

**Delivery System Reform Subcommittee**

**Date: January 7, 2015**

**Time: 10:00 to Noon**

**Location: Maine Quality Counts**

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

**Access Code: 7117361#**

C:\Users\Lisa Tuttle\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\PRDJM42I\QC logo.jpg

**Chair: Lisa Tuttle,** Maine Quality Counts [ltuttle@mainequalitycounts.org](mailto:ltuttle@mainequalitycounts.org)

**Core Member Attendance:** Greg Bowers, Kathryn Brandt, Bob Downs, Rebecca Emmons, Brenda Gallant, Barbara Ginley, Jud Knox, Chris Pezzullo, Lydia Richard, Catherine Ryer, Ellen Schneiter, Rhonda Selvin, Katie Sendze, Emilie van Eeghen

**Ad-Hoc Members:**  Becky Hayes Boober, Gerry Queally, Julie Shackley

**Interested Parties & Guests:** Christine Beaudette, Randy Chenard, Gloria Aponte Clark, Dennis Fitzgibbons, Lisa Letourneau, Simmone Maline, Mike McLellan, Nathan Morse, Sandra Parker, Helena Peterson, Judiann Smith

**Staff:** Lise Tancrede

| **Topics** | **Lead** | **Notes** | **Actions/Decisions** |
| --- | --- | --- | --- |
| 1. **Welcome! Agenda Review** | **Lisa Tuttle**  **10:00 (10 min)** |  | **Agenda reviewed and accepted** |
| 1. **Approval of 12-3-14 DSR Notes** 2. **Payment Reform 12-16-14 Draft Meeting Minutes**   **Data Infrastructure (No Dec. Meeting)** | **All**  **10:05 (5 min)** | Payment Reform Meeting: DSR Subcommittee has Interest in seeing the report on the Measure Alignment Work Group. Should be available soon and will be distributed to interested parties. | **DSR subcommittee approved the notes of 12-3-14 SIM DSR meeting as presented**  **MHMC will distribute Measure Alignment Workgroup Summary** |
| 1. **Medical Home & Beyond** | **Lisa Letourneau 10:10 (60 min)** | Lisa Letourneau gave a presentation on the status of Primary Care Payment Reform in the State of Maine which included:   * Review of status of primary care efforts * Maine PCMH Pilot and MAPCP Demo * MaineCare Health Homes * Beyond the Pilot   (See attached ppt)  ACI meeting on January 20th 3:00 – 5:00 PM | Send out links to MQC webinars (recent)  Share multi-payer payment papers    Send resources on CCM Codes to DSR |
| 1. **Steering Committee Updates**  * **Annual Meeting Planning** * **Disabilities Risk** | **Randy Chenard; Gloria Aponte Clark 11:15**  **(15 min)** | Annual Meeting Planning: There are currently 120 people registered for the annual meeting on January 28h. The theme focus will be on high level accomplishments and looking forward to what we can expect for year two.    Commissioner Mayhew will talk on the importance of SIM in Maine.  CMS/CMMI will be there to talk about their perspective on SIM reform efforts in Maine.  NASHP’s presentation: Sustaining Momentum in Multi-Payer Payment Reform: Transitioning from Design to Implementation  There will also be a presentation on meaningful consumer involvement.  Other Steering Committee updates:  Discussion on the topic of utilizing the SIM Governance structure to develop a Statewide data interoperability roadmap for recommendation to State leadership.  Lewin presented highlights of their evaluation plan for Maine’s SIM grants as well as a providing an example of the SIM core metric dashboard.  Three areas of evaluation focus: process & implementation, cost effectiveness, and outcomes  Leadership Development Program has contracted with the Hanley Group  Disability Risk: Dennis shared the status of identifying the risk of people’s with a range of disabilities do not receive care equal to non-disabled people.  Examples:  lack of information/communication in accessible formats; inaccessible exam tables, lack of accessible scales, mammography equipment; additional time for primary care and other visits, etc.  The system will be at risk of civil rights violations and law suits AND people with disabilities will continue to experience unnecessary and preventable primary, secondary and tertiary conditions resulting in high systemic costs.  The next steps are to finalize the risk template to include alignment with SIM Objectives and apply weighting criteria. | **Invite Lewin to March meeting**  **Disability Risk: Convene meeting with Risk Identifier and experts to frame up risk.** |
| 1. **Risk/Dependencies**   **Care Coordination**   * + **Recommendation for focused pilot on shared care plan using existing HIE Tools**   **Expected Actions: Status Updates** | **Committee Sub-Group 11:30 (15 min)** | Status update from Julie Shackley. Using Julie Shackley gave a status update on the small group work on Care Coordination Pilot.  A Draft Charter has been developed with next steps of a smaller group to finalize.  Once is goes out to full sub group, Julie will then take the scope to CMMC leadership. She is optimistic that it will be seen as positive.  The subcommittee considered applying for a grant for this work, but since determined that the fit wasn’t appropriate.  Upon a finalized endorsed recommendation from the DSR subcommittee, will present to the Steering Committee for approval.  Barbara Ginley gave a brief update on CHW Pilots on activity over the last few months since the pilots were selected. Four pilots have been funded. 8 CHW hired and all completed a 43 hour core competency training that was conducted with an organization out of Worcester, MA. Year 2 will look at making standardized training for CHW’s.  They also opened the training to prospective CHW’s who wanted to participate with the intent of making a bigger impact with these initial steps. A total of 17 have been trained.  In order for a CHW to succeed there must be an adequate level of supervision, understanding the scope of the work, working with teams etc. 12 hours of training for supervisors was completed.  Most of the direct care by CHW’s began at the end of November. Monthly meetings will be done via phone to share case studies, tools being used, etc.  January looking at sharing policies and protocols as related to safety as most of the CHW work happens in the community.  This is the work over the next 3-6 months.  Risk 31:  “Discontinued reimbursement by MaineCare of H&B code” is resolved!  MaineCare will reinstate H&B Codes in computer system so primary care practices are again supported to provide integrated care. This is not a new expenditure since they used to pay. Other payers have found that use of H&B codes reduces overall health care costs.    Payment Reform Subcommittee approved payment criteria, total cost index. Can DSR see those criteria and metrics?  Ellen S. forwarded material which will be distributed to DSR | **CHW Status Update will return on April 8th**  **Distribute slide deck forwarded by Ellen S. to Subcommittee** |
| 1. **Interested Parties Public Comment** | **All**  **11:45 (5 min)** | **NONE** |  |
| 1. **Evaluation** | **All**  **11:50 (10 min)** | **There were 30 people who participated in the meeting.**  Evaluation results scored at 7-9  Subcommittee members felt overall that there was more in depth discussion and the meeting had good time management and was well organized.  Request to have speakers speak more slowly and to send meeting materials out sooner. |  |
| **NO February Meeting**  **March Meeting: MaineCare Accountable Communities Initiative SIM Initiatives Updates** |  |  |  |

**Next Meeting: March 4, 2015**

**10:00 am to Noon**

**Location: TBD**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | | |  |
| **Delivery System Reform Subcommittee Risks Tracking** | | | | |
| **Date** | **Risk Definition** | **Mitigation Options** | **Pros/Cons** | **Assigned To** |
|  |  |  |  |  |
| 11/5/14 | Systemic risk of the health care system of not offering adequate and equal care to people with disabilities. |  |  | **Dennis Fitzgibbons** |
| 9/3/14 | Behavioral health integration into Primary Care and the issues with coding |  |  |  |
| 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 B  Revised: 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 |  |