SIM Delivery System Reform Subcommittee
Date: February 5, 2014
Time: 10:00 to Noon
Location: Cohen Center, Maxwell Room
Call In Number: 1-866-740-1260
Access Code: 7117361#

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.

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

Core Member Attendance: Lydia Richard, David Lawlor, Kathryn Brandt, Robert Downs, Catherine Ryder, Kevin Flanigan, Betty St. Hilaire, Chris Pezzullo, Robert Blanchard, Jud Knox, Greg Bowers, Rhonda Selvin, Emilie van Eeghen, Joe Everett

Ad-Hoc Members: Katie Sendze, Gerry Quelly, Ellen Schneiter, Julie Shackley

Interested Parties & Guests: Cindie Rice, Judianne Smith, Sandra Parker, Lisa Letourneau, Elsie Freeman, Sandra Parker, Kim Humphrey, Randal Chenard, Jim Braddick, Kathryn Vezina, Debra Wigand, Nathan Morse, Barbara Ginley, Mitchell Stein, Ashley DeAngelo, Jay Yoe

Staff: Lise Tancrede

Topics	Lead	Notes	Actions/Decisions
1. Welcome! Agenda Review	**Lisa Tuttle**	Lisa reviewed agenda items and materials to be used for education session and work session;	**Subcommittee to forward identified risk/dependencies**
2. Approval of DSR SIM Notes 1-8-14 **3. Notes from Payment Reform/Data Infrastructure Subcommittees**	**All**	Catherine Ryder motioned to accept 1-8-14 notes; no additional comments; subcommittee approved Lisa L brought up Issue on a dependency with the data infrastructure functions – particularly to advance the work of the HH Initiative's Community Care Teams, specifically the notification alerts from hospitals.	**HIN/Katie Sendze to discuss with Helena Peterson, ways to**

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		Katie Sendze responded that more details on the notification functions will come in March. Katie also noted that the RFP for Behavioral Health technology support has been posted. It is here: http://hinfonet.org/news-events/news/healthinfonet-releases-rfp-for-behavioral-health-hit-support Lisa T. invited DI to join one of our future DSR meetings to discuss the HIN projects. No additional notes and comments on subcommittee minutes	**connect with CCT Community.** **Lisa T/Lise – send invitation to DI subcommittee to attend a DSR meeting to discuss HIN projects.**
4. SIM Initiative Priorities Criteria **Expected Results: Discussion/Recommendations**	**Jay Yoe**	Jay gave an overview of the Draft SIM Priority Decision Framework: Covering Adoption, Reach, Efficacy, Effectiveness, Implementation, Maintenance, Sustainability and Impact. The SIM Steering Committee recognized the need for guidance to look at the criteria to focus SIM initiatives. A subgroup worked on a draft approach that in today's DSR meeting the CHW piloted. The group discussed the use of these tools and their intent for guiding SIM focus.	
5. Education Session: **National Diabetes Prevention Program** **Expected Results: Education/Discussion**	**Nathan Morse**	Nathan Morse gave an overview of the NDPP and reviewed the Executive Summary. The NDPP goal is to improve lifestyle behavior around Diabetes Prevention. Currently, 13 Program provider sites in the State	

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		of Maine; Evidenced based program that keeps people from moving into type 2 Diabetes; Provides technical support for the programs in Maine Opportunity with SIM development, seeking payment for a primary health benefit. USCDC has provided support through all different sectors in the State. The group discussed various approaches to business models and criteria that would help leaders determine their investment in the NDPP	
6. Working Session: Community Health Workers (CHW) Questions/Discussion Expected Results: Provide Recommendations	**Deb Wigand; Barbra Ginley**	Barbara Ginley provided a brief overview of CHW initiative. Two fold project: Develop capacity, how will we be able to sustain the work post SIM; Look at building the capacity by actually doing the work. 5 pilot projects (refer to PPT) Background on the What: Taken from SIM Proposal (Goals) The group discussed the relationship between the CHW initiative and peer support; Barbara reviewed the Questions applying the Priorities Criteria (see slides) Use of tool was helpful in the RFP development, Questions brought forward for CHW were related to how we anticipate threat and barriers in implementation. How we can assure the pilots are successful in coordinating care across the continuum. Kathy Vezina reminded that the Hanley Leadership Program is available as a resource to	

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		support system development and leadership. The group also discussed the relationship between the CHW and the other initiatives such as the BHHO Initiative, and resources such as patient navigation. Additionally the group encouraged pilots that would allow experience for rural vs. more urban areas and systems? The RFP timeline is short, and Members were encouraged to send additional feedback directly to Deb and Barbra.	
7. Risks/Dependencies Expected Results: Identify Mitigation Recommendations	**All**	Lisa reviewed risks/dependencies identified in the meeting.	
8. Meeting Evaluation	**All**		
9. Interested Parties Public Comment	**All**	**None**	
March Meeting Agenda Items: Care Coordination Across Continuum; Patient Provider Partnership Pilots			

Next Meeting: Wednesday March 5, 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**
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		**MaineCare; SIM Leadership Team; BHHO Learning**

		engagement efforts to encourage patients to endorse sharing of information for care		**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	1) Ensure collaborative work with the initiatives to clarify the different in the models and how they can be used in		**HH Learning Collaborative; Behavioral Health Home Learning**

	sustainability of these models in the delivery system	conjunction; possibly encourage a CHW pilot in conjunction with a Community Care Team in order to test the interaction		**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	**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**

		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**
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	