Improving and Bridging Systems Subcommittee
Minutes

Meeting Information			
Date	Thursday, November 1, 2018	**Time**	1:00 – 2:30 PM
Location	303 E 17th Avenue, 11th Floor, Room 11B	**Call-in Number**	1-877-820-7831 // 946029#
Committee Purpose	Serve as a laboratory for strategic innovations and guidance that bridge and integrate systems for Health First Colorado members, particularly those with complex needs and who require services and care coordination across systems.		
Meeting Purpose	Identify successful information sharing practices and outstanding challenges between RAEs and LTSS providers (see back)		

Meeting Attendance	
Voting Members and Participants	**Invited Guests**
Aubrey Hill, Van Wilson, Marty Janssen, Joanna Martinson, Mary Kay Kisseberth, Francine Haber, Manny Melles, Tina McCrory, Candy Wolfe, Kathleen Homan, Gary Montrose, Carol Plock, Ben Harris, Harriet Hall*, Natasha Brockhaus*, Carol Ann Hendrikse*, Clara Cabanis*, Harley Wendell*, Alonzo Payne*, Jamie Zajac*, Vicki Sanchez*	

Meeting Items					
Item No.	**Time**	**Owner**	**Description**	**Attachment**	**Action No.**
1	1:00 – 1:05	CP	**Roll call and October minutes' approval**. Ben called the meeting to order at 1:01PM and took roll call. Minutes were subsequently approved.	1	
2	1:05 – 1:15	BH	**October PIAC Report Out**. Ben gave the report out for the October PIAC. Since half of the members were new, the first meeting's purpose was to introduce the different members to each other and to level set on expectations and the ACC. Each RAE also gave a brief introduction to their region and their approach to stakeholder engagement, specifically their regional PIACs. Over the next two months, each PIAC subcommittee would provide their introduction to the PIAC. IBS would go first in November.		
3	1:15 – 1:20	BH	**September meeting follow up**. Ben gave an update on two outstanding items from the September meeting. • **MMP Demonstration Final Report**: The report was still in clearance at the Department. Ben would update the subcommittee as it moved through that process. • **BUS Access**: The Department is working internally to address any issues with the BUS management system. If any RAE staff needs access to BUS, they need to fill out a user request and give it to their respective Program Specialist or Administrator who will then forward it to the necessary personnel. They should be more readily processed since the summer influx had subsided.		

			Mary Kay gave a public service announcement about impending Medicare enrollment, which would begin on December 7th. She suggested members, providers, and RAEs could contact the State Health Insurance Assistance Program (SHIP) for more assistance on enrollment. She also provided a directory of Medicare training resources for providers. Gary asked how the subcommittee was addressing the continued challenges around Medicare trainings for providers, including the cultural competency resources made during the Medicare-Medicaid demonstration. Ben reminded him that the subcommittee prioritized that scope of work at a lower level than the current scope of work.		
4	1:20 – 1:45	CP	**Complete discussion of information sharing practices and challenges between RAEs and LTSS providers**. Carol asked RAEs 2 and 4 to offer their approaches to SEP and CCB collaborations since they were unable to at the last meeting. Tina said they have primarily focused on educating these agencies on what the RAE was, points of contact, and what their goals were. They have designated a specific staff member to address LTSS issues. Alonzo added that they have good policies and procedures in place. Geographic dispersion and irregular schedules of providers were challenges to reaching all providers and creating effective partnerships.	2	
5	1:45 – 2:25	CP/BH	**Review initial draft of guiding principles**. Carol asked the group to take five to seven minutes to review the drafted guiding principles. She then asked for feedback and whether she and Ben heard the group correctly. Mary Kay affirmed the initial draft. Carol wondered how the subcommittee could help navigate who is the lead care coordinator for the member. Mary Kay said the lead care coordinator needs to know the overall structure of the system and how members interact and move within the various pieces. Carol suggested adding identification of a lead care coordinator as a challenge. Many agreed. Joanna adding that the Medicare system is so complex and that she was still learning herself and subsequently training her staff. She wondered if there was a benefits crosswalk that compared Medicaid and Medicare covered benefits. Carol and Mary Kay affirmed the complexity of Medicare. Marty added that often times Medicaid is viewed in silos – state plan services, waiver services, etc – instead of being viewed as one whole system. Carol suggested that the overall goal with information sharing principles should be to create a holistic understanding of the system. Joanna said this was also about	3	

			building a relationship as much as it was sharing information. Often times, her staff didn't even know who to contact and request information from. Moreover, subsequent information flow then required a release of information from the member. Tina suggested that each RAE have a point person for contacting LTSS providers to simplify the communication flow. Carol said that there still needed to be shared agreement between RAEs and LTSS providers that they would be willing to work together. Van said there were contractual expectations for RAEs and single entry points (SEPs) but not for LTSS providers and community centered boards (CCBs). Kathleen said she would check on the CCBs' contracts but knew they had been messaged that recommendation to engage with the RAEs. Van said that the shared agreement needed to outline roles and responsibilities for each party as well as collective processes. He wondered if the subcommittee could develop best practices regarding the creation of memorandums of understanding (MOUs) that had these dimensions. Carol agreed and proposed adding it to the opportunities section. Gary said these elements were important but missed the real value proposition of the relationship. He said that LTSS providers can often lose sight of a member when they go to a hospital, and RAEs could track those transfers. Nursing facilities and hospitals often don't consider a community placement because they are unaware of the community-based options. Ben said that the Office of Community Living was working on a transition program in Region 3 to address this very issue and transition more members from a hospital into the community instead of nursing homes. Carol asked how the hospital notified the RAEs when a member was being discharged. Many said that the RAEs receive admission, discharge, and transfer data through their regional health information exchanges. Gary added that hospitals still needed to know what community supports were there. The challenge was whether the hospital was even linked to these exchanges. Vicki said they had developed a community based model that coordinated community services when a member was admitted. Carol asked how RAEs could connect to those community resources. Ben said there was a waiver indication of their roster reports. Van said that is was still difficult to find the point person with the LTSS provider network to engage with. There was no common warehouse, aside from the BUS, that		

			identified all of the member's care team members. Carol suggested using the SEPs as the focal point since they would know all the LTSS providers. Marty said he still felt like there was opportunity to improve the relationship between RAEs and hospitals. Francine said there was a federal push to encourage hospitals to place members in their actual home environments to achieve better outcomes. Ben thought that was the Olmstead Act and would research it. Candy asked what the role of the family was in terms of making a decision about the placement and who the lead care coordinator was. Van said if the member was able to make the decision, RAEs deferred to the member. Otherwise, the RAE deferred to the family. Mary Kay said that Colorado has a surrogate decision-making law which makes it easier for members to involve friends and family in decision-making for treatment options. Kathleen added that it also depends on the hospitalization. Carol wrapped up the discussion by asking the members to sort the document by what was most achievable. Ben added that members should think about who else needed to be a part of the conversation and how the subcommittee would measure success if the principle was adopted.		
6	2:25 – 2:30	BH	**Sub-committee housekeeping**. Ben reminded everyone that the next meeting will be held on December 19th right after the PIAC meeting and will be focused on criminal justice. The meeting was adjourned at 2:30 PM.		

Meeting Action Items					
Date Added	**Action No.**	**Owner**	**Description**	**Due Date**	**Date Closed**
11/1/2018	1	BH	Research the Olmstead Act.	1/3/2019	
11/1/2018	2	All	Consider the feasibility, key partners, and outcome measures of each principle.	1/3/2019	

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify Ben Harris at 303-866-2399 or benjamin.harris@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.

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1. **Best Practices and Guiding Principles for Collaboration between LTSS Providers and RAEs**: One of the primary interventions of the Regional Accountable Entities (RAEs) will be their development of successful Health Neighborhoods, which includes Long Term Supports and Services (LTSS) providers and other community-based organizations (CBOs), especially those capable of addressing social determinants of health. During the initial phase of the Accountable Care Collaborative (ACC), RCCOs and LTSS providers experienced care coordination challenges. Many operational details need further guidance and development including, a) practices for sharing information across systems, and b) provider education materials regarding Medicare and other topics common to MMP and LTSS populations.

a. *Information Sharing across Systems*

Project Statement: Create policy guidance for sharing information and data between LTSS providers and RAEs.

Process:
- Identify successful information sharing practices between RAEs and LTSS providers, including best practices and outstanding opportunities.
- Examine innovative approaches to sharing information through updated data and IT systems for case management and care coordination.
- Monitor progress and successes.

Deliverables:
Policy guidance articulating best practices and outstanding challenges for how RAEs and LTSS providers share information on members across systems

11/1/2018 Discussion Questions

- What were successes and challenges when it came to information sharing during the Demonstration?
  - Please try to provide specific instances of members or providers that highlight these lessons.
- How do LTSS providers and RAEs create a collective business case for collaboration and coordination that necessitates information sharing?
  - What are the advantages to collaboration?
  - What specific sub-populations are addressed within these collaborations?
- How are members involved in the development of these collaborations?
  - How is member consent built into these collaborations and conversations?
- How are RAEs including LTSS providers in their network development and contracting processes?
  - How are information sharing strategies developed as part of this contracting work?
- How do we include these strategies in standard business practices moving forward?

For initial guiding principles:
- Do these encapsulate our conversation?
  - What clarification is needed?
- What work is currently being done to address these challenges and new opportunities?