SIM

HEALTHCARE SYSTEM TRANSFORMATION

A Collaborative Partnership led by Maine DHHS

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

SIM Steering Committee

Wednesday, September 28, 2016
9:00am-1:00pm
MaineGeneral
Conference Room 3

Attendance:
Kristine Ossenfort, Anthem
Michael DeLorenzo, CEO, MHMC
Fran Jensen, CMMI (via phone)
Rhonda Selvin, APRN
Lisa Letourneau, MD, Maine Quality Counts
Dale Hamilton, Executive Director, Community Health and Counseling Services
Deb Wigand, DHHS, Maine CDC
Stefanie Nadeau, Director, OMS/DHHS
Shaun Alfreds, COO, HIN
Jack Comart, Maine Equal Justice Partners (via phone)
Jay Yoe, PhD, DHHS, Continuous Quality Improvement
Rose Strout
Noah Nesin, MD

Interested Parties:
Lisa Tuttle, Maine Quality Counts
Lisa Nolan, MHMC
Kathy Woods, Lewin
Amy Wagner, OCQI
Nate Morse, MeCDC
Liz Miller, MQC
Anne Connors, USM
Lise Tancrede, MQC
Kim Fox, USM
Kristal Peyton
Julie Trottier
Lindsey Smith, USM

Gemma Cannon, HIN
Kathy Vezina, Hanley
Don Johnson, MDDC

Absence:
Mary Pryblo, St. Joseph's Hospital (via phone)
Katie Fullam Harris, VP, Gov. and Emp. Relations, MaineHealth
Penny Townsend, Wellness Manager, Cianbro
Sara Sylvester, Administrator, Genesis Healthcare Oak Grove Center

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 NCE Year 4	*Objective: Discuss focus and SIM Governance structure in year 4* Stefanie explained that the end of this week ends the SIM Year Three, and reviewed the No Cost Extension presentation, explaining the two focus areas for Year 4, Diabetes and Readmissions. Stefanie discussed investment areas for the NCE; Predictive analytics, DFLC, Alternative Payment Models, and SIM Governance. Stefanie provided information on the continuing focus of SIM Governance. Shaun provided details on the predictive analytics tool and explained practices will be identified through claims data and the HIE, assuring practices have a strong care management team. Outcomes will be evaluated pre/post. Rose stated that medicaation reconciliation is a problem, and the change from generics and brand names pharmaceuticals. Noah said Medication Reconciliation is one of the most challenging practices in primary care practice. There is no Gold Standard for Medication Reconciliation, a lot of barriers exist. Rhonda explained that patient education is also very important. Best to be done face to face with the patient, Rhonda said she will sometimes ask for patients to bring meds they are on in a bag to the appointment. Helpful to have a pharmacist on staff. Stefanie stated she wanted to propose moving SC meetings to a quarterly basis. Noah suggested having that augmented through email report updates. SC meetings will be quarterly.	Steering Committee meetings will now be held quarterly

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3- HealthInfoNet End of Project Summary	*Objective: HIN summary of conclusions, lessons learned, next steps and outline any tangible benefits to health care reform that have been achieved as a result of this work* Shaun began reviewing the five different projects under SIM. Katie reviewed the Blue Button pilot. Worked with EMHS and with many organizations under the EMHS umbrella. She discussed the data collection methods for the evaluation of the pilot, and reviewed the pilot statistics. There was a great deal of education required for patient participants to explain what an EMR is and what the HIE is, etc. Katie explained the conclusions coming out of this pilot; essentially people want to see their health records, want the information, but market is not ready yet for this. Shaun explained the issue of Meaningful Use promoting the individual portals through the individual EMRs rather than the linking of all that information into the HIE. Shaun summarized the HIE Notifications and the SIM Impact. He outlined the conclusions for the ADT notifications and the connection with MaineCare. It was realized that in order to make sure the information is useful they had to understand the workflow of the Care Management unit and continually adapt to make this work best. HIN now provides Smart Notifications. Clinical Dashboard: HIN integrated MaineCare claims and mapped with clinical data, then layer analytics upon that. HIN worked with an analytics group out of Stanford on Machine Learning and updating risk scores for the lives covered by HIN. Machine Learning is based on every variable HIN has on that patient, diagnoses, socio-economic, service utilization, etc. Shaun discussed the St. Joe's project; they had a specific goal of reducing readmissions for Medicaid patients. They had care management staff accessing the risk scores before discharge, and there were three care managers working together. Reviewed the results of the project after 6-months. In the NCE, St. Joe's staff will advise the predictive analytics pilot. He said the inclusion of pharmacy claims had a positive impact for care management and medication reconciliation for clinicians across the state for all MaineCare members. Reviewed the conclusions from the MaineCare Analytics project. Shaun said that they are working on integrating the risk models into the actual HIE and would be accessible more broadly. Katie discussed the Behavioral Health connectivity to HIN. She discussed goals for the	

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	project. Demonstrated the 13 organizations and the 75 site locations that were connected to HIE and bidirectional data sharing. Demonstrated the increase of HIE utilizations over the months. She reviewed the BH Quality Project Goals that occurred for each organization from Jan-June 2016. Shaun discussed the evaluation of the project and findings of the quality projects. He said they will be extending the study period, so they can better understand what inputs resulted in the change in costs. He explained the continuation of the study in Year 4 and what will be included. Reviewed the conclusions of connecting the BH orgs to the HIE. Will continue this work through the end of SIM. Mike DeLorenzo discussed connecting this to the idea of "appropriateness of care".	
4- Maine Developmental Disabilities Council End of Project Summary	*Objective: MDDC summary of conclusions, lessons learned, next steps and outline any tangible benefits to health care reform that have been achieved as a result of this work* Don presented on the MDDC project, on what was included in the trainings offered to medical providers to support staff. Noah asked what the statewide category contained. Don explained attending conferences or regional meetings. He explained the benefits of the training, but what the barriers to implementing change were. He gave examples of comments made on whether the training would change the care the providers gave to these individuals. He reviewed the evaluation survey results. Don explained the challenges to getting attendees to answer the 6-month survey was due in large part to the attrition rate, many people were no longer at the provider organization. Don said they are working with UNE in training their first and second year medical students on caring for individuals with I/DD and have people with DD come help teach those classes. They are hoping to expand to other medical schools. Don said the biggest challenge with currently practicing providers is getting them together in one place to talk to them. Don said there is nothing in the DSP curriculum regarding medical conditions and the care of individual with DD. He reviewed the sustainability recommendations. Don went over the plans for next steps. Mike asked how big the DD population, Don said that there were about 46,000 in the state and they are a huge driver of cost. Rhonda said their presentation to the Association of Nurse Practitioners was very well-received. Rhonda acknowledged the challenges for some providers, they need to look at some sort of certification for practice that are willing to	

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	participate in developing their office through training and making their patients with DD feel comfortable, put effort into. There is an issue with care transitions. Dr. Letourneau said that MQC is developing an online training catalog and would be willing to work with Don/Nancy on this.	
5- Hanley End of Project Summary	*Objective: Hanley summary of conclusions, lessons learned, next steps and outline any tangible benefits to health care reform that have been achieved as a result of this work* Judiann began reviewing the presentation, explaining the different components that comprised their leadership development project. She explained how the team trainings worked, and she went through the some of the lessons learned. She said they should have brought CEOs to the table early on to get their buy-in from the start, because the number of participants diminished over time. She went through the sustainability piece of the work. Talked about a pledge they asked people to sign about investing in leadership development to the extent that they can. They need to evaluate the effectiveness of leadership development training, namely qualitative. She reviewed recommendations she had for continuing this type of work. She suggested accreditation standards around this, there are multiple accrediting bodies that could potentially be engaged. Also thought about reaching out to the trade organizations and support Leadership Development as a whole. It was asked if the participating teams excelled, and Kathy responded that the FQHC in Lubec which used this training to help with staff education and retention and did work with job-shadowing, was very successful. The cross-training helped change perspectives. There was another practice that created a weekly newsletter, to help facilitate communication practice-wide. Dr. Letourneau said that the AC that actually achieved Shared Savings was the one made up of 9 FQHCs, Lubec being one of them, and when she spoke to leadership about drivers of their success on their list was leadership training.	
6- Quality Counts End of Project Summary	*Objective: QC summary of conclusions, lessons learned, next steps and outline any tangible benefits to health care reform that have been achieved as a result of this work* Lisa Tuttle reviewed the presentation for their four objectives under SIM. She started with the HH learning collaborative and the meeting of Core Expectations and practices meeting the screening requirements. Lisa said that Cohort 4 has been struggling, practices in that cohort	

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	are on performance improvement plans, explained nexus of issues with that cohort. Cohorts exceeded their screening requirement targets. Lisa discussed the Core Expectations, stated that the practices self-report on their progress on the Core Expectations. Liz spoke to the BHH LC and their progress on implementing the Core Standards. She discussed successes regarding connecting BHH clients to HH practices, optional webinar attendance, and success of the QI projects, and the BHHOs use of data sources and data and impacting service delivery to their clients. Lisa discussed P3 Pilot, which was focused on shared decision-making. She discussed some of the successes that were realized in the participating sites. Shared a video on patient experience that was connected to both a BHH and HH. No questions from group.	
7- SIM Evaluation Results	*Objective: Present internal evaluation results to date* Jay explained that there will be more data for the Annual Meeting, the evaluation will continue into December. Jay explained the graphics for the three measures. There were some questions around the readmissions and why 2012-2013 were so low, Jay said he wasn't sure. Kathy was going to check whether the overall MC population excluded HH and BHH participants. Mike DeLorenzo asked what the drivers were for lowering NE ED use. Jay said not just SIM but also MaineCare efforts and HIN tools. Dr. Letourneau said it is also important to take into account the work of the providers on the ground. Jay went over the results of "Special Study One", explained that they have touched on AC population but still early to expect big results. Jay discussed the age breakdown between the interventions, ACs have a much younger base and BHH is much older. Jay demonstrated results that showed those with behavioral health diagnoses have almost double the risk. Jay said over 50% of folks in BHH or Section 17 have diabetes by the time they hit 60. Jay also pointed out the high burden of trauma. Jay said they plan to experiment on data analysis using clustering techniques, seeing how to identify the characteristics of who should be targeted. Amy said the BHHs are doing a good job of targeting folks that have a lot of chronic conditions.	Gloria will have TA findings around Trauma Informed Care shared with the Steering Committee at a later date.

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	Noah said trauma that leads to disease, and they should be focusing on reducing childhood trauma and increasing resiliency for those that have trauma. Amy said that the inclusion of more trauma clients in BHH may help impact that issue. Jay said that providers need to be more trauma-informed and trauma-sensitive in treating patients. Gloria said they have a Technical Assistance request for SIM for trauma-informed care, and will share what comes out of that with this group. Jay reviewed Special Study Two, it is underway now; six of the interviews have been completed. They will have preliminary data in October. Jay reviewed the components of the qualitative portion of the evaluation.	
8- Centers for Medicare and Medicaid Innovation: Request for Information on State Innovation Model Concepts and MPOC	MPOC met 9/7. Amy provided brief overview. Smaller group will pull together to develop concept paper to send to CMS. Need to assess functionality. Group decided to go with Option One, to go with our own model. Gloria mentioned the RFI and the multitude of questions that CMS has requested. Involving other and reaching out experts for more information.	
7- Public Comment	December 6th is the SIM Annual Meeting, and the SIM Program Team is working on getting the invites out. No Public Comment. Next meeting dates will be sent out. Meetings will be here.	

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