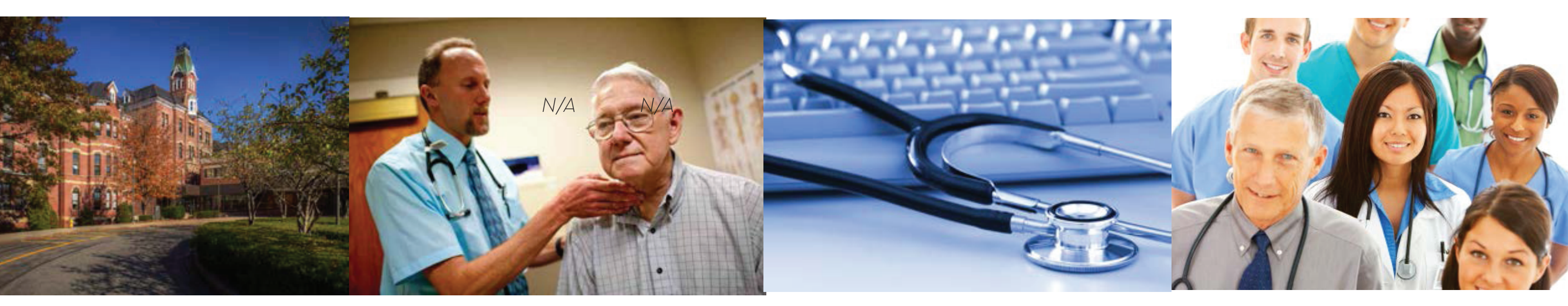
Maine State Innovation Model Quarterly Report

January 1 - March 31, 2016



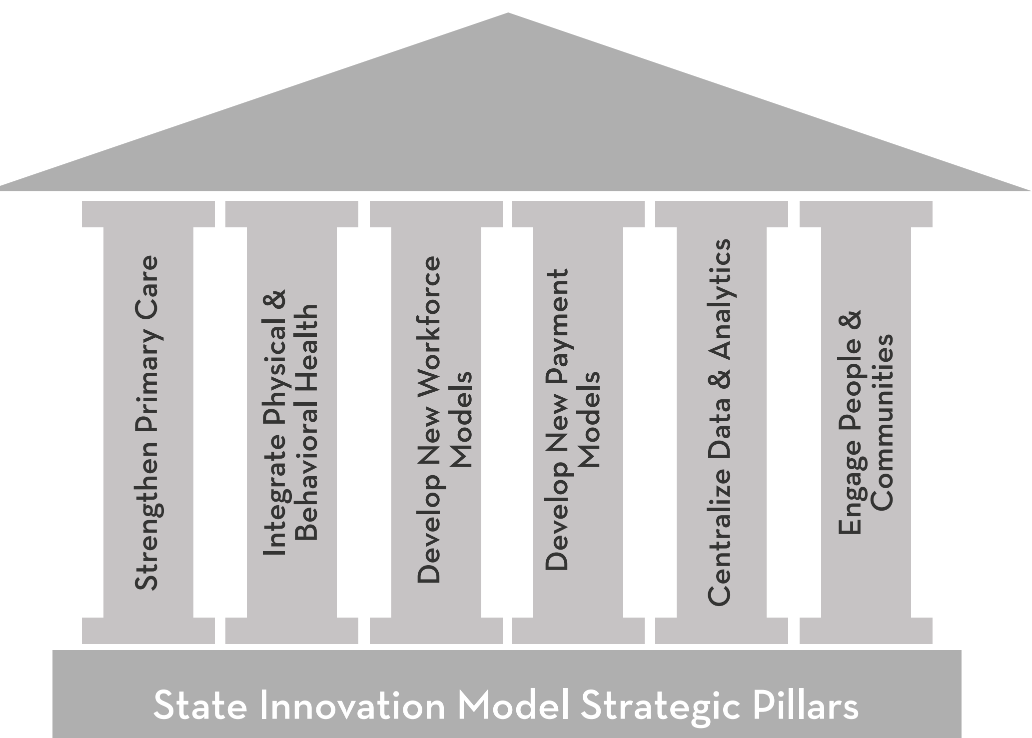
Maine State Innovation Model: Q2, 2016

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.



Quarter Two Update

Overall, some major shifts in the State Innovation Model were finalized in the last quarter, sharpening SIM's focus on a few outcomes and aligning many of SIM's objectives with those outcomes. Specifically, the intent is to focus SIM objectives on diabetic care, the reduction of fragmented care, and the reduction of readmissions. While all SIM strategies will continue to be supported through the aligned objectives, the objectives themselves will be refocused to concentrate on those specific result areas. Through experience and evaluation, it was determined that this more focused approach would be more beneficial than an "advance on all fronts" approach, and the SIM activities and the associated shifts are described in this newsletter.

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.

The Lewin Group's work to measure and report on the status of SIM goals and objectives continued progressing this quarter, most notably in the form of new MaineCare data that has been uploaded to the public dashboard in the Evaluation section of the SIM website. The data show progress in nearly all SIM core measures, but particularly in developmental screenings in the first three years of life, which have more than doubled since 2013, and in follow-up after hospitalization for mental illness, which has increased by 18 percent in the same period.

Medicare and commercial data were also slated for reporting on the public dashboard, but benchmarks and target setting by the commercial plans proved to be elusive. Goals have been set on the Medicare side for Diabetic Care HbA1c, Non-Emergent ED Use, and Use of Imaging Studies for Low Back Pain. While it looks as though the other applicable Medicare measures will ultimately have targets, the commercial payers have decided not to endorse a measure setting process, and this will be reflected in the dashboard in the coming months.

There have been some recent successes in the refinement of consumer, provider, and stakeholder interview tools. After close collaboration with stakeholders, refinements to the 2016 tools and research methods are nearly complete, and these evaluation activities are projected to begin in July.

Also of note, the Lewin Group has prepared written recommendations and two literature reviews for the 2016 "Special Studies" topics, which were selected after several meetings with stakeholders. The topics proposed for 2016 will provide an in-depth analysis of factors impacting Health Home (HH) and Behavioral Health Home (BHH) outcomes, including a focus on diabetes management and the use of anti-psychotic medications. The topics will be vetted for a final evaluation study design in the coming months.

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.

One of the SIM grant's most significant work areas is strengthening our primary care system, and Maine Quality Counts (QC) has been executing much of this work through the HH and BHH learning collaboratives, as directed by MaineCare. The learning collaboratives offer health care practitioners the opportunity to come together in a structured way to learn from each other along with national, state, and local experts about strategies to improve the quality of services they provide.

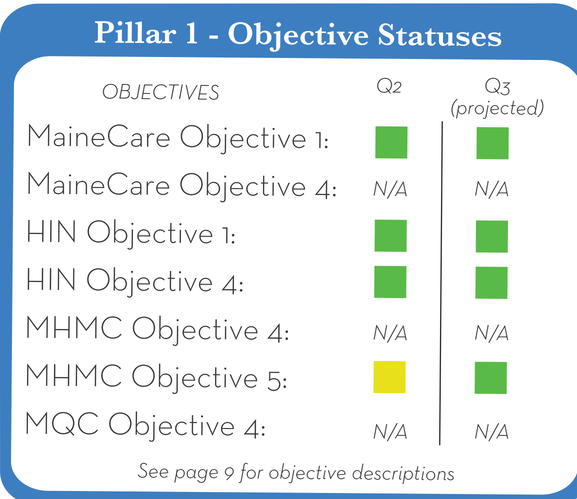
In the first two years of our SIM grant, these learning collaboratives focused intensely on supporting the practice transformation exemplified by full implementation of the 10 Core Expectations of the Health Home model, in both primary care and behavioral health organizations. As SIM Governance clarified the sharpened focus on diabetic care, the reduction of fragmented care, and the reduction of readmissions in the final SIM grant year, QC revised the overarching education plan for the HH and BHH learning collaboratives to support participants' improving work flows, relationships, and integrated information sharing to advance these focus areas. Based on evaluations, the learning collaboratives' format and structure also evolved, to maximize opportunities for tangible assistance with action planning and work flow refinement, and to advance the essential peer and regional relationships required to improve integrated care planning.

Over the last quarter, three events were held, engaging primary care, behavioral health, and community care teams statewide, and including key partners from their regional medical neighborhoods to advance the sharpened focus areas. One such event was an interactive discussion which provided opportunities for practitioners to discuss work flow and access improvements in primary care. Another convened primary care teams and specialists in six concurrent regional sessions, and focused on the continuity of care planning for patients living with substance abuse disorders and the role that primary care providers can have in reducing Maine's epidemic of prescription drug abuse. The last event provided an opportunity for behavioral health practitioners to deepen competencies in the BHH model, refining BHH team roles, and quality improvement methods, including measures to track improvements in areas of sharpened focus.

The HH learning collaboratives have made great strides to support primary care practices in achieving necessary screenings and requirements for core expectation reporting. While a small number of practices have found it difficult to implement core standard expectations due to staffing shortages and workforce capacity restraints, most are meeting or exceeding expectations.

While MaineCare has funded the training of HHs and BHHs on strategies to improve the quality of care delivered to patients, the Maine Health Management Coalition (MHMC) has been working to support all primary care and pediatric practices in the state, with actionable data they can use in their practice

improvement efforts. Over the last two years, the MHMC has been delivering Primary Care Practice Reports to these practices which include information on the practices' patient populations. The reports help practices benchmark their costs and quality against their peers, and identify opportunities for improvement. In the last quarter, reports were updated with fresh data, and they will soon go out to over 500 practices.



Pillar 1 - Objective Statuses

OBJECTIVES	Q2	Q3 (projected)
MaineCare Objective 1:		
MaineCare Objective 4:	N/A	N/A
HIN Objective 1:		
HIN Objective 4:		
MHMC Objective 4:	N/A	N/A
MHMC Objective 5:		
MQC Objective 4:	N/A	N/A

See page 9 for objective descriptions

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.

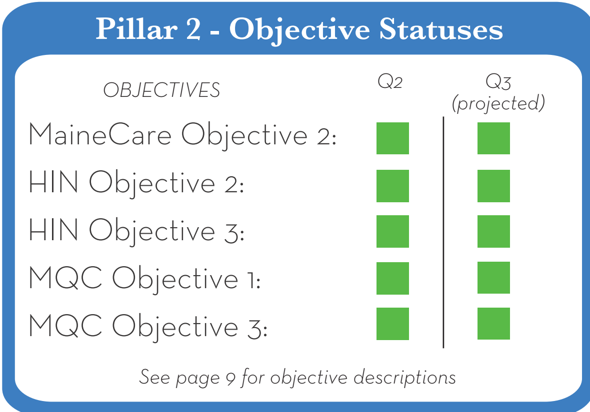
MaineCare is charting a parallel path to support BHH practices and community mental health agencies that deliver care to their members who have serious and persistent mental illness and children with serious emotional disturbance. Members enrolled in MaineCare's BHHs receive integrated, intensive care management for their mental and physical health needs, assistance with transitions of care between residential, community-based, and/or hospital settings, peer support, and other services.

In the last quarter, MaineCare added seven new BHH practices to its roster, and as of January 1, 2016, all BHH practices began receiving a higher reimbursement from the department that will help them pay for the additional resources needed to coordinate care. The new rate is the result of a rate review process that was undertaken by Burns & Associates in Q4 of 2015.

Underpinning much of the behavioral health work occurring around the state is HealthInfoNet's (HIN) efforts to support behavioral health organizations in setting up Electronic Health Record (EHR) systems and connecting them to the state's Health Information Exchange (HIE). Twenty organizations were selected to receive funding for EHR implementation, and to date, those organizations have received a total of $850,000 in reimbursements. This quarter, HIN also reported that all twenty organizations have met required milestones for setting up their EHR systems.

Progress on connecting those organizations to the HIE has been slower than expected in previous quarters, but HIN has caught up to targets, and ten of the organizations are now live with mental health data in the HIE. They expect to be able to connect the remaining ten organizations to the HIE by the end of the SIM grant period, but external vendors continue lagging behind due to a lack of resources.

Nevertheless, HIN is persevering and continues to hold monthly webinars with all twenty behavioral health organizations along with weekly individual technical calls with vendors to keep efforts moving forward.



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.

A big part of improving overall population health means engaging populations that have traditionally been under-served by our health care system, and the work that the Maine Centers for Disease Control and Prevention (CDC) is doing under SIM has been making strides in addressing those populations. The CDC has been piloting the Community Health Worker (CHW) initiative, which links individuals, communities, health care providers, and social services together to ensure that patients receive culturally appropriate health care services.

Over the last quarter, much of the CDC's CHW work has focused on capacity building activities to support the CHW workforce once SIM funding has ended. To that end, the CHW project director began initial meetings with the University of Massachusetts Medical School to develop recommendations around prospective payment models that could be adopted by Maine payers. They also began drafting and reviewing some guidance for the Maine CDC to inform future integration of the CHW workforce by the health department and ongoing dialog with Department of Licensing and Regulatory Service (DLRS) on the launch of a direct care worker registry.

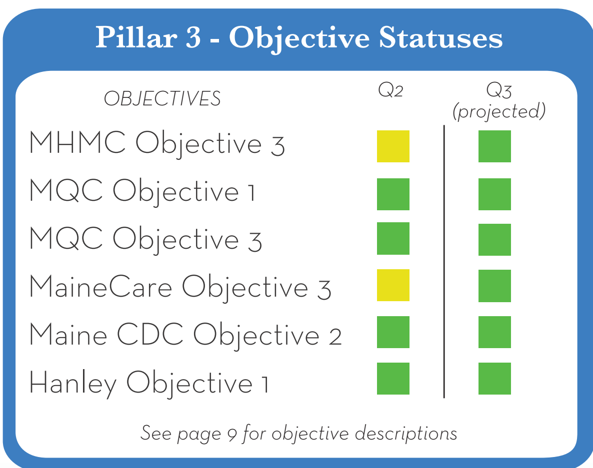
In March, the CHW Project Director also co-facilitated a CHW summit, including members of the New England CHW Coalition and the Region I Health Equity Council. This meeting focused on identifying shared aims for sustaining the CHW workforce across our region. Priorities included: standardized training for CHWs, supervisors, and clinical teams (and how to pay/sustain training), supporting informal or formal networks of CHWs, and more streamlined information-sharing on state and national policy (credentialing, standardized training, payment).

One of the highlights to come out of the CHWs' work so far was the recent publication of an article in the March/April issue of the Journal for HealthCare Quality on the success that CHWs have found improving colorectal

cancer screenings. By integrating CHWs into their practice, Oakland Family Medicine was able to increase colon cancer screening rates from 28 percent to 80.3 percent. If you'd like to read the article, it can be found HERE.

In addition to the CHW initiative, the Hanley Center for Health Leadership's work to build a leadership training program that bolsters the capacity for health care teams to manage and sustain transformational changes in our health care system shared some successes this past quarter. Most notably, the Hanley Center began hosting monthly training webinars for primary care, behavioral health, and Accountable Care Organization (ACO) team managers aimed at helping them be more collaborative and effective leaders. Webinar topics over the last quarter included an examination of different models for care improvement, relationship management, how to make the most of your team, and project measurement.

During this quarter, the Hanley Center also convened a group of senior health system leaders to continue working on the creation of a draft Health Leadership Development Vision and Plan that will guide future work in this area. Planning is currently underway for a smaller, targeted senior health system leader workgroup in June to follow up on this work and to assist in finalizing the vision and plan.



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.

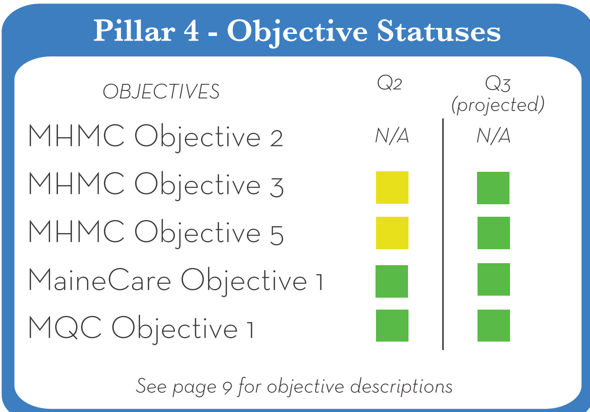
Over the last two years, MaineCare has been steadily building out its Accountable Communities (AC) initiative, which seeks to reward provider organizations that are able to save money through improved care coordination with a share of the savings. This initiative continued on course over the last quarter, gaining participants and support capabilities. As of March, 36 primary care practices had joined the AC initiative, increasing the number of patients being cared for to 45,000. Additionally, participating practices are now connecting to an online portal where they can get data on their patients' utilization of services and how well they are hitting performance targets, such as reductions in inpatient readmissions and non-emergent Emergency Department use. The Office of MaineCare Services and Muskie are working together to strengthen these reports and calculate total savings that have been realized during the first year of the work.

Another strategy that holds promise for controlling the cost of health care is Value-Based Insurance Design (VBID), which encourages the use of high-value services through lower or waived out-of-pocket costs to the patient, while increasing patients' financial responsibility for services that have

shown little clinical value. Under SIM, the MHMC has been working to build a standardized VBID model and to promote its use, and this past quarter, they focused much of that work on exploring strategies for shared decision-making, which incentivizes providers to have conversations with their patients about treatment options. It has been shown to lead to patients voluntarily opting for less costly, more effective treatment choices.

In March, the MHMC invited staff from Engaged Public, an organization that works to bridge the gap between people and the policies that impact their lives, to discuss the work that they have been doing to implement shared decision-making in Colorado. The purpose of the presentation was to inform the VBID workgroup about the particulars of shared decision-making implementation, and presenters shared challenges and successes they've had in their work.

After hearing the presentation, members of the VBID workgroup decided to proceed with developing a shared decision-making process, and they will be seeking pilot sites in which to test it.



Pillar 4 - Objective Statuses

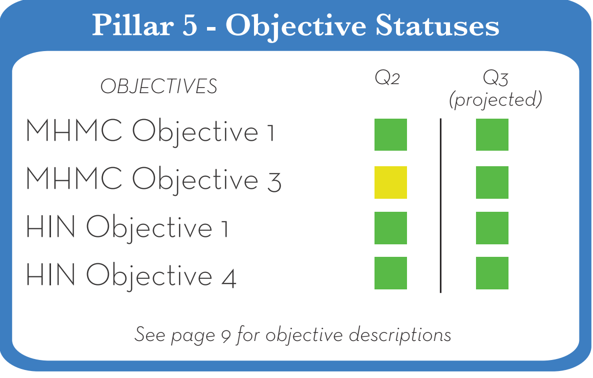
OBJECTIVES	Q2	Q3 (projected)
MHMC Objective 2	N/A	N/A
MHMC Objective 3	[yellow]	[green]
MHMC Objective 5	[yellow]	[green]
MaineCare Objective 1	[green]	[green]
MQC Objective 1	[green]	[green]

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.

Data and analysis underpin much of the SIM work around the state, but one particular project that took a significant step forward this quarter is the MHMC's work to publicly report health care quality information. The belief is that what gets measured gets improved, so the MHMC has been working to expand the number and type of services it publishes quality ratings for on its consumer website, www.getbettermaine.org. Over the last quarter, the MHMC finalized ratings and displays for gynecology, obstetric, oncology, and orthopedic practices. The addition of these specialties greatly expands the scope of the MHMC's public reporting efforts, and it represents a significant step forward in their work to make health care quality more transparent for consumers. The ratings will be published on www.getbettermaine.org on April 1st and they will be updated on a quarterly basis.



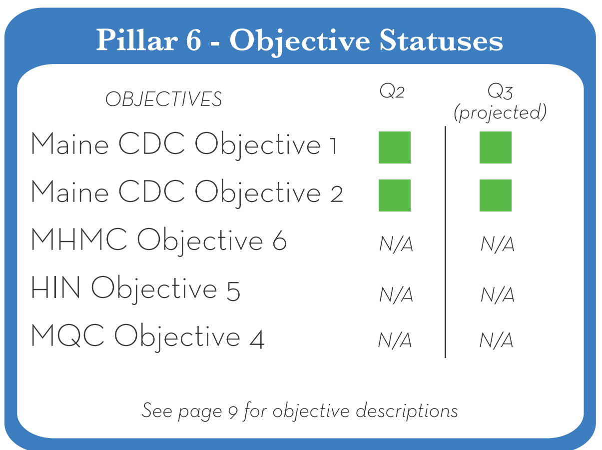
PILLAR 6: Engage People & Communities

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.

Engaging the people and communities that receive health care services is a key part of SIM work, and one of the key initiatives to accomplish this is the National Diabetes Prevention Program (NDPP). The evidence-based program promotes lifestyle changes that focus on the prevention of Type 2 diabetes. It has been proven to help people at high risk for Type 2 diabetes prevent or significantly delay the disease by making modest lifestyle changes.

The Maine CDC and SIM grant partners are working with payers to test how this program can improve health outcomes and reduce healthcare costs when applied to VBID, Patient- Centered Medical Homes, and ACOs. This work involves getting the NDPP program covered by health plans, so much of the Maine CDC's work in the last quarter has focused on defining and promoting the program to commercial health plans. The Maine CDC has been working with the national CDC and Dr. Ann Albright on payment mechanisms for NDPP, and on risk mitigation strategies for the program.

One particular success in the NDPP work is the March 23rd announcement that the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services will begin coverage for NDPP service delivery to all eligible Medicare enrollees starting in 2017. This is a major success for the NDPP program, and an encouraging sign that SIM work will continue even after the grant ends later this year.



SIM STATUS AT A GLANCE