SIM

HEALTHCARE SYSTEM TRANSFORMATION

A Collaborative Partnership led by Maine DHHS

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

SIM Steering Committee

Wednesday, May 17, 2017
9:00am-12:00pm
MaineGeneral
Conference Room 2

Attendance:
Kristine Ossenfort, Anthem
Dale Hamilton, Executive Director, Community Health and Counseling Services (via phone)
Shaun Alfreds, COO, HIN
Noah Nesin MD, Vice President of Medical Affairs, Penobscot Community Health Center
Deb Wigand, DHHS, Maine CDC
Penny Townsend, Wellness Manager, Cianbro
Sara Sylvester, Administrator, Genesis Healthcare Oak Grove
Rhonda Selvin, APRN (via phone)
Amy MacMillan, MaineCare
Allison Watson, (Interim ED) Quality Counts (via phone)

Interested Parties:
Lisa Nolan, MHMC
Lise Tancrede (via phone)
Katie Sendze
Nate Morse, CDC
Sheryl Peavey, COO, CDC
Ken Albert, Androscoggin Homecare and Hospice
Angela Richards, Androscoggin Homecare and Hospice
Anne Connors, MaineGeneral
Vicki Foster, MaineGeneral
Elizabeth Mann (via phone)
Katherine Pelletreau, Maine Association of Health Plans

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

Fran Jensen, CMMI
Jack Comart, Maine Equal Justice Partners
Rose Strout
Katie Fullam Harris, VP, Gov. and Emp. Relations, MaineHealth

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* Gloria will send out completed minutes	
2- Advancing Population Health Metrics	*Objective: Begin discussion of adding public health measures to SIM Core measures.* Sheryl discussed the effort of incorporating Public Health into SIM and healthcare transformation. Healthcare transformation definitely needs to include public health partners, as they can support practice changes and relieve some of the burden off of clinicians. There needs to be a focus at a population level and not just the individual patient level. As an example interventions like the National Diabetes Prevention Program (NDPP) in helping to lower risk scores for a population. Also important to leverage the HIE in a population health view. Public Health partners can take what is occurring in our Primary Care and Behavioral Health practices and expand its promotion across communities. Public Health partners could use District Coordinating Councils to coordinate work and access multiple funding streams. Sheryl reviewed the various CDC data repositories as a handout. While the CDC is working to become more closely aligned with the HIE, there are data resources that are already available. Sheryl reviewed the Maine Tracking Network which allows individuals to look at very specific data – for example lead or Lyme disease, and allows a query by chart, graphs and mapping. Sheryl provided examples to utilize this resource- for example the correlation of lung cancer and higher rates of radon gas. Sheryl discussed the PRAMS data, and while survey data is not the most current, the information is still useful and linking PRAMS data with clinical data could help to inform broader changes within the State. Sheryl discussed the SHNAPP information, as a joint effort between hospital systems and population health partners. Work is taking place to allow the SHNAPP data to be queriable.	

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	Gloria said the SIM Steering Committee is well poised to provide feedback regarding public health measures to be added to the SIM CORE Measures. There was a question about incorporating measures into VMS portal. Sheryl said there are discussions, with the understanding that as a payer MaineCare has specific focus and population health has a different focus. They are in discussions with Statewide Coordinating Council around efforts to coordinate between Primary Care and Public Health. Ken Albert said it would be helpful to overlay Medicaid Claims data on Maine Tracking Networking. Sheryl responded that the lead data can be queried by screening for children on Medicaid. Androscoggin HomeCare and Hospice spoke of their CCT work and leveraging the CCT to advance things like lead screening. Anne Connors discussed how helpful this presentation is, and said that MaineGeneral is working on a Public campaign and messaging for specific populations around radon and arsenic, said the Main Tracking Network data has been very helpful. Gloria will send information on that work to the Steering Committee attendees.	
3- Public Health Nursing	*Objective: Open communication regarding PHN role in health care transformation* Sheryl distributed current Infant Mortality rates from death certificate data. The data shows a decrease in deaths, but Sheryl acknowledged that there is room for significant improvement. She said that Infant Mortality reduction requires many resources working together to address this concern, not just focusing just on one resource (PHN). Sheryl said that while the message right now is that there is spike in Infant Mortality and the decrease in staff- the data does not support that claim. One of the areas of opportunity for improvement is the need for a broader discussion with stakeholders around public health and public health nursing. She pointed out that the SIM Steering Committee is a very high level and engaged group in healthcare transformation; she has had a series of questions for other stakeholders. Sheryl asked the group about their concerns around PHNs? It was asked how Public Health Nurses allocated across the state. Sheryl explained that there was a plan in 2015 to have assigned nurses in district offices where there were significant issues with Substance Exposed Newborns (SENs) and medically fragile individuals. The implementation did not happen quite as envisioned, so currently Maine CDC is working on expanding the network of Community Health Nurses. There are PHNs across the state, she is aware that there are critical gaps.	

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	It was asked what the focus of PHNs is. Sheryl said they are focused on SENs, infectious disease, Tuberculosis and Latent Tuberculosis Infection, and moving forward they will be working with the elderly population coordinating with OADS. There had been a point where PHN has filled in a lot of gaps for providers, like being the fallback for discharge planning, MCDC has pulled back on having PHN nurses competing with businesses in the community. Ms. Sylvester discussed that Skilled Nursing Facilities discharge high risk patients and often into homes that home health agencies do not cover. Ms. Sylvester asked if PHNs would be a resource for homes I that situation. Sheryl said that is part of the plan for future focus of PHNs. Dr. Nesin asked what Sheryl is building the PHN workforce to. Sheryl said they are currently reviewing and mitigating productivity issues, in order to get current nurses to capacity and ensuring they are meeting the needs of the communities they work in. He asked a follow up question on whether she thought that 20 PHNs would be sufficient if they were working to full capacity. Sheryl stated that if her staff were working at capacity and they were leveraging community resources as well, then she would be better positioned to identify where the staffing gaps were. She said they are working to maximize the nurses that exist in other agencies, and prioritizing the referrals that come in from the Office of Child and Family Services. She stated that Maine CDC leadership only now has the opportunity to drill down into workflow. She discussed briefly the launch of CradleME, which removes some of the issues of referral rejections from Central Referral and CDC can ensure that outreach is happening and needed support is in place. She stated that currently she is not able to state what the right number of PHNs would be, that it is also important to leverage other types of work forces like Community Health Workers (CHW). Ken Albert said that the number of "20" PHN is ambiguous because CHNs are growing and expanding. Sheryl discussed that CHNs needs to expand further, especially around Maternal and Child Health. Sheryl said that she spoke to an evaluator from Fort Kent recently at a conference and realized that Public Health really hasn't leveraged all the available resources in the state. Sara Sylvester pointed out the shortage of nurses in the state, a big crisis especially for long term care. Sheryl said that is why they are trying to leverage other resources. There is a recognition that nurses are at a premium. Sheryl asked the group what they thought the role of PHNs should be. Shaun discussed the fact that Maine have several different types of service providers playing a role in transitions of care, care management, etc., and asked whether healthcare providers on	

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	the ground have a firm understanding of all the players and where one role stops and another begins. It is important to educate the healthcare field on what resources are available. Sheryl said that she appreciated that comment and would like to come back to flesh that out some more. It was also stated that there are many coalitions in the state and it would be beneficial for PHNs to start attending meetings so they have a better understanding of what is happening in the communities they serve.	
4- Community Health Workers	*Objective: Discuss and update workforce development, training and registry* Gloria gave an update on what is going on with CHWs, stating that the registry was approved in statute and said that it is in rulemaking. CDC will be working to develop the public health workforce, and deploy trainings along with the direct care worker trainings. There is a training scheduled in September and two others later in the year. In addition there is a direct care worker training portal. Penny Townsend clarified that CHWs are not RNs, and asked where they will fit into care delivery. Gloria said it is up to community agencies, employers and the health systems, SIM piloted CHWs and showed the return on investment. CDC also helps convene and network for this workforce. Ken stated he is excited that this effort is moving forward, said that CHW is an integral part of their healthcare team. Through the SIM process they designed the job description for CHWs, happy to see that there will be some regulatory oversight because they do work with some vulnerable populations. Penny asked if there has been any exploration into the benefits CHWs could provide to self-insured businesses. Gloria will research more on this nationally. Ken said they can't work outside of their scope, but is some flexibility to define their role. Deb said they have some resources they have compiled through SIM. Gloria offered to bring people currently using CHWs to the next Steering Meeting. Anne Connors asked how current CHWs that have already gone through training would receive their certification once the registry is live. Gloria said the process is in discussion.	
5- TA for Substance Abuse Confidentiality Regulations- 42 CFR Part 2	*Objective: Technical Assistance opportunity- Planning for allowable scenarios for sharing information* Concerns related to 42 CFR, Part 2 and how it limits the ability to coordinate care. SIM is working with the ONC to have some TA with lawyers that know this regulation very well. ONC is thinking that organizations in Maine are interpreting this rule too strictly.	Those who want to submit question to the TA team on 42 CFR, Part 2 should send to Gloria by 6/1.

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	Amy said that there was a recent change to 42 CFR Part 2, the TA request was specifically around how changes have allowed for more flexibility. Shaun said that SAMSHA provided guidance a year and a half ago, around information sharing. Shaun gave an in-depth explanation of this restriction. The TA could be an exciting opportunity. There was discussion around the impact on payers. Ken asked on whether they are trying to integrate Mental Health and Substance Abuse information into the HIE. Shaun said the regulation is very specific on sharing MH SA information for treatment purposes for providers. It was asked how are other states are interpreting the rule. It was stated that the regulation has been interpreted similarly by different SIM States. Gloria asked if they have questions they want to put forth to the TA. Shaun said he has several and would submit to Gloria and will work on it with his counsel. He stated that Rhode Island plans to interpret the changes very liberally, and are sharing SA information. Dr. Nesin said he will ask for questions/comments from his counsel as well and will submit to Gloria. Gloria said anyone else wants to submit their questions or comments to please do so. Ken suggested they work with the health part of the Bar Association because they would be helpful to voice in. Gloria requests all questions by 6/1 and that will dictate the timeline for the TA session.	
6- MaineCare updates: Data Focused Learning Collaborative, Behavioral Health offering, MPOC	*Objective: Update and discuss* Amy provided an update on the DFLC, that there will be regional forums in the public health districts to get HH and BHHs in a room to talk together. They have received positive evaluations from those forums that have taken place. Providers have found it valuable. DFLC had focused on two diabetes measures, and they are working closely with Nate on the NDPP. She said they have seen some increase in screenings which is positive. Amy said they have added measures to the dashboard so BHH and HHs are looking at the same measure. Penny asked if there have been a separation of Type I and Type II, which skews the data. Amy said they will talk to the medical director about separating that data. Sara Sylvester said that they should pull in and focus on the LTC folks. Shaun said that the HIE can play a big role, but CFR 42 Part 2 is a barrier. Sara said that there should be some education happening re: available data on that population. Ken discussed a pilot going on	Convene transitions of care SIM subcommittee

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	between Androscoggin Homecare and Hospice with a local ACO, creating a Multi-Disciplinary Team coordinating transitions from Hospital to Skilled Nursing Facility to home, with a patient navigator, they have expanded pilot to all SNF patients, to do transitions of care. Instead of going back to the hospital, they have a rapid response team that get the patient back into the SNF. Ken said Sara should contact the new VP at EMHS, to do something similar. Katie Sendze said that there is a discharge from SNF notification in the Health Information Exchange (HIE), but it is an underutilized feature. MaineHealth and Androscoggin are trying to use a one-page form, Interact, working to develop something that is more useable for the system on transitions. Shaun Alfreds said that the HIE has the capacity to capture documentation, has capacity but need to work with individual organizations to get that information. It was decided that there should be a Transitional Care Subgroup and Gloria will pull together those interested in participating. Behavioral Health Offering: the Department has partnered with HIN to make available for Behavioral Health Organizations to purchase lower cost access to the exchange. They will not have bidirectional sending, they will have view-only access. MaineCare will still maintain the VMS Portal. HIN is now receiving daily feed from Kepro, live as of May 1st. MPOC- Had a conversation with Fran Jensen who indicated that a Medicare waiver would be needed and there would be one year minimum before that will happen. There is a lot of uncertainty right now. The Department plans to continue its current VBP investments.	
7- Predictive Analytics Pilot Update. Project Demonstrations: MaineCare Utilization Reporting Tool, HIE Portal & MaineCare PA Data	*Objective: Update and discuss* Shaun said they would demonstrate the actual system and the different functionalities for the Steering Committee. He discussed the MaineCare Utilization Reporting Tool, which was developed for MC care managers, HIN is merging the claims and HIE data that allows them to see what is happening with those MaineCare patients in real-time. The tool is very focused on ED Project. Katie provided additional explanation on the tool and demonstrated the way to pull the reports and the views that the care managers are able to see. Ken asked about the calculated Risk Scores. Shaun said they are pulling those scores in from HBI. Penny said that tool would be useful for self-insured companies; Shaun said he would be willing to connect with her offline around that. Shaun said that one login is a priority to reduce portal fatigue. Katie displayed the Patient	

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	page, what a clinician would see. She demonstrated the consent function and what a provider would see based on the patients opt-in or opt-out of information sharing on their mental health data. Shaun said that there is also a "break-the-glass" consent option for emergency situations, which also triggers an internal audit. Continuing to get the word out about the new Kepro functionality. The information is currently limited to just BHH members. Demonstrated the different information included in this functionality. Amy stated that the efficacy of the HIN MaineCare tool has saved the ED Project Team two FTEs (full time employees). Ken said that the functionality is truly transformational.	
6- Public Comment	Next quarterly SIM Steering Committee meeting is September 20th at the Ice Vault.	

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