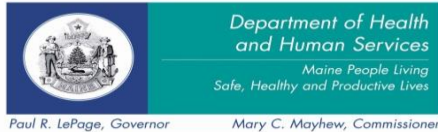

Delivery System Reform Subcommittee
Date: May 7, 2014
Time: 10:00 to Noon
Location: Cohen Center, Maxwell Room
Call In Number: 1-866-740-1260
Access Code: 7117361#

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

Core Member Attendance: Greg Bowers, Kathryn Brandt, Vance Brown, Richard Erb, Joe Everett, Kevin Flanigan, Brenda Gallant, Jud Knox, David Lawlor, Chris Pezzullo, Lydia Richard, Catherine Ryder, Rhonda Selvin, Katie Sendze, Betty St. Hilaire, Emilie van Eeghen

Ad-Hoc Members: Becky Hayes Boober, Anne Graham, Gerry Queally, Julie Shackley, Ellen Schneiter,

Interested Parties & Guests: Amy Belisle, Randy Chenard, Anne Conners, Dennis Fitzgibbons, Barb Ginley, Jim Harnar, Mary Henderson, Diane Hills, Kim Humphrey, Dan L'Heureux, Sybil Mazerolle, Nate Morse, Sandra Parker, Helena Peterson, Joseph Py, Holly Richards, Ashley Soule, Kellie Slate Vitcavage

Staff: Lise Tancrede

Topics	Lead	Notes	Actions/Decisions
1. Welcome! Agenda Review	**Lisa Tuttle**	Agenda accepted	
2. Schedule Discussion	**Lisa Tuttle**	The group discussed summer meeting schedule, agreeing to take the month of July off.	**Decision: No meeting in July but will resume in August**
3. Approval of DSR SIM Notes 4-9-14 **4. Notes from Payment Reform/Data Infrastructure Subcommittees**	**All**	The committee approved the notes from April 9, 2014 SIM DSR meeting as presented. There was a discussion about the DI notes, and Katie Sendze indicated	

Topics	Lead	Notes	Actions/Decisions
		that the issue of concern had been resolved.	
5. Working Session: **Patient Provider Partnership (P3) Pilot** **Third area of focus (BH Topic)** **Expected Results: Discuss/Provide Recommendation**	**Kellie Slate Vitcavage**	Kellie gave an overview of the Patient Provider Partnership (P3) Pilots. Included in her overview was an explanation of defining terms of the pilot; outcomes of shared decision making and decision aids. (See Slides) The recommendation from the DSR Subcommittee to focus the final set of pilots on a behavioral health issue was endorsed by the P3 stakeholder group, and at today's meeting she presented recommendations on the focus areas for the behavioral health pilots. The RFP for Shared Decision Making in Behavioral Health Pilots will go out on May 19. The group requested that it be sent to the Behavioral Health Home Organizations and as a practical matter; end up with a good pilot that would also be a BHHO. The group also discussed why children were removed from the treatment decision under depression. Kellie will check with Dr. Korsen for the answer. A majority of the subcommittee endorsed the recommendation for the 3rd area of focus for the (P3) Pilot on Behavioral Health.	Kellie Slate Vitcavage to clarify with Dr. Korsen why children were not part of the identified population for treatment decisions under the (P3) Pilot Behavioral Health Focus Area
6. Working Session:	**Lisa T. All**	The group continued to work on	

Topics	Lead	Notes	Actions/Decisions
Care Coordination Across SIM Initiatives **Expected Actions:** **Identify key Principles**		developing recommendations for providers and practice teams working at the ground level on Streamlining the Care Coordination across SIM initiatives. At our last meeting, committee members identified core functions of work in care coordination. Synthesizing this work along with the online survey results that members were asked to complete, resulted in a final comprehensive listing of Care Coordination Functions. 100% of those surveyed, agreed that the core functions were captured by the committee. Subcommittee members also agreed that the core functions were captured. Committee moved into Small Group Discussion with the goal of identifying recommendations for streamlining care coordination across the delivery system SIM initiatives that are focused on providers and practice teams (broad disciplines) working at the ground level. Recommendations from Small Group Discussions will be captured and synthesized and distributed prior to the June 4 meeting.	**Staff will continue to refine the Core Functions document, with input from Subcommittee Members and participants and distribute it for review prior to the June 4 meeting.** **Action: Amy Belisle to provide recommendation on how to adapt the Care Coordination Core Functions for children and families** **Action: Joe Everett will provide recommendations on how to include client population along with patients** **Action: Lise to resend survey link to committee**

Topics	Lead	Notes	Actions/Decisions
7. Patient All System Summary (PASS) **Expected Action: Explore Recommendations on Care Coordination Tool**	**Kim Humphrey**	Kim Humphrey, Dan L'Heureux, and Diane Hill presented on Patient All System Summary Report-PASS The team shared on the projects mission and vision, the rationale behind PASS, PASS as a tool for integration, survey results, and future opportunities. (see slides) The intention is to pilot PASS at Martin's Point but the project is still in a prototype status and needs some additional refinement. The tool of Shared Electronic Care Plan was well received by the committee and a majority of members agreed that PASS could be a good tool in care coordination.	**Action: Lise to forward PASS Draft to committee** **Subcommittee members are encouraged to provide feedback directly to the PASS team**
8. Risk/Dependencies **Track on Agenda**	**All** **11:40 (10 min)**		
9. Meeting Evaluation	**All**	There were 40 people in attendance either in person or remotely. The meeting was ranked on the scale of 6 to 10 with the majority at 8-10 A majority of subcommittee members thought that the small group activity worked very well and appreciated the collaborative discussion and sharing of recommendations. They also agreed that	

Topics	Lead	Notes	Actions/Decisions
		the meeting was well facilitated and kept on time. Some members continue to feel that the agenda is ambitious and would like to see fewer topics so that more time may be dedicated to discussion and recommendations.	
10. Interested Parties Public Comment	**All** **11:50**	**None**	
June Meeting Agenda Items: **Behavioral Health Homes Learning Collaborative** **Consumer Engagement Risk Mitigation**			

Next Meeting: Wednesday June 4, 2014 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**
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	Explore State Waivers; work		**MaineCare; SIM**

	information (e.g., substance abuse) may constrain integrated care	with Region 1 SAMSHA; Launch consumer engagement efforts to encourage patients to endorse sharing of information for care		**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,	1) Ensure collaborative work with the initiatives to clarify		**HH Learning Collaborative;**

	Care Manager and Case Manager models is critical to ensure effective funding, implementation and sustainability of these models in the delivery system	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		**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	**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**	**SIM Project Management**

		to be explicit about the stage of each initiative and what expected actions the Subcommittee has.	**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 engagement of Interested parties**	**Subcommittee Chair**

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.
Payment models and structure of reimbursement for Community Health Worker Pilots	