

**Delivery System Reform Subcommittee**

**Date: 8-5-15**

**Time: 10:00 to Noon**

**Location: Quality Counts Office**

**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:** Kathryn Brandt, Bob Downs, Jud Knox, Jim Leonard, Chris Pezzullo, Lydia Richard, Catherine Ryder, Lyndsay Sanborn, Rhonda Selvin, Katie Sendze, Betty St. Hilaire,

**Ad-Hoc Members:**  Becky Hayes Boober, Gerry Queally, Julie Shackley

**Interested Parties & Guests:**  Randy Chenard, Gloria Aponte Clark, Loretta Dutill, Barbara Ginley, Frank Johnson, Liz Miller, Lisa Nolan, Sandra Parker, Helena Peterson, Ashley Soule, Jay Yoe

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**Staff:** Lise Tancrede

| **Topics** | **Lead** | **Notes** | **Actions/Decisions** |
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| 1. **Welcome! Agenda Review** | **Lisa Tuttle**  **10:00 (5 min)** | Lisa Welcomed Everyone and Apologies for the confusion of meeting location. |  |
| 1. **Approval of 6-3-15 DSR SIM Notes** 2. **Payment Reform : June 19, 2015**   **Data Infrastructure (No June Meeting)** | **All**  **10:05 (5 min)** | No edits/corrections to the June 3, 2015 SIM DSR Meeting Notes | **Notes approved for 6-3-15 as presented** |
| 1. **Steering Committee Updates** 2. **SIM Core Targets**   **Expected Actions: Status Updates and recommendations** | **Randy Chenard 10:10 (10 min)**  **Jay Yoe**  **10:20 (25 min)** | The Steering Committee discussed the following items at their last SC meeting:   * The SIM Core Evaluation Metrics Dashboard * Status Update and review timeline on the SIM Objectives * Sustainability of SIM Objectives beyond SIM   CMS to provide update on Medicare Target development process and describe perspective on Maine’s goal development focus.  Jay gave an overview of the four methods used to set SIM Targets and explained how each of the following are calculated:   * Average Annual Rate of Change * Achievable Benchmarks of Care * Medicaid 90% percentile * Midpoint   The performance targets are being calculated based on MaineCare (Medicaid) data. The metrics will be reproduced with Medicare and Commercial data once they become fully available.  (See handouts/slides for full presentation)  As part of the SIM self-evaluation, Lewin is creating a dashboard displaying core metrics selected by the SIM Steering Committee. (See handout for description of the methodology Lewin has employed in calculating core metrics)    The plan is to come back on a regular basis with updates.  From the evaluations we will begin to see what is happening in Health Homes, BHH, and Sub Populations such as the Community Care Teams (CCT).  The first round of stakeholders, providers, and consumers interviews has been completed. It was noted that almost no one refused to participate. Next January there will be a follow up of interviews.  The second layer of assessments will be more qualitative versus the first set of evaluations which focused more on quantitative.  Lisa said we will make sure to inform the DSR of when and where the SIM Evaluation Committee meeting will take place. | **ACTION: Send out information to DSR Subcommittee of upcoming Evaluation Committee Meetings**. |
| 1. **Care Coordination Pilot**   **Expected Actions: Status Updates** | **Julie Shackley**  **10:45 (10 min)** | Julie Shackley gave a status update on the 2nd Quarter numbers from the Care Coordination Sub Pilot with Heath Homes and CCT looking at the improvement of care transitions and decrease ER visits.  (See Slides for full presentation)  There was an increase in 2nd Quarter from patients who refused. Staff will be keeping a better handle on the reasons for refusal. Patients do not see this as a need and/or don’t want people to come into the home. For this pilot the individuals are identified by who went into the hospital and who of those are willing to see the CCT.  There was a recommendation to ask the patient what might work for them in terms of follow up. Looking for alternatives for reducing the refusals. Julie said she will begin to ask that question.  At her next status update, Julie will have a breakdown of why the patients are coming in and if they are receiving BHH services.  Julie said that they are looking to do some contracting with ACO to continue the work over the next 6 months.  Liz Miller suggested doing a similar pilot with the BHHs. |  |
| 1. **PCMH/HH Strengthened Focus on Outcomes** 2. **Survey of Practices in their work on outcomes (request for Sub-Group)**   **Expected Action: Status Update and small group formation** | **Lisa Tuttle; Ashley Soule; Liz Miller**  **10:55 (30 min)** | Lisa gave an overview of QCs Stage A and Stage B Learning Collaborative Work referencing the learning sessions and the regional forums. She talked about the strengthened focus on outcomes.  Ashley Soule gave an update on what the focus for the year ahead will look like for the Learning Collaborative beginning with the October2nd Learning Session (LS).  The LS will include participants from primary care, BHH, CCT, Patient Partners/Consumers, and hospitals.  Going forward, the regional forums will focus on palliative care/end of life discussions.  Ashley gave some brief history of how the Primary Care Roadmap to Change with its 7 Key Changes has been used over the past few years. (See handout)  Liz Miller gave an update on the focus of Behavioral Health Homes Quality Improvement Projects (ED Visits, Unnecessary Utilization, Hospital Admissions) |  |
| 1. **Risk/Dependencies:**  * **Payment Reform Risk #24** * **Discern Report** * **DSR and PR Combined Meeting**   **Expected Actions: Status Update and planning combined meeting** | **Frank Johnson**  **11:25 (25 min)** | Frank gave an overview of the MHMC Role in Payment Reform.  The two arguments for payment reform:   * Infrastructure support: For practice to operate as a medical home, it requires additional financial resources * Incentive Alignment: Delivery system transformation requires moving from fee-for-service to a more rational payment model – support non-visit care and recognize case-mix differences – reward for population health, not volume   The Discern Report:  The MHMC retained Discern to examine primary care models in various markets and to offer viable strategies for Maine.  Frank reviewed some of the innovative payment options: Enhanced Fee-for-Service, Fixed Payment P4P, Shared Savings, and Comprehensive Payments.  The Discern Report recommends the following proposed approach:  Define performance expectations and measures for each tier   * Tier 1 – infrastructure and process * Tier 2 – clinical quality; patient engagement * Tier 3 – population clinical and cost outcomes   Define payment principles for each tier   * Tier 1 – fixed payments tied to specific improvements (leverage CCM) * Tier 2 – emphasis on performance-based payment; risk for primary care outcomes * Tier 3 – population risk   In the next phase, they will be engaging in similar interviews with providers in the field asking what they think their expectations are. The hope is to have both payer and provider input by September.  There was a recommendation to query those who are doing direct primary care  Both the Payment reform subcommittee and Delivery System Reform Subcommittees will possibly convene a meeting together in October. |  |
| 1. **Interested Parties Public Comment** | **ALL** | **No public comments** |  |
| 1. **Evaluation/Action Recap** | **ALL** | **There were 27 participants in attendance.** Evaluation results scored between 6 and 10 with the majority at 8.  Subcommittee members thought the presenters were well prepared, interesting topics, and good discussion.  The move of site location was a bit of an issue and did cut into discussion time but the full agenda was covered. |  |
| **Next Meeting: Status Updates on**  **Community Health Worker Initiative;**  **I/DD Initiative; PCMH/HH Outcomes Focus; SIM Targets** |  |  |  |

**Next Meeting: September 2, 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** |
| 8/5/15 |  |  |  |  |
| 6/3/15 | Importance of healthcare provider engagement of and escalation of the need for real multipayer payment reform strategies |  |  |  |
| 6/3/15 | Importance of healthcare provider engagement in SIM measure and target setting |  |  |  |
| 6/3/15 | Lack of SIM ongoing funding for consumer engagement |  |  |  |
| 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? |
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| 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 |  |