

**Delivery System Reform Subcommittee**

**Date: 6-3-15**

**Time: 10:00 to Noon**

**Location: 221 State Street, Augusta**

**First Floor Conference 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, Chris Pezzullo, Patricia Thorsen, Lyndsay Sanborn, Catherine Ryder, Jud Knox, Emilie van Eeghen, Katie Sendze

**Ad-Hoc Members:**  Regen Gallagher, Becky Hayes Boober

**Interested Parties & Guests:**  Randy Chenard, Gloria Aponte Clark, Anne Connors, Loretta Dutill, Lisa Letourneau, Sandra Parker, Helena Peterson

**Staff:** Lise Tancrede

| **Topics** | **Lead** | **Notes** | **Actions/Decisions** |
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| 1. **Welcome! Agenda Review**
 | **Lisa Tuttle****10:00 (5 min)** | August meeting we will discuss desired SIM outcome measures, including measures that apply to the Health Home and Behavioral Health Homes Learning Collaborative.We will revisit the primary care practice reports with continued discussion on the outcomes.  | **Invite Jay Yoe to August meeting**  |
| 1. **Approval of 5-6-15 DSR SIM Notes**
2. **Payment Reform and Data Infrastructure (No May Meeting)**
 | **All****10:05 (5 min)** | No edits/corrections to the SIM DSR May 6, 2015 meeting notes | **Notes approved for 5-6-15 as presented** |
| 1. **Steering Committee Updates**

**Development of targets for SIM outcomes on the Core Dashboard** | **Randy Chenard 10:10 (30 min)** | SIM Core Measures Targets will take up a lot of time for the Steering Committee (SC) over the next few months.The May 2014 workgroup, a subgroup of the SC, met to develop and establish what the SIM Core Measures would be. The Evaluators (Lewin Group) are obtaining the data to do the evaluations to see if SIM is moving forward in the right direction.Evaluators currently have the MaineCare data, and some commercial data to review. Still working on getting Medicare data.SC has reviewed a first draft of established targets for MaineCare populations and is moving forward to establish targets for other populations. Randy shared a handout (for Illustration purposes only) on SIM Core Targets. Some examples of Core Measures established were ED Utilization, Readmissions, Imaging, etc. There is still work to be done on target payment.The first round of MaineCare targets has been established. SC has looked at benchmarks and trends data against the national level around what are appropriate targets.Medicare is excited about the establishment of these targets and we have received engagement at high level at CMS.Question: Is there an Opportunity for DSR to use the input of practicing providers to inform discussion…how can that sequence work? How do we leverage the DSR to help inform?Randy said that working closely with Lewin, the SC wanted to start with an initial set of targets. The evaluation subcommittee is making the recommendations for the targets. Randy suggested we contact either Amy Wagner or Kathy Woods who are the co- chairs of the evaluation subcommittee for that discussion question.Question: Is there a hard timeline for the SC to determine those targets?Randy will determine a timeline and process with the SC to assure that we leverage the expertise. He wants targets developed and locked down by the fall.The group discussed the importance of setting appropriate targets.Members agreed to participate in a July meeting to further the discussion based on Randy’s timeline, if required.CMI would like to see more SIM risks come across the table.  | **Subcommittee members requested participation in the explorations of the SIM measure and target work, bringing the perspective of providers to the conversation.****Follow up: It was agreed at the 6-10-15 Partners meeting that the Jay Yoe  will determine to what extent and how to involve DSR members in the discussions of targets and measures. The Subcommittee contact list was shared to facilitate engagement directly. Subcommittee members are also welcome to attend the Evaluation Subcommittee and Steering Committee meetings as interested parties.   Lisa T and Lise will await direction from Randy and Jay, and will forward information to the DSR membership** |
| 1. **Risk/Dependencies:**
* **Disabilities Risk**

**Expected Actions: Status Updates**  | **Gloria Aponte Clark** **10:40 (15 min)** | Gloria gave an update on the Disability Risk. She stated that there was no clear connection to the SIM Objectives but that the closest was with Objective 4. We will bring the risk back to the August meeting for further discussion.Update from Helena Peterson on Care Coordination Pilot:Helena said that Angela Richards, who is involved in the pilot, said that there has been some usable learning from the pilot so far. Although small, it definitely has implications for scalability. * Importance of getting to patients while in the hospital.
* Lower refusal rate of the Community Care Team (CCT) since the pilot began.
* There needs to be more of a cementing of the hospital and the CCT.

BHHO update from Anne ConnorsShared Decision Making is one of the focus topics of the upcoming LS on June 25th. There has been some good consumer response to the process. | **Disabilities Risk continued to August DSR subcommittee meeting** |
| 1. **Patient Provider Partnership (P3)**

**Expected Action: Pilot Wrap Up** | **Kellie Slate Vitcavage****10:55 (45 min)** | Kellie provided a final overview of the P3 Pilot and where do we go from here.* QC hosted 10 “Patient-Provider Partnership” (P3) Pilots:
	+ 4 Choosing Wisely®
	+ 3 Shared Decision Making: Low Back Pain
	+ 3 Shared Decision Making: Medication Decisions in Behavioral Health
* Pilots include
	+ TA, mini-grants for provider groups
	+ Learning Community
	+ Community convening events

Kellie also reviewed sustainability Strategies **(See Handout of Success Stories)****Some of the Lessons Learned:*** Engaging patients in decision making did NOT extend office visit duration
* Properly executed SDM can save time by reducing call backs and patient follow-up questions
* When a patient is uninsured, extremely important to advocate that they can call different facilities and ask for the charged price of a test
* Provider driven model worked best for our practice
* Start with smaller pilot in the practice to gain best practices: PDSA approach works best

**Some of the Challenges that Impede Sustainability:**1. Payment system changes for SDM needs to occur for sustainability to move the patient provider partnership culture forward and support population health efforts
2. Difficulty finding time to spread learnings widely, especially in light of other competing efforts (PCMH, quality goals, cost/utilization analysis, etc.
3. Lack of time by provider – which again circles back to the payment issue and the opportunity to engage the full practice team
4. Information system shortcomings

(See Slides for complete Presentation) The group discussed the importance of driving for multi payer meaningful primary care payment change -- There is an opportunity from CMS to propose to bring in Medicare as a payment model. The group agreed to dedicate time to engage in these conversations with the Payment Reform Subcommittee, SIM Steering Committee, and State Leadership to stress the importance of this strategy. Provider members committed to meet as required in order to convey the importance of this effort. Risk: No more SIM funding for consumer engagement.  | **Action: Randy Chenard to take the energy from the DSR on payment reform to the SIM Steering Committee and other SIM partners. Interest in continuing to pursue payment reform and how the opportunities can be aligned and integrated and advocate for a discussion with leadership.****Follow up: It was agreed at the 6-10-15 Partners meeting that Frank Johnson will determine to what extent and how to involve DSR members in the discussions of payment reform with the Payment Reform Subcommittee. The Subcommittee contact list was shared to facilitate engagement directly. Subcommittee members are also welcome to attend the Payment Reform Subcommittee and Steering Committee meetings as interested parties.   Lisa T and Lise will await direction from Randy and Frank, and will forward information to the DSR membership****Kellie will send Lise the Collaborate tool to distribute to DSR subcommittee members****Lisa T and Lise will check in with Consumer DSR members to determine their intent to continue to participate.** **DSR subcommittee members can send to Kellie their comments on the new QC Choosing Wisely opportunity**  |
| 1. **Interested Parties Public Comment**
 | **All 11:40 (10 min)** | **No comments from public** |  |
| 1. **Evaluation/Action Recap**
 | **All 11:50 (10 min)** | **There were 19 participants in attendance.** Evaluation results scored at 8 to 10 with the majority at 10. Subcommittee members thought that due to the lively discussion on payment models, this was one of the better meetings that allowed for subcommittee input.  |  |
| **NO July Meeting** |  |  | **Lisa T and Lise will notify the group on opportunities to engage in SIM target and measure, and in Payment Reform discussions when they are clear from the Evaluation Subcommittee, Payment Reform Subcommittee and Steering Committee** |

**Next Meeting: August 5, 2015**

**10:00 am to Noon**

**221 State Street, Augusta, ME**

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| **Delivery System Reform Subcommittee Risks Tracking** |
| **Date** | **Risk Definition** | **Mitigation Options** | **Pros/Cons** | **Assigned To** |
| 6/3/15 | Importance of healthcare provider engagement of and escalation of the need for real multipayer payment reform strategies |  |  |  |
| 6/3/15 | Importance of healthcare provider engagement in SIM measure and target setting |  |  |  |
| 6/3/15 | Lack of SIM ongoing funding for consumer engagement  |  |  |  |
| 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 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** |

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| **Dependencies Tracking** |
| **Payment Reform** | **Data Infrastructure** |
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| 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 |  |