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: March 5, 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: Robert Blanchard, Kathryn Brandt, Vance Brown, Kevin Flannigan, Jud Knox, Chris Pezzullo, Rhonda Selvin, Betty St. Hilaire, Emilie van Eeghan, Greg Bowers, Guy Cousins, Joe Everett, Brenda Gallant, Elsie Freeman, Lydia Richard, Katie Sendze

Ad-Hoc Members: Gerry Queally, Julie Shackley, Lisa Letourneau, Ellen Schneiter, Barbara Ginley, Helena Peterson, Joseph Py, Anne Connors, Elsie Freeman, Mary Henderson, Linda Frazier, Cathy Bustin

Interested Parties & Guests: Randy Chenard, Liz Miller, Sandra Parker, Ashley Soule, Kellie Slate Vitcavage, Amy Belisle, Jim Harnar
Staff: Lise Tancrede

Topics	Lead	Notes	Actions/Decisions
1. Welcome! Agenda Review	**Lisa Tuttle 10:00 (5 min)**	Lisa reviewed agenda items and materials to be used for education session and work session; Directed members to access Readytalk for Webinar. This was the first meeting to be convened by phone, webinar and live meeting.	
2. Approval of DSR SIM Notes 2-8-14 **3. Payment Reform/Data Infrastructure Subcommittees (no Meetings in February)**	**All 10:05 (10:00 min)**	Lisa T presented the 2-5-14 notes for approval. Comments: Some subcommittee members are still unclear to their role in the decision making process. Members discussed their role in the Subcommittee, specifically in terms of accomplishing	**Lisa T. Reduce the amount of topics to cover at each meeting**

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		decisions and outcomes. Dr. Flannigan reiterated the importance of the multi-stakeholder perspectives at the table, and described similar discussions on the Steering Committee. He reminded the group that the SIM Governance structure is new, and has about 35 more meetings ahead. The group also described the products that are tracked from each meeting, including specific recommendations for each Initiative owner, key risks that flow into the governance structure, and dependencies on other Subcommittees. Members discussed concerns about process and inclusion: the aggressiveness of the agendas, and difficulties in making decisions in 15 minutes; and the importance of hearing the consumer voice. Lisa T reminded the group of the work that they have accomplished so far, and also about the agreement to get materials ahead of time with focus on the key questions for discussion at the meeting. She also will work on more reasonable agendas for the group. Subcommittee notes of 2-5-14 approved	**Subcommittee members come to meetings prepared to focus on discussion questions.**

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		by all with no additional corrections. Ellen Schneiter said that the Payment Reform meeting was rescheduled due to the storm. No meeting for the Data Infrastructure subcommittee in February.	
4. CHW Pilot RFP Status	**Barbara Ginley 10:15 (10 min)**	Barbara Ginley provided brief status: The RFP is in final review by DHHS. Shared Decision matrix was utilized as external input. Process includes integrating a letter for bidders conference and hope to have released within the week. Question on what criteria was used for the RFP: The Framework for people to respond to the RFP took into consideration populations and where CHW are most effective. There is a 30 day window from letter of intent and proposal.	
5. Education Session: **Patient Provider Partnership (P3) Pilot** **Expected Results: Education/Discussion**	**Kellie Slate Vitcavage; Liz Miller 10:25 (15 min)**	Kellie Slate Vitcavage and Liz Miller provided a PowerPoint Presentation with overview of Patient-Provider Partnership (P3) Pilots on the Choosing Wisely Initiative and the shared decision-making pilot priority areas. There will be a total of 9 pilots. The group discussed the importance of educating patients and consumers about the pilots. The primary focus is to engage into a "conversation" with the patient. The group also discussed the level of	

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		patient input into choosing the 8 focus areas of Choosing Wisely. A survey was given to 400 patients and consumers before the selections were made. The group also discussed the basis for the topical areas that were prioritized using available literature and prevalence to guide the recommendations.	
6. Working Session: **Patient Provider Partnership (P3) Pilot** **Expected Results:** **Provide Recommendations**	**Kellie Slate Vitcavage; Liz Miller** **10:40 (15 min)**	The group moved into discussions of the pilot priority areas. The 1st set of P3 Pilots will focus in Choosing Wisely materials. The staff recommended the top 8 health focus areas from the Choosing Wisely in Maine initiative. For the 2nd set of P3 Pilots will focus in shared decision-making in low back pain care decisions, colon cancer, and hip and knee conditions as options for focus. **Recommendation:** The 1st set of pilots in Choosing Wisely will be recommended to use Choosing Wisely materials in the 8 health focus areas from the Choosing Wisely in Maine Initiative, but are not limited to these 8 and can expand their use of materials to the full spectrum of ABIM Choosing Wisely focus areas. **Recommendation:** The shared decision making pilots should focus on one health focus area. Consensus of group was in agreement to that recommendation. **Recommendation:** 2nd set of pilots in shared decision making, evidence suggests low back pain health decisions would be	

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		an effective area to pilot shared decision making aids. Consensus of group was in agreement to the recommendation. **Recommendation:** focus the third set of Pilots on a Behavioral Health focus. The group discussed any legal ramification on providers should be a patient decide against a procedure. Because shared decision making involves two equally efficacious options, it provides evidence for providing that discussion.	
7. Working Session: **Care Coordination Across SIM Initiatives** **Expected Actions;** **Recommendations on Streamlining Care Coordination**	**All** **10:55 (30 min)**	The risk of multiple care coordination roles across the SIM Initiatives was presented from the DSR Subcommittee to the Steering Committee at their recent meeting. Dr. Flannigan gave a brief summary of that discussion and how the group could consider risk mitigation. 1- Recognize Barrier. Put out on Risk log. Figure out how to prioritize 2- Who owns it and where does it go for resolution. Would like to hear from DSR groups for recommendations. 3- How to allow care coordination resolution to get to Steering Committee In order to set the stage for the discussion of Streamlining Care Of Coordination, the group was provided with a patient story and some recommendations on practices that work. The group reviewed the story	

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		and discussed the topic. One of the agenda items in the pilots could be thinking about. Ex: Identify Community Health Worker for the Somali patient and what is available (like the CHP) and what is already there. Emilie: The Patient working with numerous providers is very confused. How do you share information together and share with the patient. One solution; one person identified to provide case management and work with the patient. This process is most efficient working with the patient but is enormously administratively difficult. Where is the balance? What works? • Create smooth hand offs so patients don't move backwards in their care. Limited number of people that can work with patient in all areas. • Ask patients what they prefer (different patient will require different follow up) • As a patient, don't assume other people know what is important to me • Centralized Planning – Decentralized Execution – Distributed control (requires investment of time and resources)	

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		How do you do that with all these people doing care coordination? Health care system has to let go of that population in order to have success. • Data on community integration services illustrates that when we don't allow time to transition, we lose people. Need to have people doing hand off in a timely and effective manner. How is information shared? Is an assessment done? Do we have to do it over? System issues get in the way of good people. • The Medical Home is a solution model. The PCP takes care of patient in its entirety. Connector may be the CCT or CHW there is a need to develop expertise at the practice level. That person sees the patient most frequently. The April meeting will continue this exploration, moving to recommendations for the Steering Committee	
8. Risks/Dependencies **Expected Results:** **Identify Mitigation Recommendations**	**Randy Chenard; All** **11:25 (20 min)**	Randy Chenard presented the SIM Program approach to risk identification and mitigation. He shared a drafted risk management plan, hot off the press that will be shared with the Steering Committee at the next meeting. He described the basic levels of information	

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		to be tracked and the risk priority assessment and ranking process. Risks are defined as potential impacts to the 20 SIM Objectives.	
9. Meeting Evaluation	**All** **11:45**	**Evaluations ranges 3 to 9 with majority at 5-6;** **Comments included:** The meeting was well organized and excellent facilitation. Respectful of others comments; materials sent ahead of time with questions helpful; Webinar good tool; Providing a Recommendation on (P3) Pilot focus areas; Good discussions in care coordination. Agenda remains aggressive with insufficient time for discussion and recommendations. Focus on one topic area per meeting. Possibly form subgroups to discuss larger issues. Suggestion of using consent agenda to get through approval of minutes. Resend materials day before meeting.	
10. Interested Parties Public Comment	**All** **11:50**		**Cathy Bustin: Request to provide a consumer meeting with subcommittee members?**
April Meeting Agenda Items: **Care Coordination Discussion; Status on P3 Pilots; Risk Management**			

Next Meeting: Wednesday April 9, 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**
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 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	Bring into March DSR Subcommittee for recommendations		

	with intellectual disabilities			
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.			**Data Infrastructure Subcommittee**

	notification and alerting) will limit capability of primary care to attain efficiencies in accordance with the SIM mission/vision and DSR Subcommittee Charge.			
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	**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**

		was done with them.		
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	