to effectively reduce readmissions. The HH Learning Collaborative successfully provided two integrated webinars focusing on the roles of CCTs and BHHs on reducing readmissions, engaging nearly 100 providers, as preparation for the Oct 2 event.

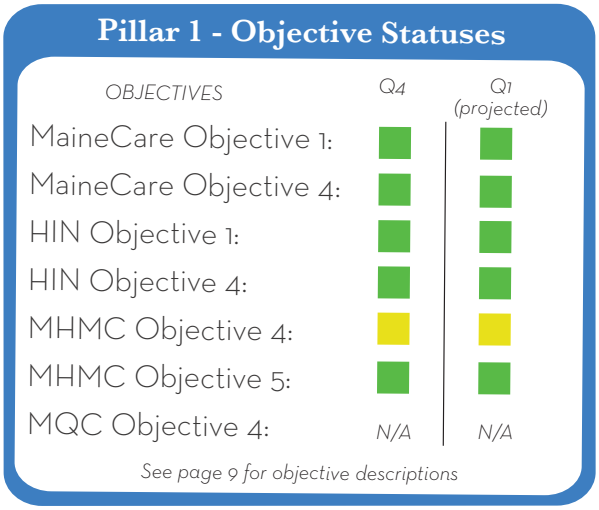
The HH Learning Collaborative also finalized plans for the primary care Fall Regional Forums focusing on improving palliative care in primary care and the medical neighborhood.

Some more exciting work took place on the IT side of pillar 1, as HealthInfoNet (HIN) continued to expand the use of "notifications" from the health information exchange (HIE) that send automated emails to care managers when their patients utilize the emergency department (ED). ED visits are extremely expensive, and in many cases could be avoided if providers were able to identify which patients required extra attention and follow-up. By sending automated emails to care managers whenever a patient uses the ED, providers make that identification and additional effort can be made to be sure the patient is receiving all the care and attention they require.

HealthInfoNet had an initial goal of 875 active users per week on the HIE, but their actual average over the last quarter was 1,189 active users – 136 percent above their goal.

While HIN is sending patient specific information to practices around the state, the Maine Health Management Coalition (MHMC) continues to send out aggregate practice level data to primary care providers through their primary care practice reports. The reports include information on the practices' quality of care, utilization, and cost relative to their peers in Maine, and they help practices identify areas for improvement.

Over the last quarter the MHMC sent out reports to over 200 practices, which represents 80 percent of the total primary care practices in the state.



PILLAR 2: Integrate Physical & Behavioral Health

Behavioral health is increasingly being recognized as a vital piece of high quality primary care. Healthcare providers understand that in order to keep patients healthy, equal attention needs to be given to both body and mind. The following SIM activities are being undertaken to strengthen the ties between physical and behavioral health in order to provide Maine patients with comprehensive care.

MaineCare's work to implement and support Behavioral Health Homes (BHH), which partner licensed community mental health providers with Health Home practices to manage the physical and behavioral health needs of eligible children and adults, continued to progress on track this quarter, with year two planning well underway. Letters have been sent to BHH organizations to opt-in to the second year of the initiative, and applications for new BHH providers opened in October.

One of the challenging aspects of the Behavioral Health Home model is the rate of per-member, per-month (PMPM) payments that

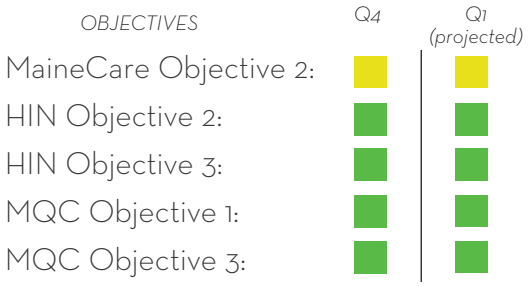
were initially negotiated at the start of the initiative. In the first year, rates were raised twice to address the added expenses to practices that weren't reflected in initial rates. After an indepenent assessment, rates will be raised again at the start of year two to reflect the total cost of the delivery model. MaineCare worked with an independent contractor to undertake a rate review process, presented a draft rate model to stakeholders in mid-August, and responded to public comments in October. The rate has been established and is currently being implemented through policy.

Maine Quality Counts (MQC), in support of integrating behavioral and physical health, engaged nearly 600 providers and consumers through their HH and BHH Learning Collaborative activities. Increasingly, MQC has been focusing on creating alignment between the efforts of Health Homes, Behavioral Health Homes, and Community Care Teams, which are all working towards the same ends of integrating and transforming health, and their educational offerings are reflecting that alignment. MQC's BHH Learning Collaborative hosted a webinar in conjunction with Primary Care Health Homes in an effort to prepare for the October 2nd Learning Session, which would bring together care partners to discuss opportunities to reduce readmissions. Additionally, the BHH Learning Collaborative successfully convened BHH Nurse Care Managers regionally to discuss best practices on the BHH team.

Meanwhile, HealthInfoNet (HIN) has been moving along steadily in their work to support behavioral health integration through new and enhanced IT infrastructure. HIN has been working to connect BHH organizations to the state's Health Information Exchange (HIE) in an effort to centralize patient records and better coordinate care, and five of twenty organizations have begun to share data with the HIE.

HealthInfoNet also reported this quarter that fourteen of twenty behavioral health organizations met the required milestones to begin to use the HIE portal and its care coordination tools. HIN is providing technical and financial support to these organizations to bolster their adoption an use of IT and expand EHR interoperability, particularly for the purpose of coordinating client care and their ability to improve quality. They have distributed a total of $600,000 out of $700,000 worth of the SIM funds targeted for this initiative, and they have continued to support behavioral health organizations with weekly individual technical calls and monthly webinars.

Pillar 2 - Objective Statuses



See page 9 for objective descriptions

PILLAR 3: Develop New Workforce Models

One of the primary drivers of high costs and poor patient outcomes in our healthcare system is the absence of coordinated preventative care. All too often we are treating health problems as they arise instead of dealing with them before they become an issue. To address this problem, SIM work focuses significant resources on expanding the ability of healthcare providers to reach and serve patients. It will bolster efforts like Maine Quality Counts' Health Homes initiatives

(pillar 2), the Maine Health Management Coalition's transparency initiatives (pillar 4), and Maine CDC's Community Health Workers (CHWs) Project.

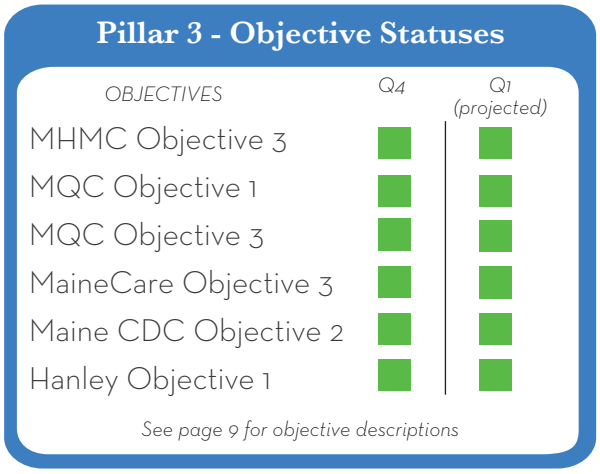
The Daniel Hanley Center for Health Leadership has been working to develop new workforce models by providing leadership development programming in an effort to prepare today's leaders to more effectively guide the work of teams in accountable care, mental health and primary care. This quarter, the Hanley Center created a draft Health Leadership Development Vision and Plan, and they delivered a day and a half long SIM Tier II Team Leaders Workshop. Thirty-four leaders working in accountable care, mental health and primary care participated in the workshop, and each left with team homework that they will bring back to workshops in December.

Last, the Maine Health Management Coalition (MHMC) reported some significant accomplishments by several of their multi-stakeholder workgroups this quarter. In the Healthcare Cost Workgroup (HCCW) a recommendation was finalized on a set of principles and criteria that could be used to evaluate—and potentially publicly support—infrastructure realignment proposals. The recommendation was approved by the Payment Reform Subcommittee, and the Coalition Board agreed to the workgroup recommendation that the Coalition act as the steward of this activity.

Also in the last quarter, the MHMC's Accountable Care Implementation Workgroup, which is working to identify a common set of metrics for Accountable Care Organization (ACO) payment, achieved endorsement by all involved stakeholders of a core measure set. A total of 27 measures for payment and 17 measures for monitoring performance have been adopted. A subset of these measures has been forwarded to the MHMC's Pathways to Excellence (PTE) Committee for consideration in public reporting.

PTE has been making strides with its specialty workgroups, formed earlier this year, which have been working to identify orthopedic, cardiology, women's health, and oncology metrics to be reported on the www.getbettermaine.org website, and they are forging ahead with a goal to begin public reporting on the following three domains: patient experience, clinical effectiveness, and safe office systems in early 2016. The PTE Behavioral Healthcare Steering Committee also endorsed new measures for GetBetterMaine in January 2016, and will begin publicly reporting a condition/diagnosis-specific domain for depression for adults and ADHD for children. These new ratings will greatly expand the amount of publicly available healthcare quality information available online, and they will help consumers choose high quality, safe, patient-centered healthcare providers.

MHMC staff are also working internally to ensure that efforts on similar topics by different workgroups are not duplicative. For example, staff are working to ensure that consumer engagement activities being pursued by the Healthcare Cost Workgroup do not duplicate consumer engagement/wellness activities underway through SIM's VBID initiative. With two years of work now complete under the SIM grant, the MHMC is also attempting to adjust various activities in response to stakeholder feedback.



PILLAR 4: Develop New Payment Models

In today's fee-for-service payment system, doctors and hospitals are paid based on the amount of services they provide, not for making patients healthier. As part of the SIM initiative, the State is seeking to change this model to align payment with improved patient outcomes. The following describes work being undertaken to promote alternative payment systems.

MaineCare's work to develop new payment models through its Accountable Communities (AC) Initiative, which allows groups of providers to share in savings for assigned populations entered its second performance year, effective August 1, 2015. Interim shared savings for the first performance year will be calculated in the spring of 2016. The four ACs – Community Care Partnerships of Maine, LLC, MaineHealth ACO, Beacon Health, LLC, and Kennebec Region Health Alliance – have given MaineCare extremely positive feedback regarding the monthly and quarterly cost, quality, and utilization data that MaineCare provides.

Importantly, one of the ACs – Community Care Partnerships of Maine, LLC – undertook a significant expansion in year two, adding 35 primary care practices through eight provider organizations that have newly joined the AC. This expansion increases total enrollment in the AC program from 30,000 to 42,000.

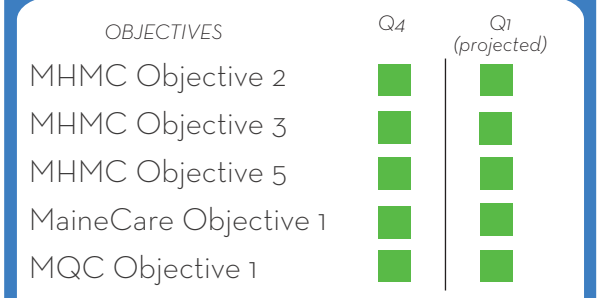
The Maine Health Management Coalition also made some significant progress this quarter on developing new payment models with its work to stimulate the availability and adoption of value-based insurance design (VBID) plans in the state. On top of convening five trainings for a total of 256 participants, members of the VBID Administrative Simplification Workgroup approved a standardized provider enrollment application and recommended it for use. Five of the major health insurers in Maine have agreed to accept the new form, and the universal application is expected to save healthcare providers and administrators a significant amount of effort since they will no longer need to submit a unique form to each one of the insurance carriers whenever a change is made to their provider rosters. Ultimately, the VBID workgroup hopes to build upon this success and to simplify and streamline a number of administrative processes that contribute to wasted time and money in the healthcare system.

Underpinning much of the payment reform work taking place around the state is a strong spirit of collaboration, and in that spirit the Maine Health Management Coalition has been working closely with Maine Quality Counts on a primary care payment reform initiative. They hope to leverage the input and expertise of participants from the Payment Reform Subcommittee and Delivery System Reform Subcommittee at a joint meeting in October where they will review recent work by Bailit Health to engage stakeholders in dialogue on expectations and accountability for advanced primary care payment. The

group will take into account the current landscape of primary care payment, key elements to advance primary care, and near-term opportunities as they work to develop recommendations for the SIM Steering Committee.

The MHMC anticipates that the meeting will be the beginning of an ongoing collaboration between the two subcommittees on primary care payment reform.

Pillar 4 - Objective Statuses



See page 9 for objective descriptions

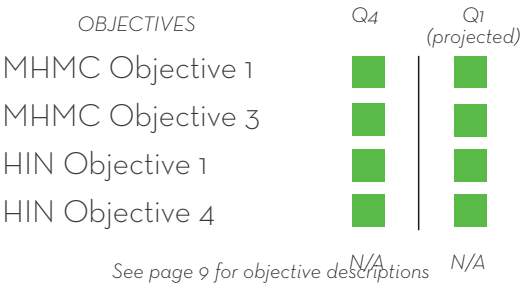
PILLAR 5: Centralize Data & Analysis

Data and analytics are an integral piece of the SIM work currently underway around the state. Robust data holds not only the potential to tell us how costs, utilization and quality vary around the state, but it can also help break down barriers between doctors and the patients they care for. Nearly every SIM objective has a foundation in data and analytics because we know that what gets measured gets improved. The following SIM activities are being undertaken to strengthen data and analytics in the state.

In an effort to help centralize healthcare data and analysis in Maine, HealthInfoNet (HIN) has been working to provide MaineCare with a web-based analytics dashboard that can combine current real-time clinical data from the Health Information Exchange (HIE) with MaineCare's claims data.

Over the last quarter HIN delivered the initially scoped analytics dashboard to MaineCare, and MaineCare staff began training and providing feedback. Although this may not sound like a major milestone in the delivery of the dashboard, it is the first test of Maine's Health Information Exchange to support a "payer" in the state using clinical electronic health record (EHR) data.

Pillar 5 - Objective Statuses



See page 9 for objective descriptions

PILLAR 6: Engage People & Communities

Whether the State Innovation Model work underway focuses on creating a new database or an Accountable Care Organization, the purpose is ultimately to provide higher quality, more affordable healthcare to Maine's people and communities. As the end-users of the work being done, it is important that Maine people are being involved and that they understand the reasons for the changes taking place in the healthcare system. To that end, the State Innovation Model puts a strong emphasis on engaging people and communities.

One of the most promising programs underway to engage people and communities in improving their health is the Maine Center for Disease Control and Prevention's (CDC) Community Health Worker's (CHW) Pilot Project. The project seeks to develop a system of CHWs to engage under-served populations around the state, and to have them help those populations access the care and services they need. Key to accomplishing their work is the need for CHWs to provide culturally appropriate health education and outreach, and to create linkages between individuals, communities, healthcare providers, and social services. Research suggests that when CHWs accomplish these roles they have the potential to significantly improve outcomes and reduce costs. This pilot project will serve as the first test of whether CHWs are a viable long term strategy for Maine's health improvement efforts.

As of the last quarter the CHW work is in full swing, and the CHW Stakeholder Group continues to focus its efforts on standardizing training, qualifications and the preparation of CHWs. The CHWs themselves have shared that they are concentrating on clients that are more intensive in how they interface with or use services, like the hearing-impaired, patients with cognitive issues, and caregivers to adult disabled children. These patients often have basic needs that require referrals and help navigating the healthcare and social service systems.

The Maine CDC's National Diabetes Prevention Program (NDPP), which helps people at high risk for Type 2 Diabetes to make modest lifestyle changes that can prevent or significantly delay the disease, is also progressing smoothly and continues to exceed all targets. As of the last quarter, 78 NDPP Lifestyle Coaches have been trained, and they have helped 837 eligible adults complete the program – more than 400% of their initial target!

HealthInfoNet (HIN) also reached a major milestone in their SIM work this past quarter with the completion of the "blue button" pilot project. The pilot set out to give patients access to their health records on the state Health Information Exchange (HIE) through a button in their local patient portal environment. The system was tested with Eastern Maine Healthcare System, and having wrapped up the testing, patients are now being surveyed about their experience using the HIE. HIN will present the results to the SIM Steering Committee in January.

Pillar 6 - Objective Statuses

OBJECTIVES	*Q4*	*Q1 (projected)*
Maine CDC Objective 1		
Maine CDC Objective 2		
MHMC Objective 6		
HIN Objective 5	*N/A*	*N/A*
MQC Objective 4	*N/A*	*N/A*

See page 9 for objective descriptions

SIM STATUS AT A GLANCE