

**Delivery System Reform Subcommittee**

**Date: August 6, 2014**

**Time: 10:00 to Noon**

**Location: Cohen Center, Maxwell Room**

**Call In Number: 1-866-740-1260**

**Access Code: 7117361#**



**Chair: Lisa Tuttle,** Maine Quality Counts ltuttle@mainequalitycounts.org

**Core Member Attendance:** Kathryn Brandt, Robert Downs, Jud Knox, David Lawlor, John Patten, Lydia Richard, Rhonda Selvin, Katie Sendze, Catherine Ryder, Betty St. Hilaire

**Ad-Hoc Members:**  Regen Gallagher, Anne Graham, Gerry Queally, Ellen Schneiter, Julie Shackley

**Interested Parties & Guests:**  Becky Hayes Boober, Cathy Bustin, Randy Chenard, Anne Conners, David Hanig, Barbara Ginley, Sandra Parker, Yvonne Powell, Jessica Newman, Amy Wagner, Katherine Woods

**Staff:** Lise Tancrede

| **Topics** | **Lead** | **Notes** | **Actions** **/Decisions** |
| --- | --- | --- | --- |
| 1. **Welcome! Agenda Review**
 | **Lisa Tuttle****10:00 (5 min)** | Introduced the Lewin Group Team, who are the SIM Evaluators.  | Agenda reviewed and accepted. |
| 1. **Approval of DSR SIM Notes 6-4-14**
2. **Notes from Payment Reform/Data Infrastructure Subcommittees**
 | **All****10:05 (10 min)** | Committee approved the notes of 6- 4-14 SIM DSR meeting as presented. Lise gave a quick review of SIM DSR material distribution process and Randy reviewed available materials that are on the SIM website.  | September meeting bring in the status on last two remaining initiatives:Direct, provide input on leadership development initiative.Inform development and execution of Developmental Disabilities/ Autism Training for Primary Care Providers |
| 1. **Recap of SIM DSR Subcommittee Work To Date**

**Expected Actions: To review DSR subcommittee accomplishments since 10-31-13** | **Lisa Tuttle****10:15 (20 min)** | Lisa provided the subcommittee an overview of DSR work done to date and accomplishments. (See Slides attached)Randy is working on a draft of the Leadership Development Program which will be going before the Steering Committee for funding approval. Gerry Queally addressed a potential risk to the SIM Project. He had concerns about the transition plan for the HCBS Waiver which has to be resubmitted by March 15, 2015.Barbara Ginley shared a status report on the CHW pilot. Currently there are four (4) pilot projected to start by September 1, 2014. **Spectrum Generations** will be integrating a CHW into their AAA.**Portland Public Health** will be working with populations challenged by difference in culture and language.**Maine General** will incorporate CHW into their prevention center focusing on patient populations that are not using health care resources appropriately. i.e. frequent ED usage.**DFD Russell** is the four will be addressing people with diagnosis of asthma to decrease ED usage, hospitalizations and breast cancer screenings.Randy shared that the steering committee has spent some time on change fatigue. This is a great example of a risk being identified at the DSR subcommittee and being escalated up to the steering subcommittee for review.The subcommittee broke up into small groups to consider Gaps in their work to date since 10/31/14 (data collected will inform future agendas) | Request was made to Randy to add potential for scholarships to the information on Leadership Development to the SC Add to Risk Log: Involve SIM in the rewriting of the HCBS Waiver transition plan required by March 15, 2015. Workgroup to include Gerry Quelly, Anne Graham, Jim Martin and consumers. |
| 1. **SIM Accountability Targets and Status Reports**

**Expected Actions: Understand existing SIM Accountability Targets and Status reporting process; Discussion to identify DSR initiatives status to subcommittee** | **Randy Chenard****10:35 (45 min)** | Randy reviewed the SIM Status at a Glance and the 6 Strategic Pillars. All of these pillars/objectives do relate to the Triple Aim. There is still work to do to map them to the Triple Aim and it will be a focus of the Lewin Team to assist in accomplishing this task.Randy gave a brief overview of the Accountability Targets and the status of each objective which is tracked quarterly and are represented by colors of Red, Green, and Yellow. Based on the actual accomplishments in a given quarter will translate to that color. Each box represents a quarter.From these process measures the Lewin group will determine what the outcomes of that date will accomplish. The challenge is to get the work at a high enough level to be meaningfully reported on because each objective has a different number of tasks, some as much as 100.Question of how were the measures determined:The measures were determined by each of the partners, based on the contracted scope of work. The outcome measures will be developed and worked on by the Lewin Group. There is still confusion on where does the DSR committee fit into the oversight of the strategies. Should the committee be looking at the impact or alignment to the Triple Aim?Randy clarified that we still need to do the outcome work, define them and be clearer about the strategies and what the objectives are. We are doing work now to define the objectives and how do we effectively engage the SIM Governance. This will help to inform what the outcomes are. | **Disseminate the Driver Diagram to the Subcommittee for review.** There was a recommendation to ensure that consumers are informing the final measures developed by the Lewin Group. |
| 1. **Risk/Dependencies**

**Review of SIM Risk Management Log****Expected Action: Provide update on current risks being mitigated at steering committee level and to identify any additional risks from subcommittee** | **All****11:20 (20 min)** | The group used the example of the risk that Gerry Quelly identified at the top of the meeting to work through their understanding of the risk mitigation process. Lisa asked the committee to think about identifying risks in their discipline and bring back to the next meeting. | **Distribute the SIM Risk Mitigation Process document to the Subcommittee** |
| 1. **Interested Parties Public Comment**
 | **All****11:40 (10 min)** | **None** |  |
| 1. **Evaluation**
 | **All****11:50** | There were 28 people in attendance. Evaluations scored between 5 and 9 with the majority at 8. (One score at 3) Committee members agreed that the group time and discussion process works well and makes them feel heard. Lisa’s recap of the past 8 months was well received. Some committee members still feel that there are too many items on the agenda with insufficient time to discuss. More time on discussion, less on process. |  |
| **September Meeting****Topics TBD****\*Note: October Meeting moved to second Wednesday (October 8th)** |  |  |  |

**Next Meeting: Wednesday September 3, 2014 10:00 AM to Noon;**

**Cohen Center, Maxwell Room,**

**22 Town Farm Rd, Hallowell**

|  |
| --- |
| **Delivery System Reform Subcommittee Risks Tracking** |
| **Date** | **Risk Definition** | **Mitigation Options** | **Pros/Cons** | **Assigned To** |
| 8/6/14 | The Opportunity to involve SIM in the rewriting of the ACBS Waiver required by March 15th. |  |  |  |
| 6/4/14 | The rate structure for the BHHOs presents a risk that services required are not sustainable  | Explore with MaineCare and Payment Reform Subcommittee? |  | **Initiative Owners: MaineCare; Anne Conners** |
| 4/9/14 | There are problems with MaineCare reimbursing for behavioral health integration services which could limit the ability of Health Home and BHHO’s to accomplish integration. |  |  |  |
| 3/5/14 | Consumer engagement across SIM Initiatives and Governance structure may not be sufficient to ensure that consumer recommendations are incorporated into critical aspects of the work. |  |  |  |
| 3/5/14 | Consumer/member involvement in communications and design of initiatives |  |  | **MaineCare; SIM?** |
| 3/5/14 | Patients may feel they are losing something in the Choosing Wisely work |  |  | **P3 Pilots** |
| 2/5/14 | National Diabetes Prevention Program fidelity standards may not be appropriate for populations of complex patients |  |  | **Initiative owner: MCDC** |
| 2/5/14 | Coordination between provider and employer organizations for National Diabetes Prevention Program – the communications must be fluid in order to successfully implement for sustainability |  |  | **Initiative owner: MCDC** |
| 2/5/14 | Change capacity for provider community may be maxed out – change fatigue – providers may not be able to adopt changes put forth under SIM |  |  | **SIM DSR and Leadership team** |
| 2/5/14 | Relationship between all the players in the SIM initiatives, CHW, Peer Support, Care Coordinators, etc., may lead to fragmented care and complications for patients |  |  | **SIM DSR – March meeting will explore** |
| 1/8/14 | 25 new HH primary care practices applied under Stage B opening – there are no identified mechanisms or decisions on how to support these practices through the learning collaborative |  |  | **Steering Committee** |
| 1/8/14 | Data gathering for HH and BHHO measures is not determined | Need to determine CMS timeline for specifications as first step |  | **SIM Program****Team/MaineCare/CMS** |
| 1/8/14 | Unclear on the regional capacity to support the BHHO structure  | Look at regional capacity through applicants for Stage B; |  | **MaineCare** |
| 1/8/14 | Barriers to passing certain behavioral health information (e.g., substance abuse) may constrain integrated care | Explore State Waivers; work with Region 1 SAMSHA; Launch consumer engagement efforts to encourage patients to endorse sharing of information for care |  | **MaineCare; SIM Leadership Team; BHHO Learning Collaborative; Data Infrastructure Subcommittee** |
| 1/8/14 | Patients served by BHHO may not all be in HH primary care practices; Muskie analysis shows about 7000 patients in gag | Work with large providers to apply for HH; Educate members on options |  | **MaineCare; SIM Leadership Team** |
| 1/8/14 | People living with substance use disorders fall through the cracks between Stage A and Stage BRevised: SIM Stage A includes Substance Abuse as an eligible condition – however continuum of care, payment options; and other issues challenge the ability of this population to receive quality, continuous care across the delivery system | Identify how the HH Learning Collaborative can advance solutions for primary care; identify and assign mitigation to other stakeholders |  | **HH Learning Collaborative** |
| 1/8/14 | Care coordination across SIM Initiatives may become confusing and duplicative; particularly considering specific populations (e.g., people living with intellectual disabilities | Bring into March DSR Subcommittee for recommendations |  |  |
| 1/8/14 | Sustainability of BHHO model and payment structure requires broad stakeholder commitment |  |  | **MaineCare; BHHO Learning Collaborative** |
| 1/8/14 | Consumers may not be appropriately educated/prepared for participation in HH/BHHO structures | Launch consumer engagement campaigns focused on MaineCare patients |  | **MaineCare; Delivery System Reform Subcommittee; SIM Leadership Team** |
| 1/8/14 | Learning Collaboratives for HH and BHHO may require technical innovations to support remote participation | Review technical capacity for facilitating learning collaboratives |  | **Quality Counts** |
| 12/4/13 | Continuation of enhanced primary care payment to support the PCMH/HH/CCT model is critical to sustaining the transformation in the delivery system | 1) State support for continuation of enhanced payment model |  | **Recommended: Steering Committee** |
| 12/4/13 | Understanding the difference between the Community Care Team, Community Health Worker, Care Manager and Case Manager models is critical to ensure effective funding, implementation and sustainability of these models in the delivery system | 1) Ensure collaborative work with the initiatives to clarify the different in the models and how they can be used in conjunction; possibly encourage a CHW pilot in conjunction with a Community Care Team in order to test the interaction |  | **HH Learning Collaborative; Behavioral Health Home Learning Collaborative; Community Health Worker Initiative** |
| 12/4/13 | Tracking of short and long term results from the enhanced primary care models is critical to ensure that stakeholders are aware of the value being derived from the models to the Delivery System, Employers, Payers and Government | 1) Work with existing evaluation teams from the PCMH Pilot and HH Model, as well as SIM evaluation to ensure that short term benefits and results are tracked in a timely way and communicated to stakeholders |  | **HH Learning Collaborative; Muskie; SIM Evaluation Team** |
| 12/4/13 | Gap in connection of primary care (including PCMH and HH practices) to the Health Information Exchange and the associated functions (e.g. notification and alerting) will limit capability of primary care to attain efficiencies in accordance with the SIM mission/vision and DSR Subcommittee Charge. |  |  | **Data Infrastructure Subcommittee** |
| 11/6/13 | Confusion in language of the Charge:  that Subcommittee members may not have sufficient authority to influence the SIM Initiatives, in part because of their advisory role, and in part because of the reality that some of the Initiatives are already in the Implementation stage. Given the substantial expertise and skill among our collective members and the intensity of time required to participate in SIM, addressing this concern is critical to sustain engagement.  | 1) clarify with the Governance Structure the actual ability of the Subcommittees to influence SIM initiatives, 2) define the tracking and feedback mechanisms for their recommendations (for example, what are the results of their recommendations, and how are they documented and responded to), and 3) to structure my agendas and working sessions to be explicit about the stage of each initiative and what expected actions the Subcommittee has. | **Pros: mitigation steps will improve meeting process and clarify expected actions for members;****Cons: mitigation may not be sufficient for all members to feel appropriately empowered based on their expectations** | **SIM Project Management** |
| 11/6/13 | Concerns that ability of the Subcommittee to influence authentic consumer engagement of initiatives under SIM is limited.  A specific example was a complaint that the Behavioral Health Home RFA development process did not authentically engage consumers in the design of the BHH.  What can be done from the Subcommittee perspective and the larger SIM governance structure to ensure that consumers are adequately involved going forward, and in other initiatives under SIM – even if those are beyond the control (as this one is) of the Subcommittee’s scope. | 1) ensure that in our review of SIM Initiatives on the Delivery System Reform Subcommittee, we include a focused criteria/framework consideration of authentic consumer engagement, and document any recommendations that result; 2) to bring the concerns to the Governance Structure to be addressed and responded to, and 3) to appropriately track and close the results of the recommendations and what was done with them. | **Pros: mitigation steps will improve meeting process and clarify results of subcommittee actions;** **Cons: mitigation may not sufficiently address consumer engagement concerns across SIM initiatives** | **SIM Project Management** |
| 10/31/13 | Large size of the group and potential Ad Hoc and Interested Parties may complicate meeting process and make the Subcommittee deliberations unmanagable | 1) Create a process to identify Core and Ad Hoc consensus voting members clearly for each meeting | **Pros: will focus and support meeting process****Cons: may inadvertently limit engagement of Interested parties** | **Subcommittee Chair** |

|  |
| --- |
| **Dependencies Tracking** |
| **Payment Reform** | **Data Infrastructure** |
|  |  |
| Payment for care coordination services is essential in order to ensure that a comprehensive approach to streamlined care coordination is sustainable | Electronic tools to support care coordination are essential, including shared electronic care plans that allow diverse care team access. |
| There are problems with MaineCare reimbursing for behavioral health integration services which could limit the ability of Health Home and BHHO’s to accomplish integration. |  |
| National Diabetes Prevention Program Business Models | HealthInfo Net notification functions and initiatives under SIM DSR; need ability to leverage HIT tools to accomplish the delivery system reform goals |
| Community Health Worker potential reimbursement/financing models | Recommendations for effective sharing of PHI for HH and BHHO; strategies to incorporate in Learning Collaboratives; Consumer education recommendations to encourage appropriate sharing of information |
|  | Data gathering and reporting of quality measures for BHHO and HH; |
|  | Team based care is required in BHHO; yet electronic health records don’t easily track all team members – we need solutions to this functional problem |
|  | How do we broaden use of all PCMH/HH primary care practices of the HIE and functions, such as real-time notifications for ER and Inpatient use and reports? How can we track uptake and use across the state (e.g., usage stats) |
|  | What solutions (e.g, Direct Email) can be used to connect community providers (e.g., Community Health Workers) to critical care management information? |
|  |  |
| Critical to ensure that the enhanced primary care payment is continued through the duration of SIM in order to sustain transformation in primary care and delivery system | Gap in connection of primary care (including PCMH and HH practices) to the Health Information Exchange and the associated functions (e.g. notification and alerting) will limit capability of primary care to attain efficiencies in accordance with the SIM mission/vision and DSR Subcommittee Charge. |
| Payment models and structure of reimbursement for Community Health Worker Pilots |  |