**MAINE HEALTH CARE INNOVATION MODEL: DRIVERS FOR BETTER EXPERIENCE OF CARE**

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|  | **ACTIONS** |  |  |  | **SECONDARY DRIVERS** |  | **PRIMARY DRIVER** |  | **TRIPLE AIM GOALS** |
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|  | Blue Button Pilot: Provide Maine patients with access to their statewide HIE record through provider portals leveraging the “Blue Button” standards promoted by the Office of the National Coordinator for HIT (ONC)  Use of shared decision making/patient decision aid tools  Media Campaign on patient engagement and optimal health care utilization  Broaden participation of consumers in all SIM workgroups  Consumer Engagement forums and education regarding Payment and System Delivery Reform  Public reporting of common metrics by provider via the work of the ACI workgroup, the VBID workgroup, the Health Care Cost workgroups and Pathways to Excellence process  Alignment of clinical and population outcomes with publicly reported Public Health performance measures  Expansion of patient advisors to Patient Centered Medical Home (PCMH) practices |  | **Health Information for Consumers** |  | **Consumer Education/ Access to Information** |  | **INFORMED CONSUMER ENGAGEMENT** |  | *By 2017, Maine will improve targeted practice patient experience scores by 2%  from baseline for participating practices that participated in the 2012 baseline survey (using CG-CAHPS survey tool)*  *By 2017, Maine will increase from 50% to 66% the number of practices reporting on patient experience of care using CG-CAHPs* |
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|  | Real-time notifications from the Health Information Exchange (HIE) expansion to include MaineCare and provider care/case managers when MaineCare members are admitted or discharged from inpatient and emergency room settings  Expansion of HIE access to behavioral health providers  Primary Care access to patient utilization claims data  Practice reports reflecting practice performance on outcome measures  Clinical Dashboard for MaineCare to monitor population health  MaineCare Discrete Medication Data Capture for HIE |  | **Health Information to Manage Care, Plan Provider and Patient-level Interventions** |  | **Improved Continuum of Care** |  |  |
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|  | Primary Care Providers   * Leadership Training * Community Health Worker Pilot * PCMH/ Health Hmes Learning Collaboratives and technical assistance * Training for primary care providers in behavioral health and developmental disabilities * Shared decision making/Patient decision aids training * National Diabetes Prevention Program   Behavioral Health providers   * Training for Behavioral Health direct service workers in physical health integration * Behavioral Health Home (BHH) Learning Collaborative and technical assistance   Community Care Teams Learning Collaborative and technical assistance  Training of Blue Button Pilot Site personnel on use of technology with patients |  | **Workforce Education and Development** |  | **Patient/Family Centeredness of Care** |  |  |