

**Delivery System Reform Subcommittee**

**Date: 3-2-16**

**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, Jim Leonard, Lydia Richard, Catherine Ryder, Rhonda Selvin, Katie Sendze, Betty St. Hilaire

**Ad-Hoc Members:**  Becky Boober, Julie Shackley

**Interested Parties & Guests:** Gloria Aponte Clark,Randy Chenard, Loretta Dutill, Carol Freshley, Barbara Ginley, Sybil Mazerolle, Liz Miller, Sandra Parker, Helena Peterson, Amy Wagner, Jay Yoe

**Staff:** Lise Tancrede

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| **Topics** | **Lead** | **Notes** | **Actions/Decisions** |
| 1. **Welcome! Agenda Review**
 | **Lisa Tuttle** |  Review of Agenda Items, no additions. |  |
| 1. **Approval of 2-3-16 DSR SIM Notes**

 | **All** | Review of 2-3-16 Meeting notes no additions or correction | **Meeting Notes for February 3, 2016 Approved as presented** |
| 1. **Steering Committee Updates**

**Expected Actions: Status Updates**  | **Randy Chenard** | Review of Recent Steering Committee work over the last few months:Randy reviewed the Maine Leadership Team Year 3 SIM Adjustment Decisions (see slides)  Overview: SORT made recommendations to the Steering Committee on which initiatives to continue and those to cease. Adjustments were made with the Leadership Team making the final decisions.In January, the SIM Maine Leadership Team decided upon two sharpened focus areas for State Innovation Model objectives: –Diabetic Care –Fragmented Care \*Readmissions will continue to be a focus where that direction had already been established  |   |
| 1. **Care Coordination**

**Fragmentation of care index****Expected Actions: Status Updates**  | **Jay Yoe****Helena Peterson** | SIM Annual Meeting work around Care Coordination:Some of the themes from the Question on The Role of Care Coordination were:* Evaluation Considerations: Need for more specific measures of effective care coordination, including more clearly defined goals for each care coordination model
* Defining Coordination: Evaluate more clearly what populations need specific services to ensure coordination model meets service goals (consider geographical differences, disease specific, risks stratification)

See handout for more details What are some of the key actions that DSR can look at to make a change in Fragmentation? Helena brought some attention to the previous work done by the DSR back in June of 2014 (See handout)Review of data from the Milbank Multi-State Collaborative (see handouts and slides)**Gaps** – have not optimized the understanding that the BHH integrated person in primary care is not used effectively in helping to make the shift to primary care particularly small practices…they do not understand BHHsJay gave a high level overview of the Fragmented Care Index (Issues to Address; Definition; Recap of Findings (see handout)Practices that have a higher FCI index will be reviewed more closely to see what can be learned about their process.Looking for practices that are struggling (more visibility) for the intervention.Recommendation to also look at some of the bright spotsLisa T. is there an Opportunity to gather information that would help us dig into strategies and ideas data more, would people be willing to convene a small group virtually. (No action)Question was asked about Common Primary Care Definition and where to find. (Jay will send to Lisa)Recommendation: In the next survey series, there may be an opportunity to ask the patient their perception of fragmented care.Recommendation: Picker Patient Satisfaction Reports (possibly have some data) | **Action: Jay to send shared materials electronically to Lise for distribution including Article that details measure of ER use on Diabetes** **Action: Helena to send Lise the web link to Milstein/Stanford Study****Action: Jay to send definition on Common Primary Care to Lise/Lisa** |
| 1. **Risk/Dependencies:**

**Payment Reform –** **Update on State-led process for Medicare alignment****Expected Actions: Informational sharing on process** | **Randy and Jim** | Randy gave an update on the Opportunity of Medicare Alignment Proposal. Back in December 2015, The State agreed to work on a Proposal to include multi-stockholder representations.Invitations have gone out to participate in that group with hope to convene the first meeting in the month of March. The Group would be facilitated by a third party.Once the concept paper has been developed it will come to the DSR for review. No due date |  |
| 1. **Interested Parties Public Comment**
 |  | **There were No comments from the Public** |  |
| 1. **Evaluation/Action Recap**
 |  | **There were 22 participants in attendance. The majority of meeting evaluations ranked at 10 with one at 8.** **Subcommittee members thought the meeting was well balanced and included great discussion.****Still at issue is the sound reception for those calling into the meeting.** |  |
| Next meeting: April 13th |  |  |  |

**Next Meeting: April 13, 2016 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** |
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| 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? |
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| 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 |  |