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|  | ***SIM Steering Committee***  ***Wednesday, March 25, 2015***  ***9:00am-12:00pm***  ***Bank of Maine Ice Vault, Augusta***  ***Conference Room*** |

**Attendance:**

Noah Nesin, MD (via phone)

Jay Yoe, PhD, DHHS – Continuous Quality Improvement

Randy Chenard, SIM Program Director

Dr. Kevin Flanigan, Medical Director, DHHS

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

Kristine Ossenfort, Anthem (via phone)

Shaun Alfreds, COO, HIN

Dale Hamilton, Executive Director, Community Health and Counseling Services

Penny Townsend, Wellness Manager, Cianbro

Sara Sylvester, Administrator, Genesis Healthcare Oak Grove Center

Rose Strout, MaineCare Member

Mary Pryblo, St. Joseph Hospital-via phone

Fran Jensen, CMMI- via phone

**Interested Parties:**

Amy Dix, OMS

Katie Sendze- HIN

Lisa Tuttle- Maine Quality Counts

Frank Johnson, MHMC

Lisa Nolan, MHMC

David Winslow, MHA

James Leonard, OMS

Jim Harner, Hanley

Peter Kraut, OMS

Kathy Woods, Lewin

Lyndsay Sanborn, MHMC

Kathryn Pelletreau, MAHP

Lisa Nolan, MHMC

Karynlee Harrington, MHDO

**Absence:**

Stefanie Nadeau, Director, OMS/DHHS

Lynn Duby, CEO, Crisis and Counseling Centers

Eric Cioppa, Superintendent, Bureau of Insurance

Deb Wigand, DHHS – Maine CDC- excused

Lisa Letourneau, MD, Maine Quality Counts- excused

Andrew Webber, CEO, MHMC- excused

Jack Comart, Maine Equal Justice Partners- excused

Rhonda Selvin, APRN (Medical Leave)

**All meeting documents available at: <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** | *Objective: Approve Steering Committee minutes from February Steering Committee meeting*  No comments on the minutes. Minutes accepted. |  |
| **2 – MHMC Changes** | *Objective: Transition plan post departure of Ellen Schneiter*  Ellen Schneiter has gone to work at NASHP. Currently, Lisa Nolan will be taking on many of Ellen’s responsibilities, along with Lyndsay Sanborn, while a replacement is sought. |  |
| **3- Leadership Development Program Update** | *Objective: SIM Leadership Development Program*  Jim Harner discussed the Hanley Center’s Program Overview document. A key piece is to engage key healthcare stakeholders to develop a shared vision and strategic plan for developing leadership skills necessary. They plan to provide one or more leadership development opportunities for healthcare teams focused on supporting successful change management. They will also work on developing a plan to spread that training to other teams across the state. They will be putting a survey together to allow healthcare workers the chance to identify the biggest gaps to change. They have created a Program Advisory Committee.  CEO Leadership Visioning Forum is tentatively scheduled for June 2. Plan to bring in a nationally recognized speaker, Derek Feeley. Plan to engage a broad spectrum of healthcare sectors, MH, Physical Health, LTSS, Home Health, etc.  Will be looking to engage consumers.  Jim will stepping down from Hanley Center and will be replaced by Judiann Smith this spring. They plan to provide quarterly updates to Steering Committee. | Hanley will be updating Steering Committee on a quarterly basis. |
| **4- Data Infrastructure Subcommittee Charge** | *Objective: Review draft Data Infrastructure subcommittee charge and approve or recommend changes*  Over a year into SIM work there is a need to look at progress, direction, and what changes need to be made, what’s struggling, etc. Payment Reform and Delivery System Reform subcommittees are pleased with participation and work they are putting forward. DIS has evaluated their own member engagement and challenges they face.  Katie Sendze reported that DIS hasn’t met formally since November meeting, partly due to annual meeting dates moving around and scheduling issues. In addition, lack of agenda items coming forward. HIN projects were advised upon and watched and implemented by the subcommittee, but there is not enough SIM objectives to warrant in-person meetings. Trying to figure out best way to use participants’ time. SIM partners had discussion on utilizing DIS if there are topics coming out of other subcommittees and those subcommittees need help figuring out how to operationalize these, or working through challenges that have DI component. Foresee some of the projects would go back to DIS to go over evaluation, but not an ongoing need. Reviewed handout that discussed what they would like to put into place, with description of mission.  Fran wants to make sure they leverage Hunt Blair and his expertise, figure out how subcommittee and interface better with SIM work. Katie said that ONC is brought into the discussions frequently and they will continue to access that TA component.  Dr. Flanigan explained that the change will be that DIS will be more of a supportive structure for the other subcommittees.  It was stated that DIS should also have a discussion about barriers to data-sharing.  Consensus was given to accepting the new direction of the Data Infrastructure subcommittee. |  |
| **5 – Steering Committee Approval of Total Cost of Care for Public Reporting Through SIM** | *Objective: Ask Steering Committee to approve PR recommendation regarding the Total Cost of Care Calculation and approval for SIM to publically report*  Last meeting weren’t able to come to consensus because this calculation was still being internally tweaked in the Coalition.  Frank gave a brief synopsis of the history of this measure. Due to unexpected variability of the calculation, requires fairly constant $1/unit. When looking at risk ratio for individual patients the calculation was far more variable that anticipated. Developed a solution, with a slightly modified process, remove patients with extreme risk ratios, top and bottom 5%, and to use a 2 year period instead of 12 months. Will continue to use ‘12/’13 data as a start point and will refresh with new data in 6 months. Real sensitivity to making sure that Maine is as closely aligned to other markets but also taking into consideration the provider and consumer population in Maine. Wanted to make sure data was as accurate as possible. PTE endorsed these tweaks right after the February Steering Committee meeting. TCOC is one calculation, a reportable number and used for Total Cost Index, and Resource Utilization Index calculations. Coalition is still helping practices to understand what the best use of this calculation is.  Can the Steering Committee come to consensus on this calculation, its use.  Nesin- How many months will reporting lag?  Frank- Not sure, probably about 6 months. July of this year, ‘12/’13 will be released and then will be refreshed with new data in six months, eventually they should have it down to 3-4 months.  Alfreds- using 24 months of data, how will this methodology impact use of the data by practices, how will it impact comparisons and benchmarks of other markets, a 24 month period isn’t able to capture adjustments that were made in  Pretty much what happens in all of public reporting for claims based data, fairly long time period. PTE vet measures, assign value and goes up on the website, purchaser decision how they use that information.  There was concern raised about reporting of this on the practice level, as it has not been demonstrated how that will look, though it has been demonstrated what reporting looks like at the practice site level and that was accepted by the Steering Committee. There was also concern around using 24 months of data and that it would be difficult to use as a comparator.  Steering Committee reached consensus to accept the calculation.  Consensus was reached for reports to be sent to the sites with this TCOC methodology.  There were concerns raised on the public reporting of the TCOC and what the different levels the Coalition planned to report at, practice site, practice level, system, etc.  Dr. Flanigan clarified that they are not trying to figure out how the internal reports will differ from the public reporting, the internal reports show benchmarks etc. compared to their peers. Public reporting will provide numeric value and translate to good, better, best for each site.  PTE has seen prototypes for this public reporting but design hasn’t been deciding upon yet.  Pending review of what a final reporting for public has been reviewed, Steering Committee won’t reach consensus on it today. There needs to be a discussion around how public can best make use of this information. Next meeting the Coalition will try to put together a one-pager that discusses the different groupings. Prototype for public reporting won’t be available by next meeting but will demonstrate once it is ready. | Next meeting the Coalition will provide a one-pager that explains the different planned groupings for public reporting. |
| **6- New risk identified by SIM Steering Committee** | *Objective: Gain consensus on appropriate articulation of risk identified at Feb Steering Committee re: budget risks to SIM*  At the last meeting there was a concern raised that the budget proposal from DHHS could have an impact on SIM grant work. Following proper protocol, if Steering Committee endorses risk, there is a need to figure out owner; this one was assigned to the Steering Committee. It was clarified that they must be looking only at the impact the proposed budget will have on **SIM** objectives. Dr Flanigan will escalate discussion points up to the MLT. There will need to also be a discussion about what may need to be done differently when considering impact.  Randy explained further that today the purpose isn’t to fill in Risk Log, it is to articulate what the Steering Committee believes the risk to be.  The following statements were made:  *~The proposed budget will shift dollars from certain providers to other providers, from behavioral health and hospital providers, to Nursing Facilities and ending the Waitlist. Thinking about SIM initiatives, desire to ensure that MaineCare is one of the key elements of recipients of SIM’s progress. There is a big issue of access when there are cuts to hospital providers; independent providers have to manage their panels carefully when it comes to accepting MaineCare members, budget proposal is to bring hospital providers down to same reimbursement rate and this will impact access., MaineHealth is participating in Accountable Communities, one of the few that have stepped up to participate and strongly supports the program. As a health system, we won’t be able to participate in that initiative if budget passes, all the investments into infrastructure and workforce takes to implement would be jeopardized if it passes. We are working hard to move to a system that uses data to meet the needs of broader populations, the data necessary is very expensive. Also, just as important, reductions of monies to behavioral health providers runs directly counter to achieving the triple aim.~*  ~*One of the pillars is the integration of primary care and mental health, that pillar will become just a statement with no meaning; that is the kind of impact that this budget will have. This needs to go to the MLT for them to understand the negative impact. Med management getting a rate reduction of 58%, community based providers will not provide it anymore, it is a serious disconnect, if we remove these types of services then we aren’t concerned about behavioral health, nor concerned about impact on people receiving these services. SIM will not be successful, and we might as well disband. Payment Reform is not accomplished by cutting money from behavioral health and hospital providers, people will go without services. This will impact goals, the pillars will have to change, we will have to remove behavioral health if you want to be honest.* ~  *~Primary care practices, hospital based and private practice, FQHCs , are paid differently. But idea behind this budget is not going to benefit people of Maine. Primary care wants reform but not at expense of other service systems, this will not be zero-sum game.~*  *~The state of Maine needs behavioral health appropriately funded, this is critical.~*  *~ The federal government hasn’t funded Behavioral Health as they do hospitals and primary care. Behavioral Health organizations aren’t able to afford data capacity and that is why we don’t have their data to go on. Antithetical to our goals and what we are doing here. HIN projects are getting data to MaineCare to make better decisions for their members, this budget impacts HIT projects. They won’t be able to afford the necessary data systems.~*  Dr. Flanigan informed the Steering Committee that information such as this is very well received by MLT. Provider input and information is helpful, but Steering Committee members can get in touch with their legislators and DHHS leadership and remain engaged. He summarized the comments and message to be carried to the MLT: 1.) Access specifically on physical health side can become a dramatic issue on systems, change in reimbursement schedule will have a major impact. 2. From an ACO perspective; the way the budget is proposed, it will be difficult for ACOs to complete implementation phase. They have agreed to participating in this MaineCare program, but that structure can’t maintain fiscal solvency. 3.) From Data Infrastructure standpoint; investments in HIE is a key part of this grant, but organizations won’t be able to afford to implement and participate in the HIE. 4.) Behavioral Health pillar will be just a statement and nothing more. The Steering Committee is concerned about leaving a shell of services. Dr. Flanigan will deliver message to MLT.  It was stated that when the budget decisions get made, the Steering Committee will need to revisit this discussion and figure out how SIM is impacted and what needs to be done.  Katie Fullam-Harris stated that MaineHealth along with the members of the Steering Committee strongly support desire to address waiting lists and NFs, but to do so will require new money and is critically important.  2.) We have started down a track of Value-Based Purchasing and we believe that is the future of health care and essential to achieving Triple Aim and the budget runs contrary to these efforts.  It was stated that even currently, MaineCare is paying providers 83% or 70% of cost which is not sustainable, and commercial side picks it up the cost. Behavioral Health almost entirely depends on Medicaid. All providers are now being squeezed. So it was summarized that even if nothing changed, still don’t have a sustainable model.  Payment Reform is well embraced by all sectors in healthcare system, but budget is contrary to shift to VBP. | Dr. Flanigan will bring Steering Committees concerns about the impact of the DHHS budget on SIM objectives to the MLT. |
| **7- Establishment of SIM Core Measure Targets** | *Objective: Jay to provide update to Steering Committee regarding upcoming ask in April from Steering Committee to determine target for SIM core measures*  Randy gave SIM Core Metrics and stated that executive update have been provided to theCommissioner, she directed Steering Committee to recommend core targets for each of these metrics. Lewin is creating the benchmarks right now, doing that analysis. The hope is to come to April meeting with a recommendation of targets. This important piece of work and the Commissioner is very interested in this. Randy just wanted to provide heads up that this will be coming to the Steering Committee will also look for input from Jay Yoe and Lewin how these will be calculated.  It was asked for there to be alignment with the plethora of data and analysis already being done. | Steering Committee will be presented with targets to the SIM Core Metrics once these are established. |
| **8- Risk or Issue Review /Identification** | *Objective: Standing agenda item- allocate time for Steering Committee members to identify risks or issue to SIM Risk and Issue Log*  No risks identified |  |
| **9- Public Comment** | Karynlee Harrington spoke about the work that the MHDO is currently engaged in, that could potentially be leveraged by SIM. She explained that the MHDO is the state entity that collects claims data from commercial, Medicare, Medicaid, and a lot of data from the hospitals. They also are tasked with the responsibility to publically report on that data. They are beginning to build a website that will integrate cost/quality data by insurer and practice site.  She also stated that she felt the MHDO should play a role in the Data Infrastructure subcommittee, whether as a member or even as a co-chair. Katie stated that DIS welcomed the participation of other data organizations. The DIS is the perfect forum to have the discussions on around different topics from both clinical and claims data sources. |  |