



Minutes

SIM Steering Committee Meeting

Thursday, January 14 – 5:00 p.m. to 7:00 p.m.

Hewlett Packard Offices, Conference Room 203

301 Metro Center Blvd, Warwick, RI 02886

SIM Steering Committee Attendees:

Blue Cross Blue Shield of Rhode Island: Matt Collins; Rich Glucksman

Neighborhood Health Plan of Rhode Island:

Tufts Health Plan:

United Healthcare of New England: Jenny Hayhurst

Lifespan:

Care New England: Dennis Keefe

South County Hospital: Lou Giancola

CharterCARE:

Coastal Medical: Al Kurose, MD

RI Health Center Association: Charles Hewitt

Rhode Island Medical Society:

RI Council of Community Mental Health Organizations:

Drug and Alcohol Treatment Association of Rhode Island: Susan Storti

RI Kids Count: Jill Beckwith

Rhode Island Foundation:

YMCA of Greater Providence: Mr. 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): Rebecca Boss

Office of Health Insurance Commissioner (OHIC): Kathleen Hittner, MD

HealthSource RI (HSRI):

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; Amy Zimmerman

Department of Health: Ana Novais; Samara Viner-Brown; Melissa Lauer; Ailis Clyne, MD; Ted Long, MD; Sandra Powell

Office of the Health Insurance Commissioner: Cory King; Sarah Nguyen

HealthSourceRI: John Cucco

SIM: Marti Rosenberg



Other Attendees:

Tina Spears (RIPIN); Alok Gupta, Laura Adams, and Elaine Fontaine (Rhode Island Quality Institute); Alex Speredelozzi (Care New England); Denise Audet (TMG), Matthew Rice (TMG), Jenna Legault (Brown University/CEBM), Stacey Springs (Brown University/CEBM), Beth Lange (PCMH-Kids), Gus Manocchia, MD (BCBSRI), Owen Heleen (The Providence Center)

1. Welcome and Introductions

The meeting was convened at 5:10 p.m. by Lou Giancola, SIM Steering Committee Chair and CEO of South County Hospital.

2. Review October Meeting Minutes

The October 15, 2015 and December 10, 2015 meeting minutes were both reviewed and no changes were necessary.

3. Brief Administrative Updates

Ms. Rosenberg informed the Committee that the state received a 3 month no-cost extension on the grant. However, she noted that this date actually means that the federal deadline to submit the plan and other deliverables for their early review is February 29th. We owe them three things:

- The operational plan (which has many standalone things we can indeed get them by February)
- Components dependent on Steering Committee decisions, like our funding plan for transformation activities (which may be complete by the end of February, but perhaps not until March)
- Our integrated Population Health and Behavioral Health Plans (which we know will not be done by February 29th and not necessarily done to the level we will want by April 29th either.

Rhode Island's federal program officer is looking into what can be done to adjust RI's timeline in comparison to the official timeline.

This timeline does not mean that we will run out of money for Year 1. We have enough money in our Year One budget to continue on until we are finished with these Year One planning activities.

SIM Job Updates:

OHHS – HIT Specialist, Melissa Lauer, has been hired.

BHDDH – Ann Dietrich has been hired.

RIDOH – Interviews start tomorrow and finish next week.

HSRI – The position will be posted soon.

Project Management Vendor - The Vendor contract for project management and the population health plan with behavioral health component is being finalized.

Program Reports - Program reports had been sent out to the Committee before this meeting. Ms. Rosenberg will try to send out reports the week before each SIM Steering Committee meeting to save some time during the meetings. The reports cover what each part of the team is doing.



Measure Alignment - Mr. King provided an update on the SIM State Measure Alignment Workgroup. Two more meetings are scheduled. The next meeting will involve reviewing any additional proposed measures, assessing the draft measure set, and scoring the measures relevant to the criteria. The group selected 10-12 criteria that measures should meet in order to be considered for the full measure set (but they do not have to meet all measures). The very last step will be to evaluate which measures should be core and which are menu measures. The stakeholders have put a lot of time into this process and are very engaged. Michael Bailit who has been leading us through this process put together a memo on the process which was distributed to Committee members.

Mr. King noted that measure set governance is also a critical issue, because we will need to develop a strategy to adopt the measure set and remove/add measures as time goes on. The All Payer Claims Database (APCD) could be used to create metrics across payers and providers to provide to providers. One use could be to create profiles specific to a single practice. Ms. Galgay commented that the payer representation at that meeting were mostly quality staff, and the component to require this as part of contracting will likely involve different staff at the payers. There was very active participation from all payers at the meetings. She looked to Dr. Hittner to possibly help this incorporation into contracting. Dr. Hittner commented that this was a particularly complicated process with a large group of participants, and that the work product is looking extremely good. Mr. King added that Bailit Healthcare which has facilitated the meetings has done a great job. Mr. King also plans to post all of these items to a website to be available to everyone. Mr. Giancola also thanked Neighborhood Health Plan, BCBSRI, United Healthcare, and the Hospital Association of Rhode Island for helping to fund this project. He asked that we also in the future engage Dr. Alexander-Scott and RIDOH deeply to look at how this aligns with the population health plan.

Accountable Health Communities CMS grant – The grant is to support the Community Health Team concept for Medicaid and Medicare patients. Dr. Alexander-Scott commented that CMS is looking to see the impact on costs when we implement structures which can address social and environmental determinants of health. RIDOH looks forward to working with the different organizations which are interested in applying for the grant to see if we can create a single coordinated application for Rhode Island, which should help RI have a strong application where everyone is not competing against each other. There are a limited number of awards, so one strong application may be more successful. The state cannot apply, but will be pulling together all interested parties to a meeting to help coordinate the different ideas to make this effective and beneficial. The state will provide more information on this process within the next week or so.

4. Strategic Discussion

Ms. Rosenberg discussed the progress made by the group at the last meeting. She prefaced that in the meeting we will work to get closer to making funding decisions. There will be homework again after this meeting with some things to think about before the next meeting.

Assumptions

The responses to the survey homework were compiled and organized onto a handout given out today. We will not talk about this yet, but will wait instead until we get closer to which projects we will be funding.



Mr. Charbonneau asked about the difference between the assumptions and the criteria. Ms. Rosenberg defined the assumptions as being the things we know about the world that we believe are the case. The criteria will be how funded items are prioritized.

Aims/Drivers (Goals)

Note: From now forward, what were previously referred to as “SIM Goals” will be called the “SIM Aims,” to line up with the Driver Diagram document that we must complete for CMS within our Operational plan. She led the group through Connecticut’s driver diagram which was provided as a handout. She then went over a draft of four aims that the SIM staff workgroup has been working on. This is step one, because once we come to consensus with the aims, we can put buckets around the items we decide to fund. After the next 2 months of these meetings we should have a decent draft of a driver diagram that the Steering Committee can come to a consensus on.

The Aims considered at the meeting were:

1. Improve Health: Lead to measurable improvements in Rhode Island’s physical and mental health, in areas including diabetes, obesity, tobacco use, depression, and other measures. Set specific metrics to insert in this Aim, with a recognition of the impact of health disparities and social determinants of health.
2. Reduce cost trend growth through movement to value-based system (80% value based payments by 2018, with 50% in alternative payment methodologies).
3. Improve the capacity of x% of Rhode Island’s healthcare workforce to achieve the shift to a value-based payment system through a set of practice transformation activities
4. Improve patients’ care experience and quality of healthcare they receive through investments in provider’s capacity.

Discussion on the aims:

- Ms. Galgay was concerned about the first two Aims because she is not sure how to show the work of this project compared to what is already happening through other initiatives.
 - Dr. Hittner responded that an effort is being made to track that. We are putting together an inventory of things that are going on - in other agencies, grants that have been awarded or might be awarded, etc. - then we will look at this list to see how these things already going on that could make a large impact, then try to see where we could use SIM money to help make a difference. She added that Primary Care is where we are going to go to make changes. All the money does not necessarily go to support the practices, but it could be into something that will help those practice improve, for example integrating SBIRT. We talk about narrow and deep, but that does not necessarily mean it cannot be a small project with a large impact.
 - Mr. Giancola commented that we do not have to prove that SIM was what created the impact we are looking for.
 - Mr. Keefe stated that in that inventory, it is important to include what providers are doing.
 - Mr. King commented that it may be important to bring work that OHIC has done to help define and expand alternative payment methodologies and present it. **Ms. Rosenberg will circulate the APM framework and OHIC work on this to the group in the next couple of days.**
 - Ms. Zimmerman commented that CMS will also be doing an evaluation of everything that is going on, and we as a state are also supposed to conduct our own evaluation.



- Ms. Rosenberg stated that the inventory needs help from SIM steering Committee Members. **She will send it out electronically and ask for members' engagement with it to help fill in missing blanks or add other activities that are missing.** The inventory does include the information that SIM Steering Committee members shared with the state after a request for value based purchasing information at one of the original meetings.
- Mr. Glucksman asked about how this links into other initiatives to move toward value based payment (VBP). Dr. Hittner responded that we have an assumption that if we move to VBP, it will lower the cost of healthcare – and that the inventory will help us track all of the other initiatives.
- Mr. Charbonneau commented that when we talk about transformation to the 80% VBP by 2018, we need to be mindful that we have pushed down on the system before and had additional costs pop up in another place. When we say that ACOs are forming, there is some literature that they reduce costs, and some that say it raises prices. We should make educated guesses of the costs of change we have.
 - Ms. Hayhurst commented that United Healthcare has evidence that nationally ACOs have reduced costs. It is not an overnight savings, but takes time.
 - Mr. Charbonneau noted that lowering costs to payers vs. consumers are different things. Which is occurring?
 - Mr. Berson commented that we have talked about bending the cost curve, caps, containing the cost curve. We should at some point determine what is the end result we want?
 - Mr. Keefe stated that there are a lot of studies out there that show ACOs work, and the feds really believe that it works. He believes we are beyond the question “do ACOs work” but rather to how do we execute an ACO correctly.
 - Mr. Giancola summarized the discussion: new payment methodology will effect change. How then do those translate into insurance rates? If lowering cost does not reduce insurance premiums OHIC will have failed at its mission.
 - Mr. Keefe adds that there may not be an immediate effect upon premiums because there are a lot of processes to determine the cost of premiums and it may just take longer for that reduction in premium to happen.
 - Ms. Rosenberg noted that while the SIM vision mentions lowering the cost of healthcare – which is appropriate because a vision is a longer-term process - aims are steps on the way toward the vision. We may not succeed at lowering the cost in 3 years, but we can lower the trend to get toward the vision of lowering the cost.
- Dr. Alexander-Scott asked if we can align the aims with the triple aim vision.
- Ms. Rosenberg went into more detail with the third bullet. She noted that as Dr. Hittner has said, payment reform is already happening and we do not need to fund that. Instead, the way to think about SIM funding may be to fund assistance to those groups, providers, individual providers, facilities, to better engaged with this new world of payment reform.
 - The Committee clarified that “capacity” in this bullet describes competence: the appropriate skillset rather than number of individuals.
 - Ms. Boss asked that the text include behavioral health workforce in healthcare workforce.
 - Dr. Kurose thinks that it is both capacity and knowledge – it is retraining and hiring people into positions that have not existed before. Some of both are needed – i.e. to



hire new people with different skillsets and to retrain people who will transition their traditional role into something different.

- Mr. Berson commented that when you want to change culture its about the people. Just because the system is changing, doesn't mean people will change. If they cannot function in the new world, then we will not success.
- Ms. Rosenberg moved to the fourth bullet and the Committee suggested changing it to "Improve patients' care experience and quality of healthcare." Mr. Giancola commented that this is about getting patients engaged.

Public comments:

- Dr. Beth Lange noted that people are talking about provider experience more and more, and that it bears mentioning in the Aims. A study just came out that said 47% of physicians are dissatisfied with their jobs and want to retire early.

Funding Decision Criteria

The criteria fit into a couple different groups which Ms. Rosenberg went through with the Committee.

Criteria Related to Project Funding

**Making SIM Funding Decisions:
Criteria**

Criteria Related to Project Funding:

- 1) Project fills financial gaps, where SIM dollars would have most impact.
- 2) Project does not duplicate funding that is already allocated.

We would fund projects that in the absence of public action would never be funded – that the private sector could never fund.
- 3) Project is sustainable after SIM dollars spent.

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Comments:

- One member commented that items 2 & 3 seem inconsistent, and the group decided to take out the "never" in # 2.
- In the discussion about #2, Mr. Giancola stated that this could use the capital project idea – sometimes you have to fund the infrastructure and then people would be willing to fund to maintain it after.
- In thinking about the third aim (delivery system transformation), Dr. Kurose did not think making the distinction between what is publicly or privately funded is relevant and instead, we should focus on the end result we are going to get and spend the dollars on something for which we will get the biggest bang for our buck. He would not put it in the first couple of criteria and do not find these three to be the most important to him. Mr. Giancola responded, questioning whether there are things that the private sector is not likely to invest in because they cannot get



a return, but collectively we can invest together. Dr. Kurose is not sure because private/public is not as separated as it used to be due to the plans at CMS over the past few years pushing together the public and private sectors.

- Mr. Berson commented that money invested through SIM will be to seed a change in behavior. How do we incent the things we want knowing that capital may flow once someone is ready to make the first step?

Criteria Related to Project Content

Making SIM Funding Decisions: Criteria

Criteria Related to Project Content:

4) Project ties funding to SIM vision/goals.

Projects that are part of innovative systems transformation (such as PCMH Kids and the Child Psychiatric Access Project).

Project ensures more effective service delivery to populations (such as child/adolescents) with trouble accessing right services at right time (such as mental health).

Project will strengthen RI's primary care infrastructure.

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Making SIM Funding Decisions: Criteria

Criteria Related to Project Content:

5) Project addresses most pressing need(s).

6) Project addresses payment reform.

The potential for project to accomplish SIM goals (e.g. 80% value based payment).

7) Project makes healthcare affordable.

What is the project's impact on cost? Small, medium, large or no impact?

What is the project's impact on premiums? Small, medium, large or no impact?

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Making SIM Funding Decisions: Criteria

Criteria Related to Project Content:

8) Project is evidenced-based (nationally or locally).

Impact can be measured with progress tracked along the way.

9) Project will have generational impact (impact on next generation of children) or does project have more short-term goals (spend now on other needs that children have).

10) Project will have appropriate level of complexity to achieve desired change.

11) Project will have SIM-appropriate effect on workforce.

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Comments:

- Ms. Rosenberg clarifies that criteria 1 “most impact” would be impact on the metrics and the aims that we give to CMS.
- There was a question about whether the actual ability to spend the dollars (procurability – political support, etc.) for us to do it should be a criteria.
- There was a question about what the generational impact means, because any change in a child’s health has a genetic effect. Mr. Berson responded that he thought this meant quick wins with noticeable affects that will last rather than long term changes.
- Dr. Kurose thinks we are making it too complicated: we have a set of aims, we have some money, and we need to fund things that will help accomplish the aims. Mr. Berson states that problem is that we need additional criteria because we have too many options and need to focus how money is spent.



Applying the Funding Decision Criteria

Committee members began the discussion of how to apply the criteria to the potential activities and noted that it was a complicated process. Some committee members felt that they needed more financial information to determine where the gaps in funding were. Mr. Keefe commented that this list was generated in December 2014 and asked whether it is still the right list? Mr. Berson stated that this list came up when we were working with a \$60 million budget. He questions how we can leverage the investments we already made in these categories with dollars we have.

For example with practice assistance, RIQI has the TCPI grant, but they can only serve a small subset of providers with a set of things they are going to be doing. Laura Adams described how only about 20-25% of those they engage will be primary care with this grant, which is 8.3 million over 4 years. Practice assistance funding is also in CTC. The question then became whether those gaps are funded elsewhere and also how the SIM project could help can accelerate the processes going on.

The PCMH expansion line item connects to Community Health Teams. A comment was made about the budget for PCMH Kids which is up and running with 9 pilot practices and generously supported from the payers but also counting on this funding to cover the data management and staffing and run out of that money as of March 31st.

Child Psychiatry Access Program – A comment was made that this program will immediately reduce costs and there are successes demonstrated in Massachusetts.

Advanced Illness Care Initiatives – Mr. Giancola commented that it is important to fund this.

Additional comments:

- Mr. Giancola asked what would it take to accomplish the aims - a lot seems to revolve around the capabilities of the people in the system to accomplish this. He asked if in lieu of another meeting, we should have a subgroup that takes aim 3 and really looks to see what we need to do to leverage current resources and apply new resources to improve change.
- Mr. Keefe asked if the Committee can be given more guidance – perhaps a limit like the Committee can approve 4 healthcare transformation initiatives and 1 HIT initiative. It may help wean down the list. Ms. Kwiatkowski suggests that patient engagement should be embedded in each of the other categories rather than a separate item as a required component of those items.
- As for moving money from one category to another, Ms. Rosenberg commented that we can make a proposal to CMS and if it is smart and thoughtful it may succeed.
- Mr. Giancola stated that technical assistance is needed to do this work and the vendor is needed to assist the work.
- Mr. Berson stated that we need the population health discussion to weigh in early in this process.

5. Public Comment



Laura Adams from RIQI commented that there may be better ideas for consumer facing tools than the language that is in the original budget. There may be major differences in the type of tools available that would be much more useful to consumers and drive improvement in diabetes, etc. more effectively.

Tina Spears from RIPIN said that she was concerned that we have waited a long time for the population health plan vendor to come aboard, and if we continue to wait, we could be waiting another year and a half before we can get these projects implemented. If not funded the behavioral health crisis for children will continue. At the rate and pace we are going, some of these projects are not going to be funding for 6-8 month even if we made the decision today. There are things we already know: not enough child psychiatry access in state, need to expand PCMH, need to build community health teams.

6. Adjourn

Another meeting is proposed for 2 weeks from this date on January 28th, to have a group prepare a strawman for decision-making in February. Meeting details will be sent out by Ms. Rosenberg.

With no further business or discussion, the meeting adjourned at 7:12 pm.

Notes prepared and respectfully submitted by:

Melissa Lauer, MPA
Chief, Public Health Informatics
Department of Health
January 19, 2016