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|  | ***SIM Steering Committee***  ***Wednesday, January 27, 2016***  ***9:00am-12:00pm***  ***MaineGeneral***  ***Conference Room 2*** |

**Attendance:**

Jay Yoe, PhD, DHHS – Continuous Quality Improvement

Deb Wigand, DHHS – Maine CDC

Rhonda Selvin, APRN

Sara Sylvester, Administrator, Genesis Healthcare Oak Grove Center

Rose Strout, MaineCare Member

Kristine Ossenfort, Anthem

Katie Fullam Harris, VP, Gov. and Emp. Relations, MaineHealth

Dale Hamilton, Executive Director, Community Health and Counseling Services (via phone)

Lisa Letourneau, MD, Maine Quality Counts

Randy Chenard, SIM Program Director

Stefanie Nadeau, Director, OMS/DHHS

Mary Pryblo, St. Joseph’s Hospital

Andrew Webber, CEO, MHMC

Jack Comart, Maine Equal Justice Partners

Shaun Alfreds, COO, HIN

**Interested Parties:**

Lisa Tuttle, Maine Quality Counts

Lisa Nolan, MHMC

James Leonard, OMS

Kathy Woods, Lewin

Kathryn Pelletreau, MAHP (via phone)

Judiann Smith, Hanley

Lisa Harvey-McPherson, EMHS

Lyndsay Sanborn, MHMC

Liz Miller, Maine Quality Counts

Ashley Soule, Maine Quality Counts

Lorrie Marquis, MHMC

Robin Allen, MHMC

**Absence:**

Lynn Duby, CEO, Crisis and Counseling Centers (retired)

Eric Cioppa, Superintendent, Bureau of Insurance

Penny Townsend, Wellness Manager, Cianbro- excused

Noah Nesin, MD

Fran Jensen, CMMI

**All meeting documents available at:** [**http://www.maine.gov/dhhs/oms/sim/steering/index.shtml**](http://www.maine.gov/dhhs/oms/sim/steering/index.shtml)

| **Agenda** | **Discussion/Decisions** | **Next Steps** |
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| **1-Welcome – Minutes Review and Acceptance** | *Approve Steering Committee minutes from September Steering Committee meeting*  Meeting minutes approved. |  |
|  | Randy gave an overview of the SORT review process. He explained that the next step is making adjustments based on the decisions that came out of this process. The MLT has looked at SIM Core Measures and finalized the areas for a sharpened focus for the remainder of SIM. They are will be looking to the Steering Committee for guidance on how to put more effort into these new focus areas. Randy displayed the SIM Priority Assessment Grid, which highlighted the Diabetic Care and Fragmented Care Index measures and explained that those two are going to be focus areas, and the MLT is looking for all objectives to be focused on improving outcomes in those two areas.  There was discussion around what the Fragmented Care Index actually is, what the definition is for that measure.  Jay explained that it is based on the number for primary care visits across different primary care providers that a member sees. He said that they will send around the definition again to the Steering Committee members. Jay recommended focusing mostly on improving this measure for the behavioral health population, where they tend to see a much higher score than in other intervention populations, but SIM leadership will be looking for guidance around how to focus on the different interventions.  Sara Sylvester brought up concerns about the Long Term Care population and capturing their true fragmentation of care, including specialists and hospital visits.  Deb asked if the measure only focused on PCP visits and did not take into account the specialists. That question was then followed up with a question on whether or not behavioral health services were included, since the behavioral health population had a higher score.  Jay answered that the measurement just included PCP visits, and that members with behavioral health issues have a higher FCI because they are not being hooked up with PCPs.  It was pointed out that impacting this measure would be a struggle due to laws preventing the easy sharing of behavioral health information. It was stated that this may be an opportunity for the Department to help providers break down some of those legal barriers.  It was also stated that Maine tends to have more data available than most states and should be looking at the FCI measure differently than as it’s defined by the NCQA. There should be more discussion about the data sources available and what actual data is available.  Jay cautioned that if they were to come up with a homegrown measure, then it would not be validated, but that this topic merits further discussion.  It was pointed out that there is a difference between the quality measure and actually measuring how FCI impacts care, and that may actually be more valuable to know.  Jay agreed that there is a need for a more comprehensive FCI, and said he would send around an article from which the current measure was adopted.  One of the SIM partners tried to clarify what they were supposed to accomplish moving forward, and asked since these are now the highlighted focus areas of SIM until the grant ends the partners are expected to tweak all of the work they are doing to focus on those two measures  Randy explained that was the expectation for the objectives for which it had been decided through the SORT process that there needed to be a sharpened focus in year three.  It was then pointed out by a SIM partner that refocusing the objectives was going to be a lot of work and would take some time to accomplish, to which Randy responded that it the point was understood.  It was then asked if there was a thought about cost and likelihood in terms of impacting cost, there would be a need for individual practice level data and providing that in a real time way.  Shaun said that HIN has built notifications of Hba1C and are looking for a partner to test it that functionality with.  It was pointed out that the functionality wouldn’t actually get to the specific SIM diabetes measure.  Randy explained that the intent is to realign resources to these two measures. How they go about doing that is all open to discussion. If there is a current gap then that should be identified, so that SIM look at investments to close that gap. They will be forming the workgroups to tackle these discussions.  It was repeated that they will need practice level data in a timely manner so that it can be understood which practices and organizations are struggling with these two measures and can then target TA efforts on them.  Jay said that they are getting feeds coming in from Lewin, so that would be possible but they would need to put some more resources into that work.  It was asked that if the FCI focuses entirely on Primary Care visits, how they are planning to focus on behavioral health.  Jay again explained that he recommended they focus on SMI population under Behavioral Health Homes, as it is a group which has multiple chronic conditions complicated by inconsistent Primary Care connections; many get kicked out of practices for behaviors or missing appointments. They should be focused on improving that connection.  Sara pointed out that they should be looking at anyone with behavioral health diagnosis, and gave the example of someone who is eighty years old and in Long Term Care; there isn’t anyone that comes to the LTC facility. That person gets sent to the hospital and then is sent back to the facility haven been given Haldol five times and they sleep for a week. SIM should focus on creating better access to behavioral health resources.  Randy acknowledged the concern and the fact that there are lots of needs across the healthcare system, but explained that right now SIM is trying to focus on areas that would be impactful and has data available to support measuring the improvements. SIM started advancing on all fronts, and is now narrowing the focus based on what has been learned over the past two years.  It was also clarified by Stefanie that these aren’t the only areas to be focused on, but the MLT would like to see more emphasis on these two areas. |  |
| **2- SIM Objective Review Maine CDC Report Back** | *Objective: Report back regarding SORT recommendations*  Deb presented on a chart included in the packet, which demonstrates how the CDC will be integrating recommendations made by the Steering Committee and SORT into their work through the rest of SIM.  Conversation:  It was asked if for the CHW pilot they are going to be review on sustainability strategies. CHWs have mostly been funded across the country through grants, though a couple states are paying for that service through Medicaid.  Deb said she agrees that sustainability is an issue for this pilot, after they have analyzed the survey results, they will have more information around the benefits of this service. She did ask that if anyone has more suggestions to please let her know. They are taking this to the Payment Reform subcommittee, but are looking for more avenues for sustaining this in the future.  It was pointed out that as things progress in discussions around alternative payment models, part of the discussion can focus on how to incorporate the CHWs within them.  Deb thanked the Steering Committee and said they are willing to come back with more updates as asked. | Deb will bring the sustainability of the CHW pilot to the Payment Reform subcommittee. |
| **3- SIM Objective Review – Quality Counts Report Back** | *Objective: Report back regarding SORT recommendations*  Dr. Letourneau and her team came to present on key elements that they do in supporting the HHs and the BHHs, and are looking for input from the Steering Committee on current activities and ideas for sharpening focus. She explained that they had understood that they were to focus on the avoidable readmissions measure based on conversations with MaineCare, so the activities for this last year had that focus. She also spoke about the memo that is included in the packet that explains how they have organized the learning collaborative activities and other background information. They also brought the draft of the learning session agendas.  Ashley Soule and Liz Miller walked through the QC PowerPoint and explained the purpose of the learning collaboratives, what they are, and what they include. Explained the difference between the learning sessions and the overall learning collaborative. They also explained expectations for involvement from the organizations and how the providers’ input helps to focus Learning Collaborative activities.  They then presented the agendas for the February learning sessions for both PCMH/HH and the BHH one. Ashley said that people really wanted some multi-tiered learning opportunities based on where the practices are in transformation. QC then split the breakout sessions into two tracks; one for beginners, and one for those who have already achieved full implementation of the core standards.  It was asked if there are specific barriers they have come across for practices to fully implement best practices.  Dr. Letourneau said it came down to time, because of the fee-for-service model constraints.  Ashley also pointed out that there is a lot of staff turnover, and having to constantly be training new people is a barrier.  Liz presented the BHH agenda and explained that the focus is on integration with primary care, based on feedback from previous learning sessions were that the BHHs would like to have more time with PC practices. She said they have a workshop scheduled in the morning with their primary care partners, who have been invited to participate from 8-1pm; it is designed to start conversations between BHH and HH partners. She is finalizing the keynote speaker, which will be someone within the behavioral healthcare system in Maine. She said that the BHH Learning Collaborative has also focused on readmissions based on conversations with MaineCare.  They shared what is coming up for June and September, which both have a general focus on greater integration between BHH and HHs and they are planning to have both be combined learning sessions.  Lisa Tuttle said she wanted to highlight the MaineCare involvement in planning for both BHH and HH learning sessions.  Dr. Letourneau said that the results from SIM evaluation have been helpful in guiding focus, and they are eager to figure out how to bring about a stronger focus on these two identified measures.  Katie Fullam-Harris stated that the participants from MaineHealth that have participated in the learning collaborative activities have had positive things to say about them.  Randy asked Quality Counts how much advanced notice they need in order to get an increased focus on diabetes in the June learning session agenda.  Ashley said they will need to know as soon as possible because they begin planning for the June session right after the February one.  Dr. Letourneau offered that they can include some information in the June learning session without making it the entire focus. She said they would need to get some practice specific data in order to better tailor content and audience.  Shaun said that one of the challenges they have in the data world is attribution. He said that they see 90% of all lab results and wanted to get lists of members from the practices.  Katie Fullam-Harris agreed that attribution is one of the most complicating factors, that just because patients are assigned doesn’t mean they are actually going.  Shaun said that if they are going to start using data, they need to come up with some agreements with how they are going to use that data, and leverage some methodologies that does this give some idea of the trend.  Dr. Letourneau said that this could be positive process as long as everyone understands that the data is imperfect.  Jim Leonard said that the Steering Committee should really look at reconstituting the Data Infrastructure subcommittee with this new focus. Jim suggested that he and Shaun begin organizing this subcommittee and its membership and then have a monthly report back. He said for this type of conversation they would need a membership that is familiar with how practices are being measured today. They will want to provide data this is helpful, they don’t want people just focused on arguing about the data.  It was stated that they need to include behavioral health providers in that subcommittee; data does not flow as well to or from behavioral health providers, and they want to be getting the same data.  Randy asked if there was consensus around reinstituting the Data Infrastructure subcommittee, the Steering Committee did reach consensus on that.  Stefanie asked Quality Counts to back the general direction that they plan to go in for the June learning sessions to the February meeting.  It was asked if QC been thinking about sustainability of this work beyond SIM, whether there is a business model to support some of this work.  Dr. Letourneau said that the big development was securing the Co-op agreement with CMMI to provide similar support for practices that aren’t including in Medicare ACOs. Gap is for SIM and MaineCare and what are the remaining needs for the HHPs and BHHOs that aren’t in Medicare ACOs. MaineHealth has their own learning activities, but other major systems don’t have formalized educational opportunities. She said the other big piece is that many practices participate in this with financial benefit, soon the MAPCP will end and they have to consider what will happen at that point.  Randy said that the MLT was also looking for models of sustainability for SIM objectives and are looking to the Steering Committee to make recommendations. | Quality Counts will bring back their plans for addressing the new focus areas in the June and October Learning Sessions to the February Steering Committee meeting.  Jim will provide an update on the creation of a redesigned DI subcommittee. |
| **4 -** **SIM Objective Review – MHMC Report Back**   |  | | --- | |  | | |  | | --- | | *Objective: Report back regarding SORT recommendations* | | Lisa Nolan started with presenting on the handout prepared to explain where they are heading for the next year across their objectives. The Coalition had been asked for work plans with sharpened focus, and based on that request they developed this document to explain further. | |  |   It was determined by the Steering Committee that the information contained on the handout around Objective One and MHMC’s data vetting process answered the questions that the Steering Committee previously had.  Lisa gave an overview of the second objective, including the Steering Committee concerns and recommendations, and Robin Allen provided additional information about the VBID group and the different conversations they have had. Andy said that there has been some good work done by plans and employers moving in the direction of adopting some of the elements of VBID; that across the board insurers and employers have adopted simple elements, but they need to push beyond that. He explained that part of the VBID concept is to incentivize consumers to high quality services and providers. Employers have started to do that, and health plans are starting to tier networks, which is a necessary compliment to payment reform, the right coverage and information to consumers to select appropriate services.  Shaun stated that healthcare is a business across the board with a lot of competition, and asked if data will be made available to make better plan and coverage decisions.  Andy said that there has been good research that demonstrates that benefit design leads to greater quality and reduced cost, and they can begin to look at and track impact of VBID overtime.  Dr. Letourneau pointed out that they can try to tie the new focus measures to VBID, that it can reduce fragmentation of care, and include the elements of diabetes care.  Kris asked about the last bullet on work plan, pointing out the timeframe on the development of template is for August, and wondered what they planned to report on in September.  Andy said that at some point they want to follow up with healthcare plans and purchasers and ask about adoption, and find out how they are using VBID.  Kris pointed out that they are filing their plans for 2018 in advance to get approved by CMS for the Exchange this May or June.  Andy said it was important for everyone to understand that adoption is a couple years down the road.  Lisa reviewed the revised work plan for Hypothesis E.  Randy asked her thoughts around how those activities under Hypothesis E relate to the new focus areas.  Lisa said that the whole idea of the measure set was to bring semblance of sanity to the amount of measures providers are responsible for, and said that they can look at adding a few different diabetes measures to the list and that can be part of a discussion.  Andy said that ACO contracting is marching along and as negotiations occur across payers they need greater consistency around the core measures across the payers.  Katie Fullam-Harris said that the first body of work is well done and the set should be evaluated for updates periodically, but she has a lot of questions about value of benchmarking. All ACO entities are collecting this information, and she does not understand the benchmarking work when clinical benchmarks are already set and based on science.  Lisa Nolan said there is a value of looking at a statewide benchmark.  Katie stated that they aren’t looking at benchmarks themselves, the benchmarks are stated in contracts.  Lisa then pointed out that this would add a state benchmark to compare the systems’ data to, but your questions are valid and that is why we are looking at doing a pilot to see if it adds value.  Randy said that the recommendation from MLT was to look at the work and see how it can impact the focus areas. He asked for the Coalition to bring back a more refined work plan on how they plan to accomplish that.  Lisa started presenting inform on BH PTE.  Lorrie came to speak to the BH PTE Steering Committee activities. She explained that they were previously trying to elevate all boats. She said that as they have been paying attention, they have seen better focus from practices and systems to get behavioral health members connected to primary care. The BH PTE Steering Committee has tended to move away from focuses just on the BHH/MaineCare population. They have been working hand in hand with behavioral providers. If the new direction is to move toward reducing fragmentation, the committee can look at address barriers to accomplishing that from the behavioral health perspective. She said that one of the current focus areas is identifying a case management public reporting measure which does fit very well with the FCI. She will bring all this back to the PTE BH Steering Committee and find out how they can get to a better focus. She said they will need to think more about how they can incorporate diabetes into their work. She pointed out that on the PTE primary care side, they already address diabetes. She will come back with a revised work plan February on how they can incorporate these new focus areas.  Lisa began presenting on practice reports and the work plan they developed for this coming year. She said do already include nephrology screening, eye exams, and Hba1c tests. In terms of fragmentation, they can go back and look at what might be available for additional measures. They will also bring this back in February meeting to with more detail around the focus areas.  Stefanie asked how they have been receiving feedback from providers.  Lisa said that some of it is ad hoc-based conversations, but they look for any opportunity to discuss utility with providers.  Andy said that they have a new data director that has begun meeting with large systems leaderships about what data needs are and how these reports do or don’t meet those needs, and how these can be sustained in the future. Also met with Jim Leonard who gave some great feedback including connecting with the Learning Collaborative activities through MQC.  Katie said she still thinks that the PTE physicians group is the most logical place to have a conversation around these reports, and have an understanding around broader policies.  Andy explained that the PTE group has a clear mandate to vet measures for public reporting, and that most of the information in the practice reports are not public. He said that the Board would have to rethink PTE charge, because that would broaden their focus. PTE is a forum where a lot of practices and providers come together.  Katie said that they could think about having the conversation because it’s the right group to get feedback from, but they don’t necessarily need to make it a formal charge.  Randy asked for them to bring back in February more information about practice reports and the TA piece, once they have had time to collaborate with other SIM partners.  Andy said that they met with Dr. Letourneau’s staff and they have a piece on the learning session agenda around using practice reports.  It was decided, based on comments and questions around the Fragmented Care Index, that there should be a special session for Steering Committee members and interested parties by Lewin and Jay to get more in depth into the Fragmented Care Index. Randy said he would organize this as soon as possible. | The Coalition will return in February with refined work plans for their objectives that in include plans to address the new focus areas.  Randy will set up a special session for Lewin and Jay to give an in-depth presentation on the Fragmented Care Index. |
| **6- Public Comment** | *Discuss health resource infrastructure review process*  Lisa Harvey- I can say for Beacon health those contracts are negotiated, we would not find any value in the work for benchmarking measure set. I would question further SIM investment in an activity that the two largest health systems have said it doesn’t have any value. |  |

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