

**Delivery System Reform Subcommittee**

**Date: October 8, 2014**

**Time: 10:00 to Noon**

**Location: Cohen Center, Maxwell 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:** Becky Hayes Boober, Linda Frazier (on behalf of Guy Cousins) Betty St. Hilaire, Jud Knox, David Lawlor,

Lydia Richard, Ellen Schneiter, Rhonda Selvin, Katie Sendze, Emilie van Eeghan

**Ad-Hoc Members:**  Julie Shackley,

**Interested Parties & Guests:**  Amy Belisle, Cathy Bustin, Randy Chenard, Gloria Apponte Clark , Nancy Cronin, Frank Johnson , Simonne Maline, Sybil Mazerolle, Sandra Parker, Lydia Richard, Amy Wagner

**Staff:** Lise Tancrede

| **Topics** | **Lead** | **Notes** | **Actions/Decisions** |
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| 1. **Welcome! Agenda Review** | **Lisa Tuttle**  **10:00 (5 min)** |  | **Agenda reviewed and accepted** |
| 1. **Approval of 9-3-14 DSR SIM Notes** 2. **Payment Reform (no Sept. Meeting)**   **Data Subcommittee Draft Sept. Meeting Minutes** | **All**  **10:05 (10 min)** | No discussion on DI September Minutes | Subcommittee approved the notes of 9-3-2014 SIM DSR meeting as presented |
| 1. **Steering Committee Updates**  * **Status of Leadership Development Initiative** * **Status of Care Coordination Risk Discussion** * **Status of Meaningful Consumer Involvement Risk** | **Randy Chenard; Lisa Tuttle**  **10:10 (10 min)** | Randy gave a status update on the Leadership Development Initiative. Based on feedback from DSR and Steering Committee meetings, the State will move forward with an RFP. The initiative owner is Dr. Flanigan.    DSR subcommittee asked if scholarships be available for people attend and Randy said that the intent is to fund participation through the SIM funding. | **Action:** In November Meeting include status of Leadership Development initiative |
| 1. **Status from OADS on individuals Living with Developmental Disabilities and Autism Training**   **Expected Actions : Understand initiative and generate subcommittee recommendations on coordination and comprehensiveness with SIM initiatives** | **James Martin; Sybil Mazerolle**  **10:20 (30 min)** | Nancy Cronin, Executive Director of ME Developmental Disabilities Council, gave an overview of the Intellectual Developmental Disability Care Coordination work. **(See Executive Summary)**  The initiative plans to put into place a three pronged approach to address the care of individuals with I/DD.   1. Develop curriculum to provide training to Targeted Case Managers on integrating physical health information and goals into the PCP. 2. Leverage QC learning collaborative to educate PCP about the connection between physical health issues and BH. 3. Provide Case Managers and PCP’s with TA.   Sustainability beyond SIM will be addressed in the contract and linked to payment. It is hopeful that maintenance can continue but will not be part of the council. | **Action: I/DD come back in 6-7 months for DSR to look at curriculum.** |
| 1. **Risk/Dependencies: Collaborative Subcommittee**   **Exploration/Recommendation: Care Coordination Risk**  **Expected Actions: Identify a combined subcommittee recommendation on Care Coordination with Mitigation to the Steering Committee** | **Frank Johnson; Katie Sendze**  **10:50 (60 min)** | Randy gave an update on the status of the Care Coordination Risk which was presented to the Steering Committee from DSR 3-4 months ago. The Steering Committee is requesting an aligned recommendation across all Subcommittees  Katie Sendze presented an overview of Data Infrastructure Subcommittee scope of work and their guidance on SIM projects involving Health Information Technology (HIT) and Electronic Health Records (EHR) and how they are leveraged as well as how they can support Care Coordination efforts. **(See PowerPoint Presentation)**  Recommendation to consider for Care Coordination:   1. Use HIE tools that exist today 2. Measure and understand the impact of those tools (at point of care – test it) 3. Seek funds external to SIM to support convening of stakeholders to produce a plan for implementing a community “shared care plan” | Subcommittee endorsed the recommendations made by Katie; and agreed to bring the discussion back to the November agenda to refine a recommendation for the Steering Committee. Frank Johnson will also present in November on aspects of Payment Reform to support care coordination.  **Action: DSR November Subcommittee will explore opportunities to structure a pragmatic use of the HIE tools by users in the SIM Initiatives who are willing to work on how the tools can provide a solution to incorporate the core functions and key principles.** |
| 1. **Interested Parties Public Comment** | **All**  **11:50 (5 min)** | **None** |  |
| 1. **Evaluation/Action Recap** | **All**  **11:55 (5 min)** | **There were 23 people in attendance**  **Evaluations scored between 8 and 9**  Subcommittee members thought the presentations had great content with more time allowed for discussion.  Still limited time for discussions but getting better. There was a request to get materials out sooner. |  |
| **November Meeting:**  **Care Coordination recommendation for focused pilot; Status Update on Risk Mitigation for Behavioral Health Integration Codes & Meaningful Consumer Involvement** |  |  |  |

**Next Meeting: November 5, 2014**

**10:00am to 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** |
| 10-8-14 |  |  |  |  |
| 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 unmanageable | 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 |  |