Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Delivery System Reform Subcommittee
Date: 9-1-15
Time: 10:00 to Noon
Location: 221 State Street, Augusta
First Floor Conference Room
Call In Number: 1-866-740-1260
Access Code: 7117361#

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

Core Member Attendance: Jud Knox, Jim Leonard, Lydia Richards, Rhonda Selvin, Katie Sendze, Betty St. Hilaire, Patricia Thorsen, Lyndsay Sanborn, Emilie van Eeghen

Ad-Hoc Members: Julie Shackley

Interested Parties & Guests: Randy Chenard, Gloria Aponte Clark, Barbara Ginley, Frank Johnson, Jennifer MacDonald, Liz Miller Sandra Parker, Helena Peterson, Evelyn Preston, Ashley Soule,

Staff: Lise Tancrede

Topics	Lead	Notes	Actions/Decisions
1. Welcome! Agenda Review	**Lisa Tuttle** **10:00 (5 min)**	Review of Agenda with no additions. Lisa is recommending that the October 7th DSR meeting be held virtual with the plan of joining the combined Payment Reform subcommittee meeting on October 20th. Focus topics on the 7th will be on the preparation work for the combined DSR and PR meeting. The purpose of the combined meeting is	

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		to review the recommendations that came through the Payment Reform subcommittee and the DISCERN report and for both DSR and PR to talk through those recommendations.	Action: There was a consensus of the majority of subcommittee members who were in agreement to hold the October 7th SIM DSR subcommittee meeting virtually.
2. Approval of 8-5-15 DSR SIM Notes **3. Payment Reform August 27, 2015 Data Infrastructure (No August Meeting)**	**All** **10:05 (5 min)**	No edits/corrections to the August 5, 2015 SIM DSR Meeting Notes	**Notes approved for August 5, 2015 as presented**
4. Steering Committee Updates	**Randy Chenard** **10:10 (10 min)**	Randy gave an update on the Steering Committee Meeting of August 26th. Focus for the month included: • Looking to finalize the establishments of targets and provide endorsement to the SIM Maine Leadership Team at their September meeting. • Updates on the Payment Reform work and the collaboration on best strategies to accelerate Payment Reform. Review of the SIM core Measures Dashboard which will be used for public reporting of SIM key measures outcomes. The SC is in the process of refining the SIM core dashboard.	
5. SIM Core Targets **Expected Actions: Status Updates and recommendations**	**Jay Yoe** **10:20 (15 min)**	Jay Yoe gave a brief recap of his presentation from the August 5th meeting talking through the SIM targets and how	

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		they were identified. They are now working with Lewin on the development of SIM core measure targets for the Commercial and Medicare populations. At the next DSR meeting, the dashboard may be available to share with DSR.	
6. Community Health Worker Initiative **Expected Actions: Status Updates**	**Barbara Ginley 10:35 (20 min)**	Barbara gave an update on Year 2 of the CHW Initiative. (See Slides for full presentation) The 4 pilots are: MaineGeneral; DFD Russell; Portland Public Health; and Spectrum/Seniors Plus and are all operational with 9 CHWs working. The served over 650 patients during the first 3 quarters. Pilot's Focus on Triple AIM • Individuals out of care/falling out of care/in need of PCMH/ED Utilization • Self-Efficacy & Patient Satisfaction • Connecting to Social Determinants of Health • Improvement/Refinement on Data Reporting Training on motivational interviewing has been completed by all CHWs. This year we looked at lots of work on	

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		standardized training. Moving into year three, we will need some fine tuning around sustainability efforts. <u>Timeline of Year 2:</u> • Start Up of CHW Pilots • Establishment of the CHWI Stakeholder Group • Begin TA support to pilots • Development of Evaluation Plan • June 3, 2015 Inaugural CHW Convening A question was asked about the difficulty in hiring CHWs due to low wages. Barbara said that some CHWs have other responsibilities that offer higher wages. Question of how do the CHW and pilot group document the work they do? Currently some, like DFD Russell, document right into their EMR. There is a range of documentation methods and it depends on the host organization. On the performance side it has been difficult to merge the data across the pilots. Question: For people with SMI, to what extend do the CHWs know if they have a case manager? How do they avoid duplication? Barbara said that resource sharing has not been an issue.	**Action: Reach out to Hanley for Video on disparities to share with the group**
7. Intellectual/Developmental Disabilities and Autism Initiative	**Jennifer MacDonald**	Jennifer gave an update on the progress of work under the I/DD Initiative. The have	

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Expected Action: Status Update	**10:55 (20 min)**	completed a one hour training for medical providers. It was somewhat challenging to make those connections due to their limited availability. They have provided two hour training to 132 direct support personnel, guardians, and others who work with the population. Jennifer shared her concern about the use of anti-psychotic medication with this population to decrease behaviors. Often the expressed behavior is a way they communicate their pain and/or discomfort. A core-expectation committee was created to review the environment these individuals live in. They will develop Tools that help recognize behavior changes, set baseline, and if a behavior happens. This will help Caregivers better understand what is going on with that person. The use of a Behavior Check list and Chronic Pain Checklist has been helpful. There are challenges at the Primary Care practice with the ability to assess those in wheelchairs. There are lots of cardiac issues with this population. The #1 reason for deaths with the population is around bowel obstruction. Funding, training, and space continue to bel issues.	

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		Training will be provided to UNE students to help better manage this population. Evaluations are done at each of the trainings. The ideal success would be the adoption of the Core Expectations by the Medical Homes. The complete list of Core Expectations has been started but not completed. <u>Jennifer Recommendation:</u> • The use of anti-psychotic as a chemical restraint should be limited to personal harm of themselves or others. • Individuals have the right to be physically assessed by the medical home. <u>Emile recommendation</u>: Convene a small group to coordinate discussion around use of anti-psychotics.	**Action: Jen will send a Case Study to share with DSR** **Action: Convene subcommittee meeting with Patricia Thorsen, Emile vanEeghan, and Jen MacDonald to coordinate discussion around anti-psychotic drugs used for the I/DD population**
8. Risk/Dependencies: • **Payment Reform Work** **Expected Actions: Status Update and prepare for combined PR and DSR October 20th meeting**	**Frank Johnson 11:15 (25 min)**	Frank gave a recap on the Discern Report/Bailit Reports and the interview process. (Will send out a copy of the Bailit Report to DSR) Jim asked why Medicare/CMS was not Interviewed. With Maine being a SIM State, we should be able to get that perspective. Frank said they were not able to identify a contact. Frank and Jim	**Action: Send the Bailit Report to DSR** **Action: Frank, Jim, Randy will identify a contact from CMS Medicare to interview**

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		will work together to identify someone at CMS to interview. The next Payment Reform Subcommittee meeting will be held on October 20th from 3:00 pm to 5:00 pm. And will be a combined meeting with DSR. Prior to that meeting, both DSR and PR will look at pieces of the conversation from the Bailit report. Frank said that the second phase of those interviews will be available and the assessments will be provided to the subcommittees. The DSR will plan to use the October 7th virtual meeting time in pre form the 20th combined discussion. Part of the combined focus discussion will be to review the rule related to participation in multiple shared savings strategies.	
9. PCMH/HH Strengthened Focus on Outcomes **Expected Action: Status Update**	**Lisa Tuttle; Ashley Soule; Liz Miller 11:30 (10 min)**	Ashley gave a recap on the Learning Collaboratives strengthened focus approach; leveraging the medical health home model to impact measurable progress on reducing 30 day all cause readmission rates. The Framework is being put together for the almost 200 practices which include monthly webinars and the upcoming October 2nd learning session.	**Action: Send LS invitation to the DSR**

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		Currently, our efforts include getting the appropriate contacts from the hospitals who do the care transition work to come to the Learning Session. <u>Recommendations: Reach out to</u> • Hospitals themselves • MHA association • CONs from the hospitals • QIOs Helena suggested to provide a list of who from the hospitals have registered…and then leverage the personal relationships to get others to attend. We could ask them for just the half day instead of the whole day.	
10. Interested Parties Public Comment	**ALL 11:50 (5 min)**	**None**	
11. Evaluation/Action Recap	**ALL 11:55 (5 min)**	**There were 22 participants in attendance.** Evaluation results scored between 5 and 10 with the majority at 9. Subcommittee members thought the presenters gave excellent status reports on the initiatives and included good discussion. Some members felt that the agenda is still aggressive and rushed at the end. Members who are remote are not able to hear the comments from the audience. Recommendation to include the presenter's org name and affiliation on the	

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		agenda and also to state the connection with SIM during their presentation.	
Next Meeting: Aligned meeting with Payment Reform and DSR; Practice Reports			

Next Virtual Meeting: October 7, 2015
10:00 am to Noon

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

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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**

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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	Launch consumer engagement campaigns		**MaineCare; Delivery System Reform**

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	structures	focused on MaineCare patients		**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	1) clarify with the Governance	**Pros: mitigation**	**SIM Project**

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	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.	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.	**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**	**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	1) Create a process to identify Core and Ad Hoc consensus voting members clearly for	**Pros: will focus and support meeting process**	**Subcommittee Chair**

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	unmanagable	each meeting	**Cons: may inadvertently limit 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	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

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delivery system	mission/vision and DSR Subcommittee Charge.
Payment models and structure of reimbursement for Community Health Worker Pilots	

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