**MAINE HEALTH CARE INNOVATION MODEL: DRIVERS FOR SUSTAINABLE SYSTEMS DELIVERY REFORM**

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|  | **ACTIONS** |  |  |  | **SECONDARY DRIVERS** |  | **PRIMARY DRIVER** |  | **TRIPLE AIM GOAL** |
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|  | Identification of common metrics across payers for public reporting and alignment with payment via the work of the Accountable Communities Implementation (ACI) workgroup, the Value Based Insurance Design (VBID) workgroup, the Health Care Cost Workgroups and Pathways to Excellence process  Health care cost tracking  Analysis to tailor programs and policy to target high cost populations and variable/ high cost service utilization  Alignment of clinical and population outcomes with public health performance measures  Advanced Primary Care Recognition reporting  Clinical dashboard for MaineCare to report on population clinical measures  Expand, operationalize, maintain various sources of metrics, provider ratings systems, and backend rating databases for public reporting. |  | **Health Information to Influence Market Forces and Inform Policy** |  | **Data-Informed Policy, Practice and Payment Decisions** |  | **REFORMED SYSTEM DELIVERY** |  | *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)*  *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  Provider Portal: Primary Care access to patient utilization claims data  Practice reports reflecting practice performance on outcome measures  Clinical Dashboard for MaineCare to monitor population health |  | **Health Information to Manage Care, Plan Provider and Patient-level Interventions** |  |  |  |
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| **Improved Continuum of Care** |  |
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|  | Primary Care Providers   * Leadership Training * Community Health Worker Pilot * Patient Centered Medical Home (PCMH)/Health Home (HH) Learning Collaboratives and technical assistance (including patient advisors) * 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 (CCT) Learning Collaborative and technical assistance |  | **Workforce Education and Development** |  |  |  |
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|  | Leverage Allied Health Workforce (e.g., community health workers, home visitors and home based services, paramedics) in support of health promotion through linkages via PCMH/ HH Learning Collaboratives  Through Workgroups, leverage Existing Work/Best Practices with Partners, such as: Improving Health Outcomes for Children (IHOC), Child Health Insurance Program (CHIP-RA) and Advisory Board, Balancing Incentives (Office of Aging and Disability Services), Health Information Technology (HIT-SC) and State Coordinator, Regional Extension Centers (REC) |  | **Community Linkages** |  |  |  |
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| **Consumer Engagement** |
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|  | Enhanced Payments to PCMH/ HH practices, CCTs and BHHs  Promotion of Shared Decision Making incentives from payers to primary care practices  Provide Health Information Technology (HIT) and HIE adoption incentives to behavioral health providers |  | **Value-Based Payment** |  |  |  |
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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, aligned with publicly reported public health measures  Expansion of patient advisor representation in PCMH practices |  | **Consumer Education/ Access to Information** |  |  |  |
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