|  |  |
| --- | --- |
|  | **SIM Steering Committee****Wednesday, July 29, 2013****1:00 p.m. – 3:00 p.m.****State House, Room 228****Augusta** |

**Attendance:**

Noah Nesin, MD

Rebecca Ryder, Franklin Memorial Health

Penny Townsend, Wellness Manager, Cianbro, via phone

Deb Wigand, DHHS – Maine CDC

Jay Yoe, PhD, DHHS – Continuous Quality Improvement

Shaun Alfreds, COO, HIN

Randy Chenard, SIM Program Director

Eric Cioppa, Superintendent, Bureau of Insurance

Jack Comart, Maine Equal Justice Partners

Michael DeLorenzo, Interim CEO, MHMC

Dr. Kevin Flanigan, Medical Director, DHHS

Dale Hamilton, Executive Director, Community Health and Counseling Services

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

Frances Jensen, MD, CMMI, Project Officer, via phone

Lisa Letourneau, MD, Maine Quality Counts, via phone

Stefanie Nadeau, Director, OMS/DHHS

Sara Sylvester, Administrator, Genesis Healthcare Oak Grove Center

Lynn Duby, CEO, Crisis and Counseling Centers

Rhonda Selvin, APRN

**Absence:**

Representative Richard Malaby

Rose Strout

Kristine Ossenfort, Anthem

**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** |
| --- | --- | --- |
| **Accept 7/24/13 Steering Committee Minutes** | Following a reminder regarding Microphone use, the meeting was called to order, a couple of minutes were allowed for members to review the 7/24/13 Steering Committee Minutes which were adopted by consensus. |  |
| **Updated Review of Operational Plan Progress** | Randy walked members through the “SIM Operational Plan Components: July 29, 2013” progress document.All documents: Executive Summary Draft, SIM Logical Models and Driver Diagrams, Main Content Detail, Multiple Contributors and the List of Deliverables/draft Gantt Chart were distributed to Members Friday, July 26th by e-mail for review. Discussion:Since Friday additional information has been added to the Operational Plan by the “Multiple Contributors” and the final edition of the plan following this meeting, to incorporate feedback, will be forward prior to submission on CMMI on August 1st. | Final Operational Plan will be forwarded to members. |
| **Review Updates to the Driver Diagrams based on Steering Committee Feedback on 7/24/13****Review Updates to the Driver Diagrams based on Steering Committee Feedback on 7/24/13 cont.** | Dr. Flanigan presented the updated overarching driver diagram entitled “Maine Health Care Innovation Model: Drivers for Sustainable Reform” document.Again the majority of the discussion surrounded the “Triple Aim Goals” of 1. Reduce Health Care Costs; 2. Advance population health; 3. Improve the Experience of CareDiscussion/consensus regarding the four measures listed for achieving the “Triple Aim Goals”1. **“By 2017, the total cost of care and commercial health care premiums in Maine will fall to the national average” – the Core working group felt that this measure was appropriate as a measure rather than a goal, given the fact that cost would only have to be reduced by 50% for Maine to be within the national average. The GOAL is to reduce per capita cost.**

Questions: Is the overarching goal for the MaineCare population to move towards this goal based on Per Member Per Month or is the goal to move the entire population towards this goal? *The requirement of the SIM grant is to move the entire population towards this goal.*Has the Core group prepared a “cross walk” of quality control to cost control? *Not in detail but the measures outlined in the “driver diagrams” with the arrows to the drivers and goals provides a form of cross walking.*Concern was expressed that the “commercial health care premiums” not be singled out in the measure. It was mentioned that if you reduce total costs, premiums would go down, but there needs to be a way to measure/acknowledge the cost shifting that occurs.Consensus was reached that the wording in this measure should be changed to “the total cost of care per member per year” rather than “commercial health care premiums” and some of the tools to measure the success of achieving this could be reviewing commercial health care premiums, what conditions have been improved, looking at systems change, etc.1. **By 2017, Maine will improve the health of its population in at least four categories of disease prevalence (such as diabetes, mental health, obesity, and tobacco usage)** – *Members agreed by consensus that “such as” should be changed to including diabetes, mental health………..*
2. **By 2017, Maine will improve targeted practice patient experience scores by 2% from baseline for participating practices that participated in the 2012 baseline survey (suing CG-CAHPS survey tool).** *Members felt that this measure was small and attainable but difficult to reach. Consensus was reached that this measure as written.*
3. **By 2017, Maine will increase from 50% to 66% the number of practices reporting on patient experience of care using CG-CAHPs.** *Concern was expressed that 50% to 66% was not an ambitious enough measure. It was felt by the core work group that this was a middle ground. Members were reminded that the incentive for providers to access the CG-CAHPS is cost prohibitive even with the $70,000 incentive. Members reached consensus in leaving this measure as written.*
 |  |
| **High Level Review of the Operational Content Narrative and Address Steering Committee Inquires****High Level Review of the Operational Content Narrative and Address Steering Committee Inquires cont.****High Level Review of the Operational Content Narrative and Address Steering Committee Inquires cont.** | Dr. Flanigan provided an overview of the “SIM Model” PowerPoint packet which outlines Maines’ current “Fee for Service” system and the Multi-payer ACOs, Patient-Centered Medical Home and Health Home initiatives currently underway to reform this system and the planned implementation of the Behavioral Health Homes’ model. The SIM grant provides the tools for training, health information access and reporting understandable by all to inform decisions.*Note:* Dr. Flanigan reaffirms the governance structure and the use of current infrastructure and resources such as existing workgroups within the Three partners’ organizations. Where existing infrastructure is in place it will serve as the foundation for a SIM specific workgroup. There may be free flow of ideas and information but meetings in which SIM work is to be discussed those meetings must be ones in which the membership of the workgroup is expanded to include any willing participants and the SIM items must be the only agenda items. The existing workgroups are not to do SIM work without the expanded team present but may review the work and share insight and information.**Next** was the discussion of the six strategies to reaching the Triple Aim goals outlined in the executive summary document entitled “Maine State Innovation Model (SIM) Summary (July 29, 2013)*Lisa Letourneau presented:*   Component #1 **Strengthen Primary Care**: Expand the enhanced primary care model supported by the Innovation Plan from 26 to 76 by January with the help of Community Care Team support – Improve care to reduce avoidable readmission and ED use – support workforce models, this activity includes supporting the training of workers for the Maine CDC implementation of the National Diabetes Prevention program and other programs using the Community Health Care model – practice report to provide access to medical data for providers and patients, aligning incentive across payers for shared decision making pilot.Component #6 **Increase Patient Engagement**: Increase knowledge base of consumers on cost of care; Increase patient/provider interactions to improve care; measure patient experience of care; add community health workers; engage patients by providing access to their statewide HIE record.*Michelle Probert presented:* Component #2: **Integrate Primary Care and Behavioral** **Health –** by participation in the HealthInfoNet electronic health information exchange; solicit behavioral health providers with planned incentive program focusing on the those with the highest need, serious mental illness and children with severe emotional illness by Request for Proposal (RFP) with a learning collaborative to support Behavioral Health Homes which will be established by January 2014. Maine Health Management Coalition will work with behavioral health providers to develop health quality measures through the PTE process.*Debra Wigand presented:*Component #3: **Link to Public Health & Special Populations** – increase patient engagement within the MaineCare population, align long-term care with enhanced primary care; HealthInfoNet to provide a clinical dashboard that allows MaineCare to review population health; develop and test five pilot sites employing “Community Health Workers” including diabetes prevention program.*Mike DeLorenzo presented:* Component #4: **Support Development of New Payment Models -** Implement MaineCare Shared Savings Accountable Communities; transparent data reporting of cost and outcomes to improve safety and quality across systems; continue Health Care Cost Work Group initiative, develop strategies to drive the implement of new payment models, sustain expanded allied health workforce (Community Health Care Workers)Questions/Comments:Will the Health Care Cost Work Group coordinate across various work groups and initiatives? *Maine Health Management Coalition will work with work groups, stakeholders and the State to build on best practices.*Members suggested changing the wording included in (4) Develop strategies from “MHMC has developed a replicable……” to MHMC **will develop** ………It is important to note the Maine Health Coalition is the convener of stakeholders to develop this strategy.Component #5 : **Use Centralized Data and Analysis to Drive Change**: Support the use of a common measure set and public reporting, analysis and feedback to provider and stakeholders; MHMC work with providers including Behavioral Health providers to develop common set of measures: MHMC will also offer drill-down services of date to individual members for the purpose of care management and provide a clinical dashboard to look at population health, utilization and clinical outcomes for Medicaid patients. *Members discussed that if CMS develops a set of core measures, those would be implemented wherever possible.*Dr. Flanigan informed members that the SIM State Leadership Team along with the State partners will be traveling to CMS in Baltimore to present the Operations plan on August 2. An update regarding this meeting will be providing at the next Steering Committee meeting.Question:  Is the Camden Coalition of Healthcare Providers MaineCare Analysis “Hot Spot” report included in the SIM Grant Operational plan? *This information is indirectly imbedded in the plan with the “High Cost User”, Clinical Dashboard, Community Health Workers, etc.* | Update on August 2nd CMS presentation will be provided at the August 14, Steering Committee meeting. |
| **Public Input** | None  |  |
| **Next Meeting** | The next meeting of the Steering Committee is scheduled for August 14, 10:00 am. – 12:00 p.m., Room 228, State House (Capitol Bldg.), Appropriations’ Committee room. Audio Link is: <http://www.maine.gov/legis/ofpr/appropriations_committee/audio/> | Meeting reminder and materials will be sent and posted (if available) by Denise prior to the meeting. |