



## Minutes: SIM Steering Committee Meeting

12/10/15 5:30pm

### SIM Steering Committee Attendees:

Blue Cross Blue Shield of Rhode Island: Rich Glucksman  
Neighborhood Health Plan of Rhode Island: Peter Marino  
Tufts Health Plan: David Brumley  
United Healthcare of New England: Neil Galinko, MD  
Lifespan: Mark Adelman  
Care New England: Gail Costa  
South County Hospital: Lou Giancola  
CharterCARE: Chris Dooley  
Coastal Medical: Al Kurose, MD  
RI Health Center Association: Jane Hayward  
Rhode Island Medical Society: Steve DeToy  
RI Council of Community Mental Health Organizations: Richard Leclerc  
Drug and Alcohol Treatment Association of Rhode Island: Susan Storti  
RI Kids Count: Jim Beasley  
Rhode Island Foundation:  
YMCA of Greater Providence: Jim Berson  
Executive Office of Health and Human Services: Secretary Elizabeth Roberts  
Department of Health: Nicole Alexander-Scott, MD/MPH, Director of Health  
Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH):  
Department of Human Services: Yvette Mendez  
Office of Health Insurance Commissioner (OHIC): Kathleen Hittner, MD  
HealthSource RI (HSRI): Zach Sherman  
Office of the Governor:  
Rhode Island Primary Care Physicians Corporation: Andrea Galgay  
Carelink:  
Rhode Island Business Group on Health: Al Charbonneau

### State Agency Staff:

SIM: Marti Rosenberg  
Executive Office of Health and Human Services: Amy Zimmerman  
Department of Children Youth and Families:  
Department of Health: Ana Novais; Sandra Powell; Samara Viner-Brown; Melissa Lauer, Ted Long  
Office of the Health Insurance Commissioner: Cory King  
HealthSource RI: John Cucco

### Other Attendees:

Denise Audet and Matthew Ricci (TMG); Celeste Corcoran (Coastal Medical); Pano Yeracaris and Debra Hurwitz (CTC); Patrice Cooper (UHC);



### 1. Welcome and Introductions

The meeting was convened at 5:40 p.m. by Lou Giancola, SIM Steering Committee Chair and CEO of South County Hospital.

### 2. Review October Meeting Minutes

The October Meeting Minutes will be reviewed at the next meeting to allow for additional time for committee members to review.

### 3. Brief Administrative Updates

Chairman Giancola began with some comments about the overall SIM process. He shared that as SIM is a state and private sector partnership, how difficult that can be. He acknowledged the work that SIM needs to do to clarify the \$20 million budget that was quickly cut down from \$60 million. He also noted that the state procurement process is a barrier that has resulted in some significant delays in selecting the project management/ population health plan vendor and will be a challenge when we move to disperse monies to meet the grant deliverables. He put forth his hope that during this evening's meeting, the Committee would make an effort to decide how to get the most bang for the buck in advancing healthcare reform. Chairman Giancola adds that he feels it is worth the wait to be careful, as we can only spend the limited SIM funds once.

Ms. Rosenberg provided some administrative updates:

- The state has applied for a no-cost extension and will extend the first planning year through June of 2016. Then we can have until June 30<sup>th</sup> to finish the plans.
- The vendor selection contract is moving along and she hopes to have an announcement in January.
- Hiring is moving along. There are 5 positions total. The EOHHS HIT position has been offered and is in the HR process. The BHDDH interviews have concluded and the position is in the HR process. The OHIC position is filled, HSRI position is next to post, and the RIDOH position just closed.

Rather than make reports on the workgroups, staff submitted a written report on the workgroup accomplishments.

### Strategic Discussion

Ms. Rosenberg stated that a set of strategic decisions needs to be made before the work starts on the first set of SIM deliverables: the population health, behavioral health, and operations plans. These are decisions that are to be made by the SIM Steering Committee.

### Reviewing the SIM Theory of Change, including the SIM vision, Goals, and Assumptions

Ms. Rosenberg presented a draft SIM Theory of Change – A group's 'Theory of Change' is the articulation of a group's planned strategies, tactics and actions and how those strategies, tactics and actions are expected to lead to the intended results – that is, how the group expects change to happen.

#### Vision

The Committee reviewed the proposed SIM vision, which included:

- Improving the patient experience of care (including quality and satisfaction);
- improving the health of populations (including both physical and behavioral health);
- Reducing the per capita cost of health care



- Ensuring provider satisfaction.

Ms. Rosenberg presented that the first three components of the vision are the Triple Aim, but the last part of the vision, ensuring provider satisfaction, was added separately after some comments from the Rhode Island Medical Society.

Dr. Alexander-Scott commented that ensuring provider satisfaction is a component of improving the patient experience of care, and suggested maintaining consistency of the Triple Aim. Dr. Hittner agreed that we should not alter the Triple Aim since it is being used across the country.

There was some discussion about whether reducing the per capita cost of health care might conflict with improving the health of populations, and some comments that the health of populations vision should be prioritized. Mr. Charbonneau commented that they could both go together.

### **The Committee reached a consensus on making the vision align with the Triple Aim.**

#### **Theory of Change**

Marti sought consensus on the idea that through a focus on payment transformation and reform – plus investments in a set of program activities, we will improve Rhode Island’s population and behavioral health and thus move toward our vision of the triple aim.

The Theory of Change considered by the committee is:

*If we:*

1. Change the payment system to focus more on value and less on volume.
2. Make investments to:
  - a. Support advancement of healthcare data analytic capabilities at the statewide population level
  - b. Implement cost and quality performance improvement workflows and technology within provider entities
  - c. Improve access to behavioral health and primary care providers, and reduce disparities in access
  - d. Support team based care models
3. Evaluate return on those investments for the model test

*Then we will move toward our vision of the Triple Aim*

The committee discussed the Theory of Change:

- Dr. Kurose asked, is it effective to just put a payment model out there (i.e. an ACO) or do you need a payment model with some sort of incentive to specifically change workflow and practice inside the practice.
- Mr. Charbonneau asked, is the SIM project the change agent or does RIQI or others in the industry also have change elements that can be incorporated?
- Ms. Galgay comments that this also depends on where the practice is at the beginning. The practice does not necessarily know where it is in transformation, and it can feel onerous to make the changes the state wants until the practice is involved and can understand the changes.
- Dr. Hittner does not think incentives will be enough. The way physicians were trained was to do things their own way. RIMS this morning was one of the most uplifting meetings because of the way the providers are trained today is different. Dr. Kurose agreed the students were idealistic and energetic.



- Dr. Alexander-Scott suggested that we make sure we are clear about what we want the change to be so we have the outcomes we are looking for.
- Mr. Charbonneau questioned whether we were talking about incentives for doctors or hospitals? Would incentives work as well for hospitals as doctors?
- Mr. Glucksman stated that a lot of these things have taken time for a number of reasons, which makes him think there is a third option of regulated/acquired change, because a lot of change has occurred on the payer side with the new OHIC regulations.
- Mr. Berson stated that we are assuming patient behavior will also change, and he does not want to lose the issue of patients and individual behavior (healthcare seeking behavior) to be lost in this discussion.
- Dr. Yeracaris talked about how the language that CMS is now using about this is “person and family engagement” – 80,000 lives saved over the last 3 years through hospitals through patient and family engagement. Integration of care across the spectrum is the other key component.
- Mr. Glucksman asks if “we” is the state or SIM Steering. If SIM steering is the “we,” he thinks there should be an acknowledgement of all the work everyone is doing, even beyond the scope of the SIM. Deputy Secretary Wood said that SIM is explicitly all-payer and that the “we” should be seen as the entire system, writ large.

Ms. Rosenberg summarized the comments, to ready the group for reaching consensus: in general we are going to change the payment system and will choose among a variety of ways to implement those changes. (These could be just change the payment model, change the model with incentives, or regulate the changes) and we will make a series of investments as described in the Theory of Change language. We will make these changes because in the end, we believe these will improve Rhode Island’s population health. She also addressed the process: the Theory of Change is the frame onto which we will put our goals and activities – but it’s important to agree first on the vision and the general idea of how we will make change.

In response to a question about SIM goals, Ms. Rosenberg pointed out that when the Committee does determine the project’s goals, that they align with the other goals in the state from the Secretary, the Governor, and other state stakeholder groups. The goals should overlap throughout all of the workgroups and projects, but the funding should not, so that we are not spending SIM dollars on things that are being funded in other places. Secretary Roberts commented that if people see the goals as diverging, they should call that out.

The Committee reached a consensus on accepting the Theory of Change framework as described above.

### **Brief review of the original SIM budget, from the grant submission**

Ms. Rosenberg reviewed the December 2014 proposed \$20 million SIM budget. She stated that in discussions with in the full Steering Committee group and in the individual meetings she has had with members, there is an acknowledgement that spending money on all of those projects would mean that we might not achieve significant system change. Therefore, our essential question is: do we try to fund all projects on the list with small amounts of money or fund a narrow list of projects more deeply?

Discussion:

- Ms. Galgay says that given the goals set forth, going broad would be risky, and believes we should go deep with the practices that would lead to this transformation. Mr. Marino agreed and questioned whether we could choose one of the investments and go deep to see what we can achieve. With the limited dollars focused deeply, you could in 2-3 years say this actually transformed the system.



- Dr. Kurose stated that the Steering Committee has already allocated approximately \$3 million in the All Payer Claims Database and the Common Provider Directory. Therefore, we have about \$11 million left for the other components of the budget, which include: Practice Assistance, Community Health Teams, PCMH Expansion, Child Psychiatry Access Program, Advanced Illness Care Initiative, Behavioral Health Transformation, Patient Engagement Tools, and the Health Care Quality Measurement, Reporting, and Feedback System.
- Mr. Berson suggests we ask what is sustainable in terms of change. A one-time plug may not continue past that point. Ms. Rosenberg notes that we will indeed come up with a detailed list of criteria to help us make this decision.
- In response to a question from Ms. Rosenberg about whether anyone wanted to speak for the idea of funding all of the line items in the budget, Mr. Adelman mentioned that those numbers came from somewhere – and someone thought there was merit to each of these. He noted that he would argue that more spending on fewer items is better, but he is concerned that others would state that a lot could be done with that amount of money in these areas.
- Mr. DeToy commented that the list was created with input from many people, but he does not actually see payment reform as a part of any of the topics on the list. Tina Spears from RIPIN commented this was done through a thoughtful community process within the SHIP grant. This is a portion of payment reform and the community felt that payment reform was a broad goal but that the other investments filled needed gaps.
- Dr. Kurose stated that this is a small amount of money and advocated for going deep on a small number of projects. He asked, “What evidence will you see 5-10 years later??”
- Secretary Roberts mentioned that at the time of the budget cut, they took everything on the list and pared it down to make the budget work. She thinks we should think about the goals and how we can make the investment most wisely so that is a sustainable change.
- Ms. Rosenberg noted that it is possible that SIM is not the only place to get money and that we could try to expand the pie. She said that we would create a set of criteria for selecting investments, along with an inventory of current projects and funding sources. Mr. Berson agrees that we could fill in gaps on projects that need a little more to be completed.
- Chairman Giancola added that if we can identify opportunities that achieve the end, we could spend our money to improve Rhode Island’s behavioral health system and save a lot of money in the long run. It should be more about how to make sure that we get the change and invest wisely to achieve the outcome.
- Dr. Hollingshead made the point that while it made sense to look carefully at the budget, we should acknowledge that these decisions were made in context and it might be that losing some of these investments could have a negative impact on other funded programs, with a potential loss of financial leverage.

The Committee reached a consensus that it would review all funding decisions to make the most effective ones. These are likely to be narrow and deep rather than what is in the current budget, although they will work from the current budget.

### **Discussion of draft criteria for decision-making on funding transformation projects**

Ms. Rosenberg next asked the committee to participate in creating criteria for making funding decisions. She began by presenting some initial possible criteria that Steering Committee members have raised in their individual meetings with her:

- What are the biggest needs?
- What money is being spent now, so we don’t duplicate funding?
- What are the financial gaps, where SIM dollars would have the most impact? Could be seed money, mezzanine money, leverage money, or money to finish the project (cap money)



- What projects are sustainable after SIM dollars are spent?

Committee members then added the following in a brainstorm. Criteria should include projects that:

- Address payment reform
- Tie funding to the vision
- Make healthcare affordable.
- Choose projects with evidence that it has worked elsewhere – and another suggestion was choosing projects with evidence that it has worked here, because of the struggle to import out-of-state models here.
- Fund projects with generational impact – where we will have an impact on the next generation of children. In response, there was also a comment that we should look at more short-term goals so that we have money now to spend on other needs that children have. In response, it was noted that we may be able to pair the social services and healthcare cost reductions together.
- Leverage other dollars
- Has the right level of complexity to achieve the change we need
- What effect would it have on the healthcare workforce?

Ms. Rosenberg asked the Committee to think of more criteria to share with the group electronically. The SIM staff will hone them and prepare the Steering Committee to apply them in January.

### **SIM Assumptions**

Ms. Rosenberg described this process as building a house. The Committee has now agreed on the frame and looking at some criteria we can use to build the house to a place where we all would feel comfortable. The next step will be to put our assumptions on paper – because in order to ensure that the projects we choose can meet our goals and vision, we need to understand the assumptions we are making. The description in the meeting PowerPoint stated: “Any initiative is only as sound as its assumptions. Unfortunately, these assumptions are too often unvoiced or presumed, frequently leading to confusion and misunderstanding in the operation and evaluation of the initiative. To address that problem, a Theory of Change documents assumptions to ensure agreement for planning and posterity.”

Two assumptions raised by Steering Committee members in the meeting were:

- Patients will change throughout this process
- There is sufficient leadership commitment throughout the healthcare community to make these changes.

As with the criteria, Ms. Rosenberg said that she would reach out to Committee members to facilitate their further brainstorming of assumptions. Once the assumptions are brainstormed, we must go through a process to determine whether they are true, and if not, what we can do to make them true.

### **SIM Goals**

Ms. Rosenberg noted that now that we have addressed criteria for decision-making, we need to come up with specific goals for our work to bring us toward our vision of the Triple Aim. She reminded the group that there were no smart goals in the grant application (goals that are Specific, Measurable, Achievable, Realistic, and Time-bound) and we need to brainstorm the goals as homework, and at future meetings.

As an example, Dr. Alexander-Scott mentioned one potential goal. She noted that to address population health, we should connect what goes on within the healthcare facility to an option/element/profession that



connects to the community – where food access, employment issues are known. Community Health Teams are a model already in place, and so she would propose adding a profession of community health workers to the CHT model, which is a proven, structured mechanism. Ms. Rosenberg noted that to make it a SMART goal, we would say that we would create X# of community health workers by X date to work in XX places.

### **Public Comment**

There was no additional public comment.

### **Adjourn**

Ms. Rosenberg asked the Committee if in January we can have a longer meeting and have it start earlier. The committee is open to adding some time on the beginning of the meeting, but also to consider breaking up the work into multiple meetings.

The next meeting date/time is January 14, 2015 at 5:30pm. Adjustments to that schedule will be announced.

With no further business or discussion, the meeting adjourned at 7:00 pm.

### **Notes prepared and respectfully submitted by:**

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Department of Health  
December 11, 2015