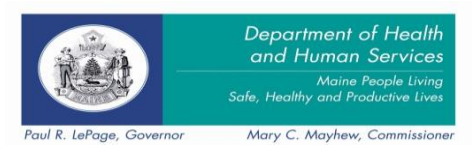

SIM Delivery System Reform Subcommittee
Date: January 8, 2014
Time: 10:00 to Noon
Location: Cohen Center, Maxwell Room
Call In Number: 1-866-740-1260
Access Code: 7117361#

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

Core Member Attendance: Teresa Barrows, Greg Bowers, Kathryn Brandt, Vance Brown, Guy Cousins, Kevin Flanigan, Brenda Gallant, Holly Harmon, Chris Pezzullo, Gerry Queally, Lydia Richard, Catherine Ryder, Ellen Schneiter, Betty St. Hilaire, Emilie van Eeghen
Phone Attendance: Bob Downs, Joe Everett, Jud Knox, James Martin, Andrew Molloy, Katie Sendze
Ad-Hoc Members: Joseph Py; Lisa Letourneau, Becky Hayes Boober

Interested Parties & Guests: Jim Harnar, Kitty Purington,

Staff: Lise Tancrede

Topics	Lead	Notes	Actions
1. Welcome! Agenda Review	**Lisa Tuttle**	Review of goals and agenda; Lisa T introduced guest presenter Kitty Purington; Clarified where subcommittee members can find meeting materials on the QC website	
2. Approval of DSR 12-4-13 Notes **3. Notes from Payment Reform/Data Infrastructure Subcommittees**	**All**	Notes approved	
4. Subcommittee Process **Charter Approval**	**All**	Lisa reviewed the Charter edits highlighted in yellow; Discussion concerned the importance of clarifying whether sending a designee by a Core Member violate the By-laws at a higher level (SIM grant); Lisa L. stated that the SIM By Laws do not violate	**Lisa L forwarded a copy of By Laws to be shared with members.**

Topics	Lead	Notes	Actions
		the issue of Core members sending a designee. The charter does state that 100% participation/attendance is required by Core Members; however, if unable to attend the meeting, they must notify the Chair. The group reiterated that consistency is important and meeting is public but the obligation of Core members is that they attend. If a Core Member sends a delegate, they send that delegate with full authority and voting rights.	**Group agreed to accept the edits to the Charter**
5. Education Session: **MaineCare Behavioral Health Home initiative; Behavioral HH Learning Collaborative** **Expected Results: Education**	**Kitty Purington**	Kitty Purington presented an overview of the Mainecare Behavioral Health Homes Initiative. A new service being offered by MaineCare, with implementation in April, 2014, per the Affordable Care Act, a Behavioral Health Home offers: Care Management of physical and mental health needs; Care Coordination and health promotion; Help in transitional care, including follow up; Support to help self-manage physical and mental health conditions; Referral to other services; and the use of Health Information Technology to link services. Discussion concerned the importance of understanding how many practices where in Stage B and what has been the experience with collecting data from Stage A. A current analysis indicates that around 7000 patients are being served in primary care practices not currently enrolled in the HH model. Discussion ensued on how to best reach the practices that serve these patients – work is underway between MaineCare and QC to reach out to the larges practices. The	**Kitty, Lisa T: Send notice to committee about applying for State participation in BHH** **Bring back to the group discussion in March a discussion of ensuring streamlined collaborative approach to Care Coordination across the various SIM DSR initiatives.**

Topics	Lead	Notes	Actions
		group also discussed the requirement for co-location of physical and behavioral health – Co-location is not a requirement, but integrated care is. Kitty was asked to clarify Request for Proposal for EHR supports and connectivity a Health InfoNet function under SIM. Kitty stated that the RFP will be released by the end of January, confirmed by Katie Sendze. Group discussed the challenges of engaging consumers and which part of SIM Collaborative will solve the problem of the ability to effectively pass personal health information in a comprehensive way. Individual patients can authorize their release of information, and the group requested that MaineCare develop focused education for consumers on the importance of their release of information to all of their health providers.	
6. MaineCare Health Home Primary Learning Collaborative Behavioral HH Learning Collaborative **Provide Recommendations**	**Kitty Purington; Lisa Tuttle**	Lisa L reviewed the Learning Collaborative Model Process that QC is using with the PCMH and HH initiatives; Learning Collaborative to begin in April 2014 Recommendations for the BHH Learning Collaborative: Concerning the issues related to the exchange of personal health information (PHI), include in the learning collaborative an operationalization of consents for release. How to help patients/BHHs support patients who	**Follow up with Jim Harnar on the Hanley Disparities initiative and how it could serve the Learning Collaborative.**

Topics	Lead	Notes	Actions
		elect to transition to a new primary care provider/practice and the need to address barriers to sharing Mental Health information across care settings (federal, state privacy requirements). Explore how effectively patients can be transitioned with no negative outcomes – Impact analysis? Look at ACT team model; identify transition items, etc. Provide a solid technical platform to support the learning collaborative: Identify ways to support BHH participants in addition to/outside of learning sessions to support virtual learning - e.g. online discussion boards, web-based tools Engage primary care in unifying and establishing structures for integration – acknowledging that the locus of services may be in the BHHO; look at the ACT team for examples. Explore best practices for HIT in BHHO; specifically seek solutions to appropriately capture the full care team in Electronic Health Records Address solutions to stigma facing many consumers with SMI particularly in the emergency department, and across the continuum of care; Bring in the resources from the Hanley Disparities Initiative work. Incorporate Shared Decision Making Incorporate the recovery model Incorporate Peer Support structures	

Topics	Lead	Notes	Actions
		Need to work on improving access in BHHOs & primary care Need to recognize gap of improving care/coordination for patients with addiction/substance use disorders (i.e. this is not really focus of Stage A HHs or Stage B, other than patients with co-occurring MH/SA disorders) Work to integrate various care managers/care coordinators across care settings (e.g. care managers from various settings); work with VT to explore how they've approached this (have similar structures in place) Need to lay the groundwork for providers and consumers on existing gaps in care, and the critical need for this work– i.e. that patients with SMI die on avg. 26yrs before their non-SMI peers Is it possible to convene a focus group with Stage A practices to identify their recommendations on how they could be most effectively involved in the Learning Collaborative? Connecting with Community Health Worker initiatives/pilots Engage focused strategies on consumers and sharing of PHI. Look to previous MeHAF efforts with Kennebec Valley Health surveys on behavioral health planning as possible collaboration	**Work to identify possible mitigation recommendations to the risk of people living with substance use disorders falling through the cracks of Stage A/B**

Topics	Lead	Notes	Actions
7. Risks/Dependencies	**All**	Risks and Dependencies are tracked in matrices below	
8. Next Meeting Agenda Items **Community Health Worker Discussion** **Questions and Priorities for Pilots** **Diabetes Prevention Initiative**	**All**		
9. Meeting Evaluation	**All**	Positive comments on agenda format, education component, meeting pace and facilitation, member interaction and planning Education materials helped prepare members for meeting, specifically Questions to consider & reference handouts i.e. MaineCare benefits manual reference Members feel they are becoming clearer about risks/dependencies. Need to reduce the amount of information presented at meeting and allow more time for Questions and Answers, make agenda less aggressive, end information sooner and provide work materials with questions in advance Difficult to engage the people on phone. Members participating remotely will receive an experience survey. **Committee Evaluations ranged between 6-10** **With majority at 8**	

Topics	Lead	Notes	Actions
10. Interested Parties Public Comment	**All**	**NONE**	

Next Meeting: Wednesday February 5, 2014 Noon; Cohen Center, Maxwell Room, 22 Town Farm Rd, Hallowell

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Delivery System Reform Subcommittee Risks Tracking				
Date	**Risk Definition**	**Mitigation Options**	**Pros/Cons**	**Assigned To**
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	Work with large providers to		**MaineCare; SIM**

	primary care practices; Muskie analysis shows about 7000 patients in gap	apply for HH; Educate members on options		**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; 2) advocacy with CMS to continue MAPCP payments; 3) ACO support		**Payment Reform Subcommittee; State DHHS**
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		**HH Learning Collaborative; Behavioral Health Home Learning Collaborative; Community Health Worker Initiative**

		order to test the interaction		
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	1) ensure that in our review of	**Pros: mitigation**	**SIM Project**

	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.	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.	**steps will improve meeting process and clarify results of subcommittee actions; Cons: mitigation may not sufficiently address consumer engagement concerns across SIM initiatives**	**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**
	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	