Common Care Plan Committee
October 13, 2016 Meeting Minutes
1:00-2:30 p.m.
Maine Quality Counts Hanley Board Room
16 Association Drive, Manchester, ME 04351
Conference Line: 1-888-450-5996 PC 771487#
Agenda

Attended: Shaun Alfreds, Becky Hayes Boober, Michelle Cloutier, Kathy Day*, Angela Fileccia*, Peggy Haynes*, Betsy Sawyer-Manter, Betty St. Hilaire (*via conference line)
Becky introduced Shaun Alfreds of HealthInfoNet (HIN). Members introduced themselves and gave updates related to the Common Care Plan work. Betty St. Hilaire, Community Health Options, was welcomed to the group.
Updates:
Rhonda reported on a Quality Counts lunch and learn session today. Shaun and Rhonda are both on the Medicaid Proposal Oversight Committee, which includes aging as well. The CPCPlus might be another option by CMMI for Maine funding.
Betsy—Community Health Options has a paid contract with SeniorsPlus to address social determinants of health with four levels of services. Over 400 attended their Aging Well/Living Well Expo and the men's health workshop was filled.
Angela—PCHC works with HIN analytics to modify its work flow to reduce hospitalizations. They meet monthly with HIN Analytics staff.
Peggy—MaineHealth is focusing on ACO population health management.
Kathy—Reported on the LAWN Institute and the Safety Academy presentations she's made at 3 Senior Expos.
Shaun shared an overview of HealthInfoNet, which is an electronic health record system. It shares information bidirectionally with all Maine hospital systems, 500 ambulatory practices, 20 community behavioral health centers, MaineCare, and the VA. They have 1.6 unique lives represented in the system, which includes 98% of all Maine people and many out-of-state visitors. Over 350,000 events of care are inputted monthly. Over 4500 automated, real-time messages are sent to providers related to patients' care and needs and over 3000 providers actively use the system each month.
They are changing the look of the screens, with new tabs (such as Medical, Community) to make it easier to use by the end of the year. There will be role-based access to data with permission levels. They also include all prescriptions from several pharmacies (Rite Aid, CVS, etc.) and payers. They have an active predictive analytics platform that alerts providers when patients are at risk of a health crisis event. The VA system (My Healthy Vet) now has all HIN records as well.
A 6-month study of 18 organizations showed a $6 million reduction in cost in six months for 443 patrons. Patients who have 2 or more ED visits previously showed a 40% reduction in ED use. Medtronic devices information (i.e. insulin pumps) goes into HIN. By tracking CFH (weight), diabetes blood sugar indicators, heart rate and rhythm, and blood oxygen, the analytics can alert providers when there's a concern rather than reliance on 4-days monitoring. Medicare limits the type of trips and meters that can be used, though.

Senseo is a self-administered monitoring device customized to individuals that alerts care managers and primary care providers. It has blue tooth connection so it's real-time alerts.

Shaun then reported on the grants related to Common Care Plan. Two years ago, the Davis Family Foundation gave HIN a grant to start discussions about the core data elements needed in common care planning. They started the discussion with health care systems (Patient Centered Medical Homes, care management teams, and providers) and focused on the clinical side. They also looked at housing, transportation, and subsistence services (TANF, SNAP, etc.) The summary report will be posted on the website soon.
Now, they are implementing a grant project with funding from the Robert Wood Johnson Foundation Grant to look across sectors and to think about how HealthInfoNet might link Health Records with Community Social Services Records from 2 CAP Agencies (Penquis and York/Nasson). They are examining where data reside now related to community services. For transportation, they have all Medicaid claims data for three years which captures both medical and nonmedical transportation. Later this year, they'll have Keplar's (was APS) prior authorization for behavioral health services including housing.
Workflow and integration of care are key. What's important to my patient? What worries you most about your healthcare?
They are aligned with PCHC ACO to test the pilot, aligning with the ACO's goals. PCHC already imports Eastern AAA's data. Driving the strategy is: What data goes in and where are they stored and how do you connect with community services' data? Which staff members need access to what data? However, you also must have structured care coordination and users who know how to use the data. In addition to having permission to share information, it is important to safely make appropriate access and use of data.
Housing data are already in FQHC's UDS reports to HRSA. HUD/MSHA/CAPs and DHHS also have housing data. The person must agree to share these data.
HIN is working with the Director of Public Health on legal language that could be used in their contracts to require sharing of information. There are 269 different data systems in DHHS public health (CDC) today.
Shaun was asked about patient portals. HIN has three patient portals, but all did not work for patients as intended, not due to the technology. Federal law says the healthcare provider legally "owns" the data. Meaningful use requires all providers to give access to a patient within 36 hours. So, providers purchased portals from EMR vendors and they aren't interoperable. The Blue Button project was tried at Eastern Maine where a patient could lick one button and get all the HIN data. However, there were three platforms so it was confusing.
Massachusetts has a referral management system as part of its HIN at the user level.
Medication reconciliation is a priority, especially regarding psychotropic medications. People with dementia are often overprescribed psychotropic medications.
Shaun had reviewed the work of the group so far and indicated this level of detail will be very helpful. He encouraged the group to continue this work, since it will help with the next step of the HIN work. He recommended being granular, prioritizing what is most important to share, and think about who "owns" what data/access to data. How can we reduce the number of connection nodes (get the most data from the least number of connections)? For example, all AAAs use the same system. Also, identify the engaged organizations willing to start with and think about replicating to non-pioneer sites later.
The future meeting schedule: November 3 and December 1; 1-2:30; MeHAF; Augusta