SIM

HEALTHCARE SYSTEM TRANSFORMATION

A Collaborative Partnership led by Maine DHHS

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

SIM Steering Committee

Wednesday, January 18, 2017
9:00am-12:00pm
MaineGeneral
Conference Room 3

Attendance:
Kristine Ossenfort, Anthem (via phone)
Eric Steele, MD, Maine Quality Counts
Dale Hamilton, Executive Director, Community Health and Counseling Services (via phone)
Shaun Alfreds, COO, HIN (via phone)
Jack Comart, Maine Equal Justice Partners
Jay Yoe, PhD, DHHS, Continuous Quality Improvement
Noah Nesin, MD
Katie Fullam Harris, VP, Gov. and Emp. Relations, MaineHealth
Penny Townsend, Wellness Manager, Cianbro
Sara Sylvester, Administrator, Genesis Healthcare Oak Grove
Rhonda Selvin, APRN (via phone)

Interested Parties:
Lisa Tuttle, Maine Quality Counts
Lisa Nolan, MHMC
Kathryn Pelletreau
Nick Kamenos, DHHS
Lise Tancrede (via phone)
Katie Sendze (via phone)
Chris Menschner
Deborah Kozick
Nate Morse, CDC

Absence:
Mary Pryblo, St. Joseph's Hospital
Stefanie Nadeau, Director, OMS/DHHS
Michael DeLorenzo, CEO, MHMC
Fran Jensen, CMMI

Deb Wigand, DHHS, Maine CDC
Rose Strout

All meeting documents available at: 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* Minutes were adopted as presented.	
2- SIM Evaluation Results	*Objective: Review SIM final evaluation results* Jay began reviewing the SIM Evaluation PowerPoint. He said the annual report should be posted within the week to the SIM website. He reviewed the three study components: Implementation, Service Use/Cost Effectiveness, and Impact Study. Clarified that most of the focus was on MaineCare interventions. He reviewed the characteristics of the members served in the various MaineCare interventions. Highlighted that BHH members have significantly higher risk scores, and more likely to have several chronic conditions and having PTSD. He demonstrated the comparison between intervention participants vs the control group, and reviewed the data. A discussion regarding which analysis were statistically significant occurred. It was noted that Maine has lower rates of readmissions compared to national data, and large decreases should not be expected. HbA1c screenings decreased for both control and HH members, which is something that the fourth year of SIM is working to impact with DFLC. There was discussion around framing things more positively, especially for BHHs since the intervention involves social workers that are experiencing a culture change. Jay also said he did not include FCI in the presentation but there was significant improvement in FCI scores. Cost avoidance was found for the Health Home members. More detail can be found in the full evaluation report. Jay reviewed the comparison between BHH members and the control group. He said it was a smaller sample size, harder to get statistically significant data. The intervention needs more time to establish itself, but there are positive trends emerging. Jay reported no negative cost avoidance due to the increase in the PMPM for BHHs. He briefly reviewed	Jay will look into national readmission rates, specifically which diagnoses are associated with readmissions and send information to Gloria to send out to the Steering Committee. Gloria will draft a TA request around residential care and hospitalizations and will send to the Steering Committee.

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	the results of the consumer and provider surveys, generally positive. Jay reviewed areas for improvement. There was discussion about addressing issues with residential services. There is significant room for improvement regarding residential care for people with mental health diagnoses. Dale stated the importance of examining the social determinants of health, i.e. housing and stable housing, taking into consideration gaps. Jay agreed. Amy asked if Jay could take a look at the national average for readmissions, and send to Gloria to send out to the group. Gloria said that they could ask SIM TA on looking deeper into the issues of residential care, hospitalizations. Gloria will draft a request for TA on this topic and send to the committee for revisions. Amy stated she couldn't understand why they aren't seeing real impact in readmissions. Dr. Nesin said if they are already low, it's hard to impact; sick people go to the hospital and care coordination is still a challenge. It was suggested that which diagnoses are associated with readmission be examined. It was also stated that a lot of the most effective interventions are not reimbursed. Amy asked for any thoughts people here might have on embedding CCTs within the Health Home practices, if that would be helpful for coordination issues. She also suggested that that it be part of the MPOC proposal. Dr. Nesin asked that they look at data for the effectiveness of PCHC CCT on their own patients verse patients at St. Joes. Dr. Steele suggested that there need to be more discussion around some of the Evaluation charts as several are not statistically significant.	
3- MPOC Update	*Objective: Review current status and next steps* Amy said a small group met to create a proposal, shared with the full MPOC group a couple weeks ago. She shared some of the components of the proposal. Group is interested in functional metrics and working within structures that CMMI has laid out, but don't want to be limited to the confines of a CPC+ box. There was the idea of having a waiver of CFR 42 for this population. It was stated that the new rule did not have any helpful changes, but if they want to impact substance abuse, etc. they need consumer	

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	voices to advocate for it at the table. There was a discussion about the difficulties around getting clinical data for metrics. They are also thinking of proposing a very small pilot that would use a bundled rate. Nothing has been finalized, but interest in identifying practices with high concentration of a specific population. There is not consensus around doing that yet. She also said she would like them also start thinking about adding I/DD population into that proposal. Dr. Steele pointed out that they should really get honest, comprehensive feedback from the various stakeholders before they move forward on adding many other components to the plan.	
4- Predictive Analytics Pilot Update	*Objective: Review SIM Core Evaluation Dashboard with Steering Committee; Q&A* Shaun said they are working closely with DHHS to merge claims data with the clinical data they house, and they are using that merged data to calculate risk scores, they are working with St. Joes on this. St. Joes is seeing significant impact on readmissions, and ED utilization/inappropriate ED use. Care management staff in three different sites are participating in this pilot: Katahdin Valley, Mid Coast Hospital, and HomeTown Health Care. They needed robust data, at least 12 months look back of their data. They also worked with MaineCare to look at the ED visits for these practices. They needed practices that already had care management staffing in place. HIN is working to help implement the tools into their work flow. Education has started and data connections are in place, will be using claims and clinical data to measure impact. Dr. Steele asked about the results from St. Joes that looked promising. Shaun said they have been working with them since 2013 on using the risk models. They have now launched several different risk models, and several peer reviewed articles. He explained the different risk models that have been deployed, both in the HIE but also have a separate portal or view that allows practice to look at broad population and be able to look at them from many different perspectives and be able to drill down to see individual risk scores. St. Joes has done their own analytics on impact of these tools on things like cost avoidance and readmissions. They recently did a case study on 6 month pre and post interventions and they realized some significant impacts on the measures. They are working closely with HIN in SIM Year 4, to help the three practices embed those tools in their workflow. Dr. Steele pointed out that five years ago this type of project would not be possible, without the foundation that was created through investment by the State, systems, etc.: EMRs and meaningful use, data and data analytics, care managers, workflow engineering, care givers who manage their panel with Triple Aim vision, practices acting in concert on population	

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	management with mental health and hospital, and the HIE. He said when there are people in the legislature or the Commissioner's office that are questioning the amount of money put into all this work; this type of project is the result of the foundation created by that funding.	
5- Trauma Informed Care	*Objective: Key Ingredients for Implementing Trauma-Informed Approaches to Care* Chris Menschner discussed the 3.5 year Trauma Informed Care (TIC) initiative with Robert Wood Johnson foundation. He went over the objective and the components of the initiative. He gave an overview of where the TIC started, referencing a 1998 study that 17,000 Kaiser members took an ACE Survey, and they found that 2/3 of respondents had experienced one or more of ACES. He then discussed a study in 2012, that included a racially diverse sample of men and women, the Urban study had 83% had at least experienced one ACES. He explained that an ACE score of 4 or more was a tipping point and went over higher risk factors for things like having hepatitis, using injectable street drugs, etc. The idea was that the total lifetime estimated costs associated with one year of child maltreatment was very high. He demonstrated the impact of ACES on health and behavior, and on Neurobiology. He went through the Core Principles of the Trauma Informed Approach, and then went into more detail around the organizational and clinical key ingredients for implementing the TI Approach. He offered some opportunities to advance the field of TIC. He reviewed the implementation analysis findings; the challenges and barriers faced by the grantees. Rhonda thanked Chris for his presentation and commented that this needs to be addressed and it's the core of almost all of their problems, links to provider fatigue and other issues. Dr. Steele asked about the approach, it was very thoughtful getting that embedded programmatically there are a lot of barriers to it. He said that there was a 30% reduction in ED visits, sustained over a substantial period of time due to just asking questions about trauma, even if not built out perfectly, but being able to just identify patients and help change how they are cared for. Asked for a good first step… Chris said it's something they are working on now, a brief on a light-lift TIC, there are some early stage approaches that are key. For example: educating staff on trauma, a basic screening of patients and educating them on impact of trauma on their health, which would be beneficial to both staff and patients. Jack asked if they should be screening everyone, Chris gave the example of the Camden Coalition for Health, they don't screen, and instead use Trauma Informed Approach for all their patients. He said that the consensus is that there should be universal screening	

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	but there is a debate on whether to screen much older adults. Rhonda made a case for screening the older population. Jack asked if there were validated assessment tools for patients. Chris said the ACES screening tool is the most common. Center for Youth Wellness has developed their own tool, which is in the process of being validated. Chris said a number of pilot sites have experienced some resistance from primary care providers and doing the screening. Some feel that this is outside of their job description. Gloria will send out information that they receive to the Steering Committee.	
6- Public Comment	No public comment	

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