Delivery System Reform Subcommittee
Date: November 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: Becky Hayes Boober, Kathryn Brandt, Joe Everett, Dr. Kevin Flanigan, Linda Frazier (on behalf of Guy Cousins) Betty St. Hilaire, Jud Knox, Gerry Queally, Lydia Richard, Ellen Schneiter, Catherine Ryder, Katie Sendze, Julie Shackley, Emilie van Eeghen
Ad-Hoc Members:

Interested Parties & Guests: Amy Belisle, Randy Chenard, James Leonard, Sandra Parker, Amy Wagner

Staff: Lise Tancrede

Topics	Lead	Notes	Actions/Decisions
1. Welcome! Agenda Review	**Lisa Tuttle** **10:00 (5 min)**	Frank Johnson informed DSR subcommittee of an ACI committee meeting on November 18th	**Agenda reviewed and accepted** **Action:** Frank will Send White Paper "Multi- Payer Investments in Primary Care: Policy & Measurement Strategies to forward to SIM DSR subcommittee
2. Approval of 10-8-14 DSR SIM Notes **3. Notes from Payment Reform NO Data Infrastructure Subcommittees**	**All** **10:05 (5 min)**	No discussion on Payment Reform subcommittee minutes	**DSR subcommittee approved the notes of 10-8-14 SIM DSR meeting as**

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			presented
4. Steering Committee Updates • **Annual Meeting**	**Randy Chenard 10:10 (10 min)**	Annual meeting will be held on January 28, 2015 at the Augusta Civic Center from 8:30 to Noon. A save the date notice will be sent out soon. The annual meeting will include consumer involvement.	**ACTION:** SC to send save the date on annual meeting to subcommittees
5. Care Coordination • **Payment Reform Subcommittee recommendations to support streamlined Care Coordination** • **Discussion of Data Infrastructure Recommendation for focused pilot on shared care plan using existing HIE tools** **Expected Actions: Finalize recommendation on Care Coordination for Steering Committee**	**Frank Johnson; Katie Sendze; Lisa Tuttle (10:20 70 min)**	Frank gave an overview of Payment Reform recommendations to support Care Coordination. Discussed Risk #21 (See attached document) Proposed Approach: Present findings of alternative payment inventory in commercial market. Query the health systems and payers on the expected pace of the transition from FFS to capitation. Recommend an interim step (s) that supports current, non-duplicative care coordination payments under FFS with the intent to move to sustainable care coordination reimbursement via capitation or global budgets. Frank: We should be exploring innovation and looking at what is currently happening in the market. The intent is to share information and support stakeholders in changes. Katie continued the discussion from last month's meeting with an updated	Request to Payment Reform: consider CMS Chronic Care code and the final rule **ACTION:** Send additional information on CMS Rule to DSR Subcommittee

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		PowerPoint Presentation (see attached ppt) Suggested Recommendations: Leverage HIE tools available today: *to support transitions of care (HH Learning Collaborative Fishbowl Session on TOC)* Measure and understand the impact of those tools (at the point of care, test it) Identifying effective processes across a continuum using a small test Organizations part. in SIM act. Hospital-HH-CCT- LTC to test processes (what works/what does not) There was agreement from subcommittee members to move forward with convening a small group discussion to review the recommendations and bring back to the DSR a pilot recommendation. Members who expressed interest in participating in the discussion were Julie Schackley, Catherine Ryder, Kathryn Brandt, Linda Frazier, Katie Sendze, and Betty St. Hilaire. An invitation will be sent out to the broader group to include Providers and Behavioral Health.	**ACTION:** Convene Small Group Discussion to bring back recommendation on pilot utilizing HIE tools to support transitions of care
6. Risk/Dependencies • **Risk Mitigation for Behavioral Health Integration codes**	**Becky Boober** **Randy Chenard**	Becky gave a status update on the Behavioral Health Integration Codes. Risk is resolved to some degree and can be used to further integrative care.	

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• **Meaningful Consumer Involvement** **Expected Actions: Status Updates**	**11:20 (20 min)**	Next step to develop some rules from MaineCare to make sure it gets going correctly. Randy gave a status update from the Steering Committee on the risk identified concerning meaningful consumer involvement. Dr. Flanigan offered to have a discussion with the Partners and create a risk mitigation report out of that discussion to bring back to the Steering Committee. Steering Committee members were in agreement that the consumer subgroup should be invited to give a presentation at a future meeting date. Note: Consumers to give a 20 minute presentation to SC on December 10th Dennis Fitzgibbons identified a risk on systemic risk of the health care system of not offering adequate and equal care to people with disabilities. He gave the example of need to report on BMI and with people in wheelchairs; weight is often not taken at the practice visit. Dennis agreed to take the lead in completing the risk mitigation documents.	**ACTION**: Forward copy of White paper on Meaningful Consumer Involvement to DSR Subcommittee **ACTION**: Work with consumer sub group to prepare for Steering Committee Presentation **ACTION:** Dennis Fitzgibbons to complete risk mitigation template identifying risk on systemic risk of the health care system of not offering adequate and equal care to people with disabilities.
7. Interested Parties Public Comment	**All 11:50 (5 min)**	**None**	
8. Evaluation/Action Recap	**All 11:55 (5 min)**	**There were 20 people who participated in the meeting.**	

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		Evaluations scored between 7 and 9 with majority at 9 Subcommittee members felt there was sufficient time for discussion and good participation Unfortunately we had some technical difficulties with internet access. Request for additional background material to follow discussion.	
December Meeting: Status on HCBS Waiver Risk			

Next Meeting: December 3, 2014
10:00 am to 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**
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			**Steering Committee**

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	mechanisms or decisions on how to support these practices through the learning collaborative			
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 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**

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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	1) clarify with the Governance Structure the actual ability of the Subcommittees to	**Pros: mitigation steps will improve meeting process**	**SIM Project Management**

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	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.	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.	**and clarify expected actions for members; Cons: mitigation may not be sufficient for all members to feel appropriately empowered based on their expectations**	
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**	**Subcommittee Chair**

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			engagement of Interested parties	

Dependencies Tracking	
Payment Reform	**Data Infrastructure**
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?
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.

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Payment models and structure of reimbursement for Community Health Worker Pilots	

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