



SIM Steering Committee
Thursday, October 15, 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: Richard Glucksman

Neighborhood Health Plan of Rhode Island: Craig O'Connor

Tufts Health Plan: David Brumley

United Healthcare of New England: Neil Galinko, MD

Lifespan:

Care New England: Dale Klatzker, PhD

South County Hospital: Lou Giancola

CharterCARE:

Coastal Medical: Al Kurose, MD

RI Health Center Association:

Rhode Island Medical Society: Peter Hollmann

RI Council of Community Mental Health Organizations:

Drug and Alcohol Treatment Association of Rhode Island: Susan Storti, PhD, RN

RI Kids Count: Elizabeth Burke Bryant

Rhode Island Foundation: Yvette Mendez

YMCA of Greater Providence: Jim Berson

Executive Office of Health and Human Services: Elizabeth Roberts

Department of Health: Nicole Alexander-Scott, MD/MPH

Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH): Maria Montanaro

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

HealthSourceRI (HSRI):

Office of the Governor:

Rhode Island Primary Care Physicians Corporation: Andrea Galgay

Carelink: Liz Boucher

Rhode Island Business Group on Health:

State Agency Staff:

Executive Office of Health and Human Services: Tom Martin; Cheryl Wojciechowski; Hannah Hakim; Amy Zimmerman; Elizabeth Shelov

Department of Health: Samara Viner-Brown; Ted Long, MD; Sandra Powell; Michael Dexter; Margaret Gradie

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

Other Attendees: Alok Gupta and Laura Adams (Rhode Island Quality Institute); Jim Beasley (RI Kids Count); Mark Gray (The Providence Plan); John Keimig (Healthcentric Advisors); Susanne Campbell (CTC-RI); Charles Hewitt (self); Alan Krinsky (East Bay CAP); Newell Warde (RI Medical Society); Laretta Converse (Senate Fiscal Office); Cathy Dooley; Marti Rosenberg

Introductions & Overview

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



Mr. Giancola provided an update on SIM initiatives: The RFP for a population health plan (including a behavioral health component/project management vendor has been posted. There were eight responses received from bidders. The selected bidder will be announced as soon as the review concludes and may be presented at the next meeting.

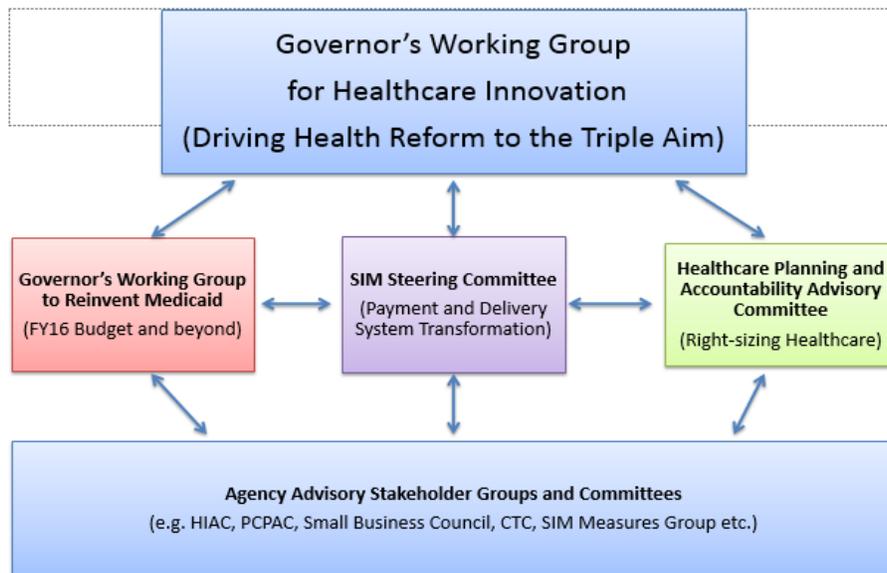
Elizabeth Burke Bryant suggested to the group that they focus now on “shovel-ready” projects, such as a children’s mental health team. She asked, “What are the “readier” projects? Deputy Secretary Wood indicated that the Steering Committee could make an exception and proceed with “shovel-ready” projects, but that the Steering Committee had previously decided that funding authorization for transformation network activities would be deferred until after a population health plan is completed. This can be re-visited by the Committee. The entire array of projects would then have to be brought back to the Committee. Secretary Roberts reminded the group that the first year is a planning year.

Mr. Giancola asked Ms. Burke Bryant to please provide background information for this request. It will be on the agenda for the next meeting of the Committee, with full notice to the Committee.

The SIM DOH and BHDDH candidates have been interviewed. The project director position was filled and announced last month. (Welcome Marti Rosenberg!) No final decisions have been made on the candidates who were interviewed. All positions will work together with the project director.

“Putting the Pieces Together, Reflecting the New Environment”

Ms. Wood presented a PowerPoint on “Putting the Pieces Together, Reflecting the New Environment.” She described the relationships among the SIM governing body and the various state stakeholder engagement groups. The relationship graphic appears as follows:



The former health care reform commission, known as the “Healthy RI Committee”, has been replaced by the new Working Group for Healthcare Innovation. All of these groups are focused on the “Triple Aim.” Under the umbrella (see above), the three biggest community input groups are the Working Group to Reinvent Medicaid, this SIM Steering Committee, and the Health Care Planning & Accountability Advisory Council (HCPAAC). SIM is focused on how government leads and develops infrastructure and uses its policy levers to achieve health



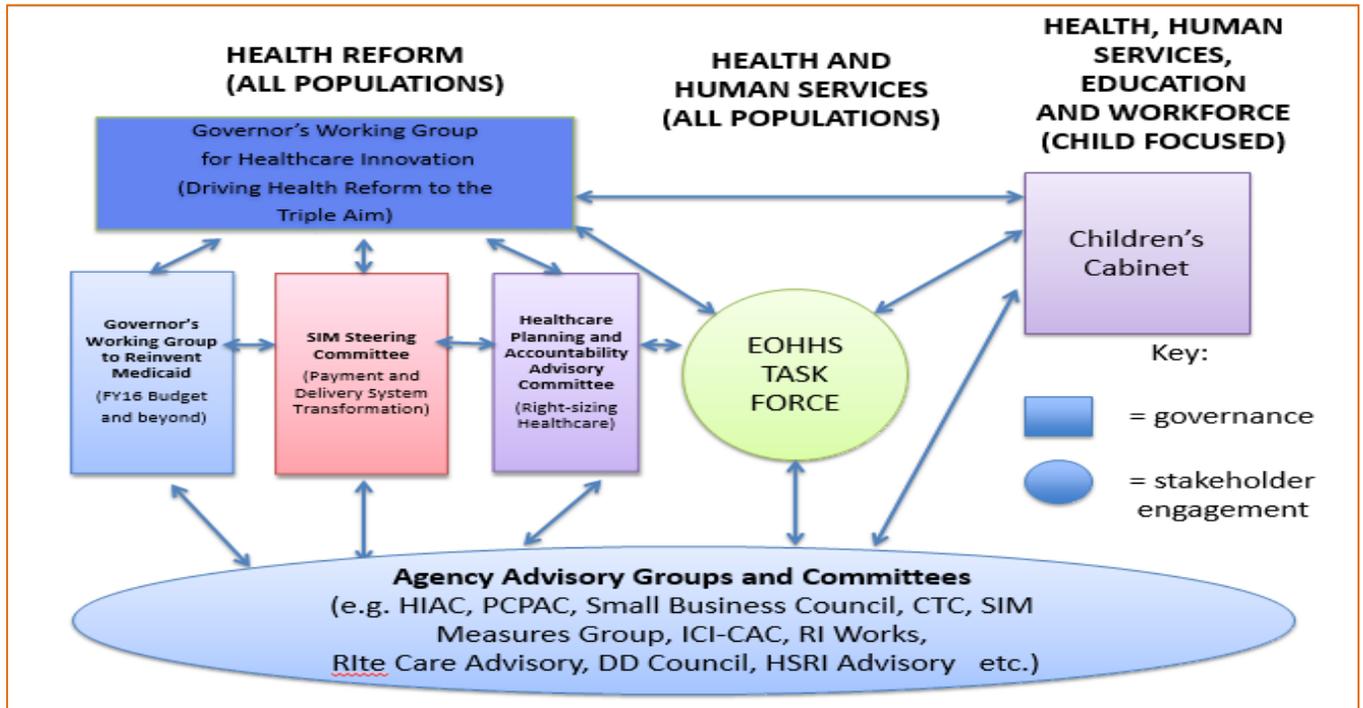
care reform. HCPAAC is focusing on right-sizing Rhode Island’s health care system, looking at needs versus capacity. This group has done research studies and has brought information forward regarding medical care. Ms. Wood noted that the state’s certificate of need program (CON) should be measured within the context of a statewide health plan.

Ms. Wood explained the diagram and indicated that the Reinventing Medicaid Workgroup has officially ended but that there are implementation teams that are still meeting. The Secretary indicated while the Reinventing Medicaid work group is officially over, there is consideration to bring the work group back together unofficially to provide updates.

It was also pointed out that the Office of the Health Insurance Commissioner (OHIC) is doing important work with community input that relates to the other initiatives listed on the chart, specifically the alternative payment and care transformation groups. These are working, consensus-driven groups. The alternative payment methods work group discussions and outcomes feed into the SIM goal of 80% value-based care arrangements by 2018. SIM supports an infrastructure to permit other initiatives to be developed and implemented.

The EOHHS Task Force group has replaced the former Medicaid Global Waiver Task Force and it deals with findings of the HCPAAC and agency advisory committees. The Children’s Cabinet has been reconfigured and is meeting again.

Below is an expanded diagram that includes selected agency advisory groups and committees, which are all public bodies:



In addition, there are two entities outside state government, Rhode Island Quality Institute (RIQI) and Healthcentric Advisors, which both play important roles within the scope of this discussion.

Ms. Wood asked for comments and for the group to please provide input. This model will continue to be refined. There were no comments from the group.



The entire PowerPoint presentation appears below:

The Intersection of Health, Education and Human Services Governance and Stakeholder Engagement

**PUTTING THE PIECES
TOGETHER,
REFLECTING THE NEW
ENVIRONMENT**

Measures Alignment Subcommittee

Cory King, of OHIC staff, presented an update on the measures alignment subcommittee, whose goal is to produce a menu of agreed-upon measures to be used by commercial payers as well as Medicaid. Twelve measure domains have been reviewed to date and include the following:

Measure Domains:

1. ✓ Chronic illness care
2. ✓ Preventive care
3. ✓ Institutional performance (inclusive of patient safety in hospitals and NFs)
4. Behavioral Health
5. Consumer experience
6. Health status/functional status
7. Medication management
8. Overuse
9. Care coordination/transitions of care
10. Access
11. Utilization
12. Cost



The upcoming work of this subcommittee includes:

- A complete review of measures currently in use;
- A review of measures selected for inclusion;
- A review of candidate measures for domains not currently populated, or for areas the work group members find worthy of attention; and
- Review final product.

Michael Bailit has been an excellent facilitator for this subcommittee, according to Mr. King.

Dr. Nicole Alexander-Scott met with measures alignment subgroup in order to facilitate open communication regarding population health measures. It is estimated that about 50% of the measures are connected to DOH population health goals. Dr. Alexander-Scott would appreciate the opportunity to present on DOH’s population health goals at the next SIM Advisory Committee meeting. Alignment between population health and measures harmonization has to be in sync. This is an important point. Alignment would be step 1; coming up with a menu of measures to be used in the contracting process would be step 2; making sure that they roll up into a set of population health measures would be step 3.

Mr. King offered to provide written reports to the Steering Committee, if that would prove to be helpful. Maria Montanaro wants “level-setting” discussions and updates on measures harmonization to continue.

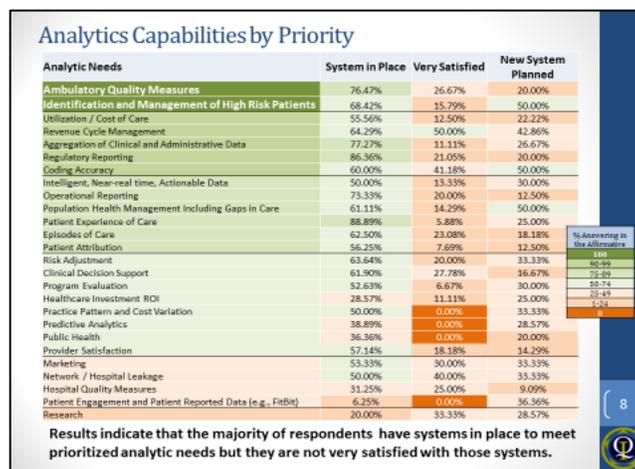
Healthcare Analytics in Rhode Island: A Statewide Inventory

Next on the agenda was a presentation by Elaine Fontaine of the Rhode Island Quality Institute (RIQI).

Ms. Fontaine presented on a statewide inventory of healthcare analytic tools. The purpose of the RIQI study was to understand the healthcare analytics landscape in Rhode Island. A copy of Ms. Fontaine’s presentation appears below.

RIQI sent out 49 surveys to stakeholders and received 30 completed survey responses.

What analytics are important? Prioritized measures appear on the left (below):





Among the findings:

- Many respondents have major systems in place but they are not very satisfied with these systems;
- Current tool use: most respondents are relying on their primary core system to support analytic needs;
- Significant investments (\$9 million) are being planned over the next two years to support value-based payments;
- Thematic excerpts from interviews are as follows:

Thematic Excerpts from Interviews

... What we really need is **one timely, accurate, organized source of information******

... right now we spend 95% of our time on data management and 5% on analysis. I would like for it to be 5% data management and 95% analytics...****

... we are in our infancy in producing data and our users are in their infancy is requesting data and knowing what to do with it...***

... one place should take ownership and hold all data and harmonize measures rather than having everyone run their own reports...***

... Plans don't understand workflow so don't deliver data as needed...***

... Hospitals are a black box...**

... We need to focus on data quality and bringing structure to our internal systems before doing more sophisticated analysis...**

...canned reports won't answer the questions I have tomorrow...

...We are drowning in data but not actionable information...

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** - **** Increasingly frequently repeated thematic comment

Key finding: People are drowning in data but need information that is actionable.

Conclusions and outstanding questions:

- How can Rhode Island build more capacity over time?
- How can Rhode Island train the health care community to better use data and metrics to drive value?
- All stakeholders express the importance of analytics in their ability to successfully undertake new payment systems;
- Many organizations expressed an intention to make significant investments in population health and care management tools in the next 24 months;
- Can Rhode Island find economies of scale for planned investments?

Healthcare Analytics in Rhode Island : A Statewide Inventory
 A Report by Rhode Island Quality Institute
 October 2015

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Health Care Quality Measurement, Reporting, and Feedback Workgroup Charge

Amy Zimmerman, of the EOHHS staff, next asked the Committee to develop a consensus on convening a measures technology platform workgroup to examine a statewide quality reporting, measurement, and feedback system. This work group will explore and prioritize the data collection and feedback processes necessary for providers to bring value to the health care system.

Among the discussion questions:

- What would bring value to providers?
- How can we leverage this work in the community?
- Is this the right next step?

Group Comments:

- Can we use the SIM measures work group to do this work? This might be a good starting point.
- There's so much expertise within RIQI that they would add so much expertise to the work group.
- Do you want a working group with additional providers, payers, experts on measurement? Do we want this as a good next step?
- Don't want the HOW to drive the WHAT.
- If nothing else, you get providers and payers in the room; that is a good thing but is very complicated.
- Need to build technical capacity; there are timing issues here.
- Human capacity issue: just because we build it, doesn't mean that people will want to or know how to use it; it involves translating information into action.
- Do we want to move down the road to be able to think about a shared resource?
- This would be a short-lived, time limited group.
- We have to highlight those providers who cannot come to meetings, ask them for input.
- Less supportive if providers who don't have a voice are not able to be represented.
- Need to have all of the right people around the table.
- Workgroup could be supplemented by other work, such as focus groups and listening sessions.
- Series of parallel steps can be taken. Maybe it's a work group and other opportunities for obtaining input.

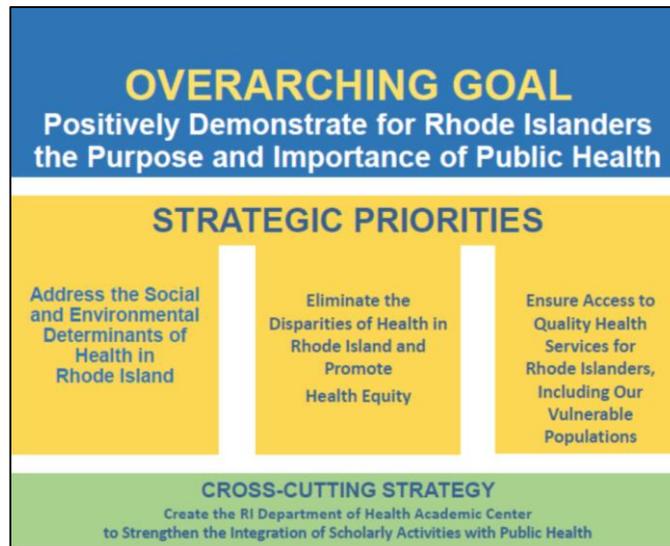
The consensus was to create several opportunities to obtain further input, including a time-limited work group.

Health Care Capacity & Utilization Study

The next presentation was by Dr. Ted Long and Sandra Powell, of the Rhode Island Department of Health, who presented an update on the Health Care Capacity and Utilization Study. Dr. Long, a Robert Wood Johnson clinical scholar, designed the survey questions contained in the Health Care Capacity and Utilization Study. Twelve specific inventories were created (e.g., practice levels, hospitals).

Response rates were extraordinary, approaching 100% in many instances. An "army" of people were involved in the completion of this survey work. The surveys were designed to assess and evaluate key health resources, unmet needs, and future demands. Recommendations will be made to expand, reduce, and/or modify facilities and services.

The overarching goal that guides this work is described below:



Dr. Long described population health-related goals: 1. Promote healthy living for all through all stages of life; 2. Reduce the proportion of Rhode Islanders with chronic illnesses, like diabetes; 3. Coordinate and have access to data; 4. Provide the best primary care, such as available in a patient-centered medical homes (PCMHs); 5. Promote a comprehensive health system that a person can navigate, access, and afford; 6. Improve access to care, including physical, oral, and behavioral health; and 7. Analyze and communicate data to improve the public’s health.

The utilization and capacity study results are due to the General Assembly by November 1, 2015. GIS mapping of relevant findings will be done within 30 days of November 1, 2015.

The DOH presentation appears below in its entirety.



Public Comment

There was no public comment.

Next Meetings

The next meeting date/time will be announced. With no further business or discussion, the meeting adjourned at 7:40 pm.

Notes prepared and respectfully submitted by:
 Elizabeth Shelov, MPH/MSSW
 Chief, Family Health Systems
 Executive Office of Health & Human Services
 October 26, 2015