Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

Maine Quality Counts
Better Health Care. Better Health.

Delivery System Reform Subcommittee
Date: April 9, 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: Greg Bowers, Kathryn Brandt, Vance Brown, Linda Frazier (on behalf of Guy Cousins), Kevin Flanigan, David Lawlor, Andrew Molloy, Chris Pezzullo, Lydia Richard, Catherine Ryder, Rhonda Selvin, Kate Sendze, Joseph Py (on behalf of Emilie van Eeghen)

Ad-Hoc Members: Becky Hayes Boober, Ellen Schneiter, Julie Shackley, Lisa Letourneau

Interested Parties & Guests: Amy Belisle, Randy Chenard, Anne Connors, Barbara Ginley, Kim Humphrey, Sybil Mazerolle, Sandra Parker, Helena Peterson, Deb Silberstein, Judiann Smith, Ashley Soule, Kathryn Vezina

Staff: Lise Tancrede

Topics	Lead	Notes	Actions/Decisions
1. Welcome! Agenda Review	**Lisa Tuttle 10:00 (5 min)**	The group reviewed the agenda. Lisa described the meeting process improvement work based on the Member evaluations and will attempt to make agendas less aggressive to leave time for the group discussion.	**Subcommittee: Complete evaluations after each meeting.**
2. Approval of DSR SIM Notes 3-5-14 **3. Notes from Payment Reform/Data Infrastructure Subcommittees**	**All 10:05 (10:00 min)**	There was a correction to the attendance from Katie Sendze and Lisa Letourneau identified a correction on the P3 Pilot discussion and will work with Lise off line to revise.	**Lise: Update 3-5-14 Minutes with corrections**

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		The committee approved the 3-5-14 SIM DSR Notes with corrections. There were no additional comments on the March Minutes from Payment Reform or Data Infrastructure.	
4. SIM Governance Process **Risks/Dependencies** **Expected Results:** **Refine Process; Identify Mitigation Recommendations**	**Randy Chenard 10:15 (30 mins.)**	Prior to Randy Chenard's overview of the SIM Governance process, Lisa stated that the subcommittee has gone through most of the SIM Delivery System Reform initiative focus areas such as MaineCare Behavioral Health Homes Initiative, National Diabetes Prevention Program with focus on the business piece, and the Patient Provider Partnership (P3) Pilot looking at informed decision making. The remaining initiatives still to come are Behavioral Health Homes Training Program and Leadership Training initiatives. From here forward we will get into the rhythm of deliverables status and understanding the subcommittee charge of making recommendations and identifying key dependencies with Data Infrastructure and Payment Reform subcommittees. Randy Chenard shared two documents with the subcommittee that will focus on Strategic Framework alignment. The Maine SIM Risk Log and the SIM Objectives Alignment.	Randy reminded the subcommittee to complete the survey sent if they have not had an opportunity. **Action: Steering Committee will Share criteria for weighting with Subcommittee** **Subcommittee: Identify risks an issues and tie them into the SIM Objectives**

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		In the framework alignment there are 20 Objectives which are funded under SIM. All described briefly and aligned under six strategic pillars (see handouts) As part of the chart, objectives are weighted : 5 is the highest weight and 1 is the lowest. Randy said that the Objectives are part of the SIM Scope and part of the Grant and the things that SIM is funding. Every risk or issue, will land on this document, to tie back the risk to the objectives. We then can calculate that risk and how do we address and mitigate it. The weighted priorities are aligned with the Objectives grid. Dr. Flanigan said that the reality is that SIM is a test. The State of Maine was selected because we already have transformations under way. SIM will determine what was effective. It is important that we are successfully testing and that barriers are being identified and resolved.	
5. Working Session: **Care Coordination Across SIM Initiatives** **Expected Actions:** **Endorse the approach; recommend key functions of effective, high quality patient-**	**Lisa T. All** **10:45 (60 min)**	Presentations on Care Coordination were made by Deb Silberstein, Quality Counts QI Specialist, Helena Peterson, CCT Program Manager, Anne Connors, Program Director for Behavioral Health Homes Learning Collaborative, and Barbara Ginley, Project Director,	**Lisa will summarize the notes and then send out to group for virtual work before the next meeting.**

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centered care coordination		Community Health Worker Initiative. (See Slides) Subcommittee members moved into small workgroups. They were asked to Identify the 3-4 critical core functions to ensure effective, high quality and patient centered care. The group was also asked to Identify who was in the group (their discipline). Notes will be compiled and distributed for Members to work on virtually before the next meeting	
6. Meeting Evaluation	**All** **11:45**	The meeting was ranked on the scale of 6 to 9 with the majority at 8-9 Things that worked well in this meeting: The Committee felt that the meeting agenda was more manageable and felt more oriented to their purpose and the process. They enjoyed the breakout session, the use of technology, and the opportunity for small group discussion. Most appreciated the overview of SIM Strategies and Risks from Randy Chenard. Things to Improve: The committee felt that more time could be dedicated to small group work. There were recommendations to having longer meetings in order to delve into issues. Have more consumers at the table and	

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		more members present at the meetings versus remote. Some members still felt the agenda was a bit aggressive and that some additional support would be beneficial, such as a scribe.	
7. Interested Parties Public Comment	**All** **11:50**	N/A	
May Meeting Agenda Items: **Care Coordination – Identify Key Principles** **(P3) Pilot 0 3rd Area of Focus**		**To ensure that the meeting agendas remain manageable for group process, the update on the Behavioral Health Home Learning Collaborative and the mitigation of the risk of insufficient Consumer Engagement in SIM will be moved into the June meeting agenda.**	

Next Meeting: Wednesday May 7, 2014 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**
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	Explore State Waivers; work with Region 1 SAMSHA;		**MaineCare; SIM Leadership Team;**

	integrated care	Launch consumer engagement efforts to encourage patients to endorse sharing of information for care		**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	1) Ensure collaborative work with the initiatives to clarify the different in the models		**HH Learning Collaborative; Behavioral Health**

	to ensure effective funding, implementation and sustainability of these models in the delivery system	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		**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	**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**

		of each initiative and what expected actions the Subcommittee has.		
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**
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	