

**Delivery System Reform Subcommittee**

**Date: 4-8-15**

**Time: 10:00 to Noon**

**Location: 221 State Street, Augusta**

**First Floor Conference Room**

**Call In Number: 1-866-740-1260**

**Access Code: 7117361#**

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**Chair: Lisa Tuttle,** Maine Quality Counts [ltuttle@mainequalitycounts.org](mailto:ltuttle@mainequalitycounts.org)

**Core Member Attendance:** Greg Bowers, Kathryn Brandt, Becca Emmons, Joe Everett , Jud Knox, Jim Leonard, Chris Pezzullo, Lydia Richard, Lyndsay Sanborn, Katie Sendze, Betty St. Hilaire

**Ad-Hoc Members:**  Becky Hayes Boober

**Interested Parties & Guests:**  Amy Dix, Randy Chenard, Gloria Aponte Clark, Loretta Dutill, Dennis Fitzgibbons, David Hanig, Jessica Newman Sandra Parker, Helena Peterson, Rhonda Selvin , Patricia Thorsen, Katherine Woods

**Staff:** Lise Tancrede

| **Topics** | **Lead** | **Notes** | **Actions/Decisions** |
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| 1. **Welcome! Agenda Review** | **Lisa Tuttle**  **10:00 (5 min)** | The group discussed the most meaningful process to keep track of status of initiatives along with the Charge of the Subcommittee  Discussion and Suggestions:  As part of package, would like to see how projects are interfacing with other groups. I.e. dependency on payment reform and how does that interact with each project.  We can review dependencies and risks and try to follow those threads through history.  Some members prefer updates to come thru written form and use our time in facilitated work on the ground.  Katie Sendze gave an update changes in the charge and composition of the Data Infrastructure Subcommittee. They are changing to a focus on leveraging integrated data solutions broadly for activities under SIM.  Helena Peterson volunteered to join the Data Infrastructure subcommittee meetings. | **Agenda Reviewed and Accepted**  **Action: Lise/Lisa T.**  **At May Meeting will incorporate suggestions from the subcommittee on a different approach to reviewing the initiative updates** |
| 1. **Approval of 1-7-15 DSR SIM Notes** 2. **Payment Reform 2-17-15 Minutes**   **No DI subcommittee meeting** | **All**  **10:05 (5 min)** | No edits to the SIM DSR notes from 1-7-15  No additional comments on Payment Reform minutes | **DSR Subcommittee approved the 1-7-15 SIM DSR subcommittee meeting notes as presented** |
| 1. **Steering Committee Updates**  * **Disabilities risk (Convene Small Group)** | **Randy Chenard, Gloria Aponte Clark, All**  **10:10 (10 min)** | Steering Committee Updates:   1. A working group has been established to review all SIM Objectives with a focus on looking at the objectives that are currently funded and are they the right ones to be funded. The working group will also review the six strategic levels. They will be looking at the things that are not going as planned and why are they not progressing as expected. 2. The Total cost of care measure was endorsed by the Steering Committee for broad public reporting. 3. Upcoming for the Steering Committee is the development of targets for all SIM core measures. 4. The Leadership Development Program is off and running. On June 2nd a CEO visioning forum will be held. |  |
| 1. **Risk/Dependencies:**  * **Care Coordination**   **Expected Actions: Status Updates** | **Committee Sub-Group**  **10:20 (15 min)** | Discussion on next steps for moving the Disabilities risk forward.  Becca Emmons would like to help support this risk and has ideas to share. A small group consisting of Becca, Dennis Fitzgibbons, and Gloria Aponte Clark will connect to identify the SIM Objectives, accountability Targets, and calculating risk score.  Katie Sendze gave an update on the status of the Care Coordination pilot on behalf of Julie Shackley (see handout)  Recommendations to the pilot:  Add a more global function assessment around community resources. Some Examples Shared: Dartmouth Assessments; How is your Health.org; Keepmewell.org; and Health Leads program out of Mass. | **Action: Small group consisting of Becca Emmons, Dennis Fitzgibbons, and Gloria Aponte Clark to convene and move the risk forward**  **and bring back into the May meeting. Gloria will be willing to facilitate the discussion and will send out materials to small group**  **Action: Forward recommendation on global assessment process to Julie and have her come prepared to discuss at May meeting.**  **Kathryn Brandt: Send additional assessment tool**  **Helena will forward the electronic version of Care Plan Domain and Definitions and Lise will send out to subcommittee**  **Chris P. will send out Keepmewell.org to Lise to share with subcommittee** |
| 1. **MaineCare Accountable Communities**   **Expected Action: Status Update** | **Amy Dix**  **10:35 (40 min)** | Amy Dix reviewed the Accountable Communities Executive Summary. She said that all contracts have been signed and that AC should start receiving data sometime next week.  The Definition of AC:  An entity responsible for population’s health and health care costs that:   * Is provider-owned and driven * Is characterized by community collaboration and a strong consumer component * Includes shared accountability for both cost and quality   In traditional managed care, a managed care organization is responsible for care and cost that is delivered through providers.  Choice of two models (in both models, Fee for Service continues unchanged):  Model I - requires minimum of 1,000 members.   * Share in a maximum of 50% of savings, based on quality performance, with cap at 10% of benchmark TCOC * No downside risk in any of the three performance years   Model II - requires minimum of 2,000 members   * Share in a maximum of 60% of savings, based on quality performance, with cap at 15% of benchmark TCOC * No downside risk in first performance year * Liable for 40-60% of losses, based on quality performance, in years two and three, with cap at 5% of benchmark TCOC in Year 2 and 10% of benchmark TCOC in Year 3   She explained what the requirements were to be considered an Accountable Community.  Program Timing:  **Round 1: Four ACs Covering 30,000 Members**  **Year 1:** 8/1/14 – 7/30/15  **Year 2:** 8/1/15 – 7/30/16  **Year 3:** 8/1/16 – 7/30/17  **Round 2: Will start 8/1/16**  **Request for Applications released:** Fall 2015  **Applications due:** Winter 2015-16  **Notification of Approval:** Early 2016  The 4 current systems participating:  Penobscot Community Health Center (PCHC); MaineGeneral; MaineHealth;  Beacon  (see ppt.) | **Amy Dix: will send ACO presentation slides and Lise will forward to group**  **Jim Leonard: Will identify the practices involved in the AC**  **MHMC: Present to DSR on how the index is calculated and bring in Primary Care Practice Reports** |
| 1. **SIM Evaluators**   **Expected Action: Status Update** | **David Hanig, Katherine Woods 11:15 (30 min)** | David Hanig presented an evaluation overview and activities to date.  Lewin is partnering with Maine DHHS to conduct a multi-year evaluation of SIM with 3 key components:  • Implementation/Process Evaluation  • Cost Effectiveness Evaluation  • Impact/Effectiveness Evaluation  (See ppt.) |  |
| 1. **Interested Parties Public Comment** | **All 11:45 (10 min)** |  |  |
| 1. **Evaluation/Action Recap** | **All 11:55 (5 min)** | **There were 25 participants in the meeting. Evaluation results scored at 8 and 9. Subcommittee members felt there was good discussion in the meeting and group stayed on task.**  **Some members would like more background info on some of the topics.** |  |
| **May Meeting: I/DD Status Update**  **June meeting P3 Wrap Up (LML or Dr. Ryan)** |  |  |  |

**Next Meeting: May 6, 2015**

**10:00 am to Noon**

**221 State Street, Augusta, ME**

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| **Delivery System Reform Subcommittee Risks Tracking** | | | | |
| **Date** | **Risk Definition** | **Mitigation Options** | **Pros/Cons** | **Assigned To** |
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| 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 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 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 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 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 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** |

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| **Dependencies Tracking** | |
| **Payment Reform** | **Data Infrastructure** |
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| 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. |
| Payment models and structure of reimbursement for Community Health Worker Pilots |  |