SIM Steering Committee
Thursday, September 10, 2015 5:30 pm
Hewlett Packard Conference Room 203
301 Metro Center Blvd, Warwick, RI 02886

SIM Steering Committee Attendees:

Blue Cross Blue Shield of Rhode Island:
Neighborhood Health Plan of Rhode Island: Peter Marino
Tufts Health Plan:
United Healthcare of New England: Neil Galinko, MD
Lifespan: Mark Adelman
Care New England: Gail Costa
South County Hospital:
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:
RI Kids Count: Elizabeth Burke Bryant
Rhode Island Foundation:
YMCA of Greater Providence: Jim Berson
Executive Office of Health and Human Services:
Department of Health: Nicole Alexander-Scott, MD/MPH, Director of Health
Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH):
Office of Health Insurance Commissioner (OHIC): Kathleen Hittner, MD
HealthSourceRI (HSRI): Anya Rader Wallack, PhD
Office of the Governor:
Rhode Island Primary Care Physicians Corporation: Andrea Galgay
Carelink: Joan Kwiatkowski
Rhode Island Business Group on Health: Al Charbonneau

State Agency Staff:

Executive Office of Health and Human Services: Tom Martin; Cheryl Wojciechowski; Hannah Hakim; Elizabeth Shelov; Deidre Gifford, MD, MPH, Amy Zimmerman
Department of Children Youth and Families:
Department of Health: Samara Viner-Brown; Melissa Lauer
BHDDH:
Office of the Health Insurance Commissioner: Cory King
HealthSourceRI: John Cucco

Other Attendees: Tina Spears (RIPIN); Therese Rochon (Coalition for End-of-Life Care/VNA of Care New England); Alok Gupta and Elaine Fontaine (Rhode Island Quality Institute); Marti Rosenberg (The Providence Plan); Yvette Mendes (RI Foundation); Peter Hollmann (University Medicine); Jean Marie Rocha, RN (Hospital Association of RI); Alex Speredelozzi (Care New England); Rich Gluckesman (Blue Cross Blue Shield of RI); Patrice Cooper (United Healthcare of New England).

Introductions & Overview

The meeting was convened at 5:40 p.m. by Jim Berson of the YMCA of Greater Providence who chaired the meeting in Lou Giancola's absence. The meeting was co-chaired by Kathleen Hittner, MD, Health Insurance Commissioner.

There was consensus that the minutes from the June 18, 2015 meeting were accurate as written and there were no additions, corrections, or deletions.

Project Updates

Mr. Berson reported that all SIM positions have been posted, with the exception of the position at HealthSource RI (HSRI) that is to be posted soon. The request-for-proposal (RFP) for the project management vendor/population health plan (including a behavioral health component) has been posted on the Division of Purchasing website on this link: http://www.purchasing.ri.gov/bidding/BidDocuments.aspx?BidNumber=7549877&Isridot=False&Status=Active(Scheduled) (Please note the correct time of the pre-bid scheduled for 9/18/2015 is at 2:00 PM-not 10:00 am). The job posting for the SIM EOHHS HIT position is posted on this link: HIT project manager.

It was reported that the All-Payer Claims Database (APCD) is up and running. By the end of the year, four years of data will be available.

At the next meeting of the Steering Committee, Jennifer Wood will share an overview of how the Governor's Working Group for Healthcare Innovation, the SIM Steering Committee and the Health Care Planning & Accountability Advisory Council (HCPAAC) will interact together.

Dr. Hittner presented background information on the project manager selection process. It was a thorough and diligent search that resulted in the selection of the new SIM project manager, Ms. Marti Rosenberg. Ms. Rosenberg earned a BA from Brandeis University and an MA from Brown University. She will be based in the Office of the Health Insurance Commissioner (OHIC) in Cranston.

Next Wednesday, **September 16, 2015 at 10:00 am**, the Truven Analytics behavioral health study will be presented at the next HCPAAC meeting. The meeting will be in this same room.

Cory King, delivery systems analyst at OHIC, presented an update on the work of the Measures Alignment Work Group. This group has met three times since August 2015. Their deliverable to the Steering Committee is a menu of specific Medicaid and commercial measures in addition to a common core set. Criteria for selection of measures and endorsement of a measures set must include the following: be evidence-based and scientifically available; able to be collected; and promote value, among other criteria (see slide below).

Measures Alignment Work Group

- The Work Group has met 3 times since August.
- Process Decisions:
  - Deliverable: A menu of specific Medicaid & commercial measures in addition to a common core set.
  - Criteria for selection of measures and endorsement of measure set.
  - Measure Domains

Measure domains include, among others: chronic illness, preventive care, behavioral health, consumer experience; and medication management.

A description of the group's process appears below:

Measures Alignment Work Group

- Process:
  - Contracting measures across RI payers were cross-walked.
  - Overlap with Medicare Shared Savings Program and Star Ratings Measures were assessed.
  - Current measures in each domain are discussed for inclusion/exclusion.
  - The Work Group has reviewed Pediatric & Adult preventive and chronic illness measures.
  - After review of existing measures the Work Group will consider additional measures.

Four additional meetings of this sub-committee are scheduled through November, with additional meetings to be scheduled soon. The Work Group plans to wrap up its work by January 2016.

Comments

- Are there any measures dealing with geriatric populations? Medicare Shared Savings incorporates measures that are defined over a geriatric population.
- What are the population health measures? The work is focused on contracting measures for now. There may be a focus on this later; measures will constantly be re-examined.

Amy Zimmerman, State HIT Coordinator at EOHHS, next presented an overview of the concept of a RI Statewide Quality Reporting, Measurement, and Feedback System as a shared resource. Ms. Zimmerman indicated that funding for two HIT initiatives, the all-payer claims database and the provider directory, were previously approved by the Committee.

Amy Zimmerman stated that the purpose of discussing this topic was to share and obtain feedback on the overall concept of developing a statewide quality reporting, measurement and feedback system as a shared resource. Ms. Zimmerman made it clear that the discussion was to introduce the topic but not to make any funding decisions at this time. Funding decisions will be made during a future Steering Committee meeting.

Questions for Discussion:

- Are providers/provider organizations currently using national or private data intermediaries? Why or Why not?
- What type of measures would you envision this system collecting: contracting, quality improvement, population health, all?
- Do you see benefits to developing and implementing this type of statewide system? If so what are they?
- What concerns do you have about developing this type of statewide system?
- What other questions or comments do you have?

Questions presented for discussion later in the meeting are listed on the left.

Ms. Zimmerman referenced the required HIT plan components (see handout attached below) that must be submitted to CMS along with the SIM operational plan during the first grant year.

Ms. Zimmerman reviewed the questions (above) with the group and provided the context for why this project was initially proposed and presented the goals of this project to the Steering Committee. See goal slide at the right:

GOALS:

1. Create the capacity to collect, analyze, and benchmark healthcare quality data from and provide feedback to providers/practice settings. System will inform:
   - Quality improvement initiatives
   - Healthcare delivery
   - Healthcare quality performance across healthcare systems and providers as part of new payment methodologies
   - Consumer choice through public reporting and transparency process
2. Reduce the need for healthcare agencies to expend resources inefficiently. " Send once, use multiple times."

The concept for a RI Healthcare Quality Reporting Measurement and Feedback system dates back to the "Trailblazer Initiative", a multistate learning collaborative from 2012-2013 that provided technical assistance to states in developing HIT strategies in support of health care reform and value-based purchasing. In 2014, there was a Request for Information ("RFI") conducted by EOHHS to gather information about developing this type of program. The RFI posed 17 questions about problems, functions, approaches, technical needs, governances, etc. The responses to the RFI were useful.

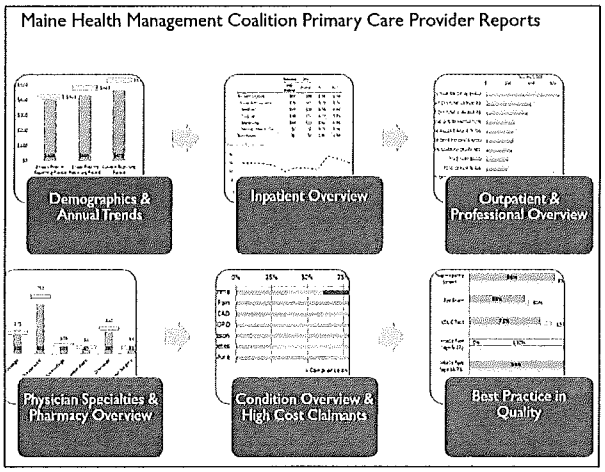
There are six components of a quality reporting measurement and feedback system as envisioned:

- Selection and Harmonization of Quality Measures
- Data Collection
- Technical Infrastructure
- Data Analytics
- Reporting and Feedback
- Public Reporting

The first component, the formation of a SIM HIT measurement workgroup has moved ahead into this round of SIM funding.

The capabilities needed by a data intermediary entity, which would develop, implement and manage the system (not a total list) include: a non-governmental entity; trusted organization; robust governance structure; ability to manage technical structures well; sustainability plan; and a strong data analytic capability.

Ms. Zimmerman then provided a few examples of quality reporting measurement and feedback systems that are in existence in other states, including the Maine Health Management Coalition. Maine sends out a six page report of measures to primary care providers (see below):



Please note that these measures are based on claims data and do not include any clinical data at this time. For examples of what data are publically reported, see: www.getbetter Maine.org

Group Comments

- Aggregate reporting is useful;
- Maine can drill down; we cannot do that with de-identified data in RI;
- How would we be able to do this in RI? We would have to review different statutes; Would have to obtain clinical data, but tonight is about the "WHAT", not the "HOW";
- Imagine that there is a shared resource/let's think about this;
- Don't let reality get in the way!!
- Maine provides a combination of cost and utilization data; we could also combine our cost and quality systems;
- Wisconsin is one of the most advanced states;
- At what level would public reporting be done? It would be at the practice level versus the individual physician level.
    - This would be a governance decision.
- What is the budget for this initiative? Total all HIT budget: $9.7 million; $3.5 million has been committed to date; $2.2 budgeted for this initiative
- Defining the "HOW" could change the cost.
- Design principles: what is worth this investment? What can be modified, tweaked, enhanced to get us along the way with policies and regulations?
- What is the framework for the decision? What is the ROI, turnaround time?
- Are there sufficient numbers of providers who could use this effectively to create value for the entire system?
- United and other insurers have similar tools/ use caution in reinvesting something that already exists.

Discussion questions (see above) were presented next and some of the comments included the following:

- It will take a fair amount of effort to get this up and running;
- It can be a challenge to get providers to insert info in correct fields (electronic records);
- Doing medical record extractions can be difficult;
- APCD has value but not always when it is de-identified;
- Where does performance data reside? Get performance data on each plan;
- Measures have to be used by all payers to be useful;
- If all payers don't agree to use the measures set, it is not valuable;
- Harmonize means it becomes the basis of contract measures;
- Measures have to align with population health outcomes;
- Health care system delivery changes have to inform population health outcomes;
- Population health outcomes will be built in as we go forward;
- Try to align where there is commonality;
- Measures harmonization will align with population health priorities as defined in the SIM grant;
- We have to address the population health measures in the SIM grant; the SIM Steering Committee could take the work further;
- Ultimate goal is to have measures lined up with population health outcomes;
- What kinds of measures are we considering? It will be an incremental build;
- Is this the way to reach all practitioners? Big and little? Challenges for small and medium size practices?
- To generate utilization and cost data: this could be a heavy lift;
- False starts? Have providers experienced this with EMR systems?
- Communication plan: what is the value-added for practices to do this well?
- Is this initiative a flash in the pan?

- Where will the data come from?
- Quality control? How do we assure that good data are available?
- Sources all have to align and be of good quality; formatting has to be done completely and well;
- Statewide system would help to manage how high the bar is set;
- Gaps in care need to be identified;
- What is a pre-condition for success? Do other things have to be in place to make this successful?
- What other work needs to be done so there is enough information to make a clear decision?
- How much do we want to invest and what is the ultimate goal?

Mr. Berson indicated that the SIM work groups are talented and are collaborating well. Deputy Secretary Wood will explain at the next SIM Steering Committee meeting how all of the health reform workgroups relate to each other and will work together.

Public Comment
None.

Next Meeting
The next meeting date/time will be announced but staff is considering Thursday, October 15, 2015 at 5:30 pm.

With no further business or discussion, the meeting adjourned at 6:50 p.m.

Notes prepared and respectfully submitted by:

Elizabeth Shelov, MPH/MSSW
Chief, Family Health Systems
Executive Office of Health & Human Services
September 22, 2015

Required HIT Plan Components to include in the SIM Operational Plan:

1. **Rationale:**
   - Define how specific Health IT elements and infrastructures, in combination with SIM program efforts will achieve state-wide health transformation
   - Identify information needs
   - Identify data needs
   - Describe current HIT environment
   - Identify HIT needs based on above
   - Identify HIT gaps
2. **Governance:**
   - Indicate how state leadership will direct the planning and oversight of HIT implementation
   - Engage HIT stakeholders
   - Align with other federally-funded programs, state enterprise IT systems and with public/private health information exchanges (ACOs)
3. **Policy:**
   - Policy and regulatory levers that will be used to accelerate standards-based HIT adoption
   - Address Transparency, patient engagement and shared decision making
4. **Infrastructure:**
   - Implement analytical tools and use data-driven, evidence-based approaches to coordinate and improve care across the state
   - ***Use standards-based Health IT to enable electronic quality reporting***
   - Integrate public health IT systems (such as clinical registry systems)
   - ***Describe how support of electronic data will drive quality improvement at the point of care***
5. **Technical Assistance:**
   - Identify targeted provider groups that will receive assistance, and what services will be delivered
   - Provide technical assistance to providers
   - Extend resources to providers ineligible for Meaningful Use incentive payments, if applicable