



## **Task Force Meeting 1**

December 13 and 14, 2015  
Stonewall Resort - Roanoke, West Virginia

### **MEETING NOTES**

**Goal 1: Identify delivery system and payment approaches that will promote a highly coordinated care delivery system built upon a comprehensive primary care model.**

- Develop agreed upon approach, or approaches, to delivering and paying for care coordination.

#### **Task Force Members: Desired Outcomes (Responses Lightly Edited for Clarity)**

*An asterisk (\*) denotes priority desired outcome(s).*

Robert Whitler, Partners In Health Network/CAMC

- MVPs or high-utilizers enrolled in comprehensive, regional enhanced care management based on some type of risk sharing that will include\*
  - Web-based registry to track care in real time
  - Health coaches or care managers
  - Community paramedicine

- Payment for chronic care management
- Implementation of chronic care management PMPM
- Payment for community paramedicine

Dr. Michelle Foster, Kanawha Institute for Social Research & Action

- Efficient payment systems
- Increased care coordination
- More high-cost consumers seeking preventative care\*
- Improved continuum of care
- Sensitivity training for medical office staff

Terri Giles, West Virginians for Affordable Health Care

1. Implement pro-consumer payment policies – address the needs of high-need/high-cost patients and reduce payments for overpriced goods/services
2. Incorporate team-based care approaches and intersect physical/behavioral health services
3. Educate consumers about health care choices and engage them about their values and experiences within the system\*
4. Address the high-cost payment for health care of non-subsidized policies
5. Simplify the system for consumers

Eugenie Taylor, West Virginia Chamber of Commerce

1. A medical delivery system in West Virginia that is principled in personal responsibility, quality outcomes, driven by fair market forces and not one picking winners and losers\*
2. An efficient system that uses data and innovate practices to lower costs and improve quality of care\*
3. Create a medical delivery model that focuses on wellness and prevention
4. A system that decreases waste from fraud and other over-utilization of high cost services

Kim Tieman, Claude Worthington Benedum Foundation

1. Establish the framework for funding community health workers (CHWs) projects (particularly around chronic disease) to demonstrate improved patient outcomes and ROI\*
2. Develop innovative methods to utilize technology and telehealth to provide quality care to patients and reduce costs\*
3. Explore innovations around improving quality, such as PCMHs
4. Integrate primary care and behavioral health to improve patient outcomes
5. Be innovative about scope of practice issues in our state to increase quality for patients and decrease costs

Sharon Carte, West Virginia Children's Health Insurance Program

A plan is developed which accounts for:

1. The health care delivery system shifts to patient-centered care goals (i.e., they care for and treat the whole person—not by episode or billing code) starting with Health Homes
2. Care coordination is part of payment down to the practice level
3. Aligned measures, incentives, risks for as much of delivery system as possible by all payors\*

Todd White, CoventryCares of West Virginia

1. Develop/agree upon a standard for how to measure health quality and outcomes
2. Identify collaborative agreements/methodologies that may (or may not) work in some areas/situation (including unique payment/reimbursement methodologies)

Wildcard – Ideas for “getting the consumer in the game” – carrots and sticks\*

Mitch Collins, UniCare Health Plan of West Virginia

- Enhance ability for providers, payors and agencies to share detail on patient clinical data
- Enhance ability of provider in data analytics to understand financial implications to their practice of value-based models
- Opening up ability of telehealth – remove requirement that first visits be in person – increased availability of providers
- Funding stream for community connections to engage patients in the community – they're not being reached today\*
- Statewide population health approaches\*

Fred Earley, Highmark Blue Cross Blue Shield of West Virginia

- Guidelines established to allow/provide for alignment of providers and payors to engage in value-based reimbursement, focused on an agreed upon set of population health goals specific to West Virginia\*
- Allow for flexibility in models in order to not stifle innovation
- Advancement toward rich modeled arrangements
- Treat all segments the same – commercial, Medicaid, Medicare, PEIA
- Create incentives for a robust telemedicine infrastructure throughout West Virginia to enhance rural access to services

Eric Schmitz, Humana

- Value-based reimbursement models which are cost effective to administer\*
- Value reimbursement models which include the consumer
- Enhanced provider/payor relationships

James Pennington, The Health Plan

1. Statewide quality incentive program for delivery of care in West Virginia
2. An accountability model from payor to provider to participant that focuses on quality of care and quality of life
3. Access to data to create and support the model

Craig Robinson, Cabin Creek Health Systems

- A plan for Medicaid (and others) to support care coordination for our most at-risk patients in primary care
- An alternative payment system for West Virginia payors that promotes improved patient outcomes
- A plan for providing clinical support and assistance to improve primary care practices in caring for defined high-risk patients\*

Dr. Christopher Colenda, WVU Medicine/West Virginia United Health System

“Don’t reinvent the wheel”

1. Local MCO relationships as opposed to national MCO involvement in managing care
2. To not destroy the hospital infrastructure in the state\*

3. To not encourage physical entrepreneurialism that will impact #2 above
4. To have common quality measures for providers\*
5. To integrate behavioral health-primary care services driven by patient needs (SMI has primary care services embedded in the CMHCs and specialty mental health services embedded in PCP services for less severe illnesses)\*
6. Addressing LTC and geriatric services both at SNF and ICF levels – and coordinating across care continuum\*
7. To move to true payor-provider integration at front end (e.g., at contract level) to avoid disincentives to either organization\*
8. Recognize that health requires addressing payment mechanism that incentivize the utilization of community-based workers to assist in care coordination
9. Encourage and expect common community connections among providers to provide ease of information transfer
10. Effectively connect with dual eligibles either through care coordination outlined in #8, #6 and # 9\*
11. Have providers work at maximum of their license
12. Physicians are not involved in therapies that require maintenance
13. Consumer sophistication/education to make better choices
14. Tobacco tax increase\*

Doug Bentz, Roane General Hospital

1. All payors and providers agree on a uniform list of quality measures and indicators
2. Payors agree to invest money and/or resources in providers who invest in quality, patient outcomes and patient experience (additional money)
3. Agree to a coordinated approach between payors/providers to better manage patient care

Dr. Dana King, WVU School of Medicine

1. Medical home coordinating and training center(s)
2. IT-connected provider quality dashboard (state) for each individual and each practice that encompasses all the value-based quality measures by all payors
3. Care coordinating training at community colleges and universities
4. A Google car assembly plant in WV

Dr. Tara Hulsey, WVU School of Nursing

- A model of care that uses all care providers at their full scope of practice to assist with all care\*

- A pay model that is based on value (quality health outcomes)\*
- Development of recommendations for assessment of quality of care
- Improve payor-provider relations

Hoyt Burdick, Cabell Huntington Hospital

- Improved health care access for West Virginians
- Fewer informational barriers between primary care and other providers
- Sustainable model that isn't funded solely by cuts to providers or increased payments by providers – administratively streamlined (no new bureaucracies)\*
- New definitions/models for care coordination and defined roles and responsibilities\*
- Standardized quality metrics with minimal manual abstraction\*
- Patient/consumer engagement

Jeremiah Samples, West Virginia Bureau for Medical Services (Medicaid), DHHR

- Identify, through consensus across stakeholders, common denominators to transition West Virginia health infrastructure to a system that effectively improves population health
  - Plan to implement agreed infrastructure pieces
  - Quality measures agreement\*
  - Care management strategy that is holistic (social services )\*
- Develop a forum by which private sector innovation is harnessed to perpetually address goals of state health policymakers and stakeholders

Karen Yost, Prester Center

- Model of health care delivery based on partnership and collaboration rather than mere duplication\*
- Identification of at least a few quality measures
- Commitment from DHHR to remove policy barriers to implementation of new models – e.g., overly burdensome activities, reporting related to outcomes\*
- Information technology and health information exchange eliminate duplication in this model
- Include providers in developing model and outcomes\*

## Task Force Members - Desired Outcomes Prioritization

1. Care Coordination Models (*13 points*)
2. Alignment of Delivery System Models (i.e. PCMH, Health Home, ACO, Integrated Health Network) (*10 points*)
3. Population Health Improvement Objectives (obesity-related illnesses, tobacco use, behavioral health/substance abuse) (*8 points*)
4. Availability of Transformation Resources **and** Integrating Behavioral Health and Primary Care / Physical Health (*6 points*)
5. Alignment of Payment Models **and** Adequate Health Information Technology (HIT) Infrastructure (*5 points*)
6. Aligning Quality Measures Among Payors and Providers (*4 points*)
7. Consumer Engagement & Incentives, including an education component (*2 points*)
8. Movement Toward Risk (*1 point*)
9. Meaningful & Timely Access to Data (*0 points*)

## Break Out Session – Care Coordination/Delivery System Approaches (Responses Lightly Edited for Clarity)

### Care Coordination

What is care coordination?

- Risk stratification for whom?
  - High-utilizers
  - Rising risk to high-utilizers
- Care coordination is being done in West Virginia already to some extent, but coordination among providers is not yet occurring.
- Need to figure out how to tailor interventions to the risk of a given patient population.
- Important to have a system for sharing real-time data.
  - How will this be done?
  - What infrastructure is needed? – option: secure web-based system
- Important to meet providers “where they are.”
- Scalability and flexibility of models.
- Opportunities for sharing and partnerships.
- Model development support is essential.

- Prescriptive model v. Flexible Organic Model.
- Centralized/regional/local – which works best for West Virginia?
- Contact with medical home/PCP/provider.
- Care coordination relates to individual behaviors.
- Information overload at the patient-level.
  - Trust is critical element.
  - Important to be done at local-level.

Who should do care coordination?

- Not strategic or effective to use highly-skilled, licensed practitioners by default.
- Capability v. Licensure.
- Peer-led
- Team-based
- Variable
- Community paramedicine (EMTs/paramedics).
- Formal Training v. On-the-Job Experience.
- Community Care Teams v. Practice Model.

What are we paying for?

- Information infrastructure (technology).
- Flexible team-based model (staffing and operations).
- Process/outcome components (risk-adjusted).
- Need upfront financial support but must ultimately be revenue-neutral.
- Data infrastructure is lacking to support outcome-based payments and show savings.
- Medical Home as a component of overall system transformation – payment is still siloed.
- Transformation resources are essential.

**Synthesis of discussion:**

- Care coordination targets resources based on risk stratification.

- Care coordination is:
  - Team-based
  - Flexible
    - Organizations (health plans, PCP, other entities).
    - Not a dictated model.
  - As close to point of care as possible.
- Shared information is critical to risk stratification, operations and measurement.
- Measurement of outcomes needs to be invested in and is critical to all parties.
- Resources for transformation are critical to success and funding mechanisms need to be developed.
- Payment should start process-based (PMPM) and over time should convert to outcomes-based when mature.

### **Delivery System Approaches**

How do you “see” the delivery system? Who/what does the system include?

- Physicians/PCPs
- Information technology/data analytics
- Social services
- Insurers
- Nurses
- Medical management
- Patients/consumers
- Faith-based entities/communities
- Peer-based workers/supporters
- Culturally-appropriate resources
- Patient/consumer engagement and education to help patient/consumer know “where to start”
- Employers? (federal laws complicate this)
- Anyone the patient/consumer accesses for care/health affiliates

Challenges of care coordination in West Virginia

- Navigation through the system – who will navigate for patients/consumers?

- Resource allocation and deployment – workforce – decentralized or centralized?
- Non-PCP providers (social workers, care coordinators, community health workers, etc.)?
- Geographic challenges.
- Mountainous terrain.
- Small population centers.
- Cultural dynamics.
- How do we improve relationships between payors, providers, etc.?
- Blended opportunities to meet unique challenges, needs, resources, etc., in various regions throughout the state

#### Model Options

- Community Care of North Carolina/Community Care Teams
  - Rural based
  - Integrated
  - Regionally-based – hub and spoke system
- Washington State Collaborative Care Model
  - Behavioral Health and Primary Care integration
  - Large population focused
- Provider (clinically) integrated networks allow for care coordination

#### Service Delivery Transformation

- Leveraging community health workers to help patients/consumers navigate health care system – particularly in rural areas
- Engage consumers in their own care/ask them what barriers exist – perhaps utilizing motivational interviewing techniques
- Two major components - navigator/health care worker and patient/consumer engagement
- Align payment to encourage innovative delivery approaches
- Addressing cultural challenges through generational changes

<p><b>Large Group Discussion - Processing of Break Out Sessions on Delivery System Approaches and Care Coordination (Responses Lightly Edited for Clarity)</b></p>
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- Accountability at the local level is important regardless of model type and/or data needs.

- Care coordination – who should provide this and at what level? (providers, payors, others).
- What is the migration strategy from the current structure to the desired state?
- Medicaid: National Governors Association Complex Care Initiative
  - Leverage pilot/programs developed for the initiative by CHH, CAMC, WVU Medicine to test SIM-related projects
  - Medicaid Health Homes for other chronic conditions can help less-resourced practices/providers to build capacity for new types of delivery/care coordination.

### Organizing Principles

- PCMH as a building block.
- Models scaled to need.
- Organizing providers.
- MACRA incentivizes providers.
- Advanced primary care model.
- Utilization of networks as an organizing principle.
- Prioritize improvement targets with incentives (i.e., obesity, tobacco use, behavioral health).

### Proposed Organizing Principles

- Organize around primary care.
- Care coordination at primary care level.
- Except patients who don't have a primary care "home" – care coordination at the payor level.

### Agreed Upon Organizing Principles

- Advance primary care model.
  - Organizing competencies that are centralized, regionalized or localized.
- Health system transformation support.
- Common agreed standards.
  - Market-driven aggregation of outliers/smaller providers.
- Expansion population (Medicaid).
- High-cost, high-users.

- Framework for provider-payor coordination of resources.

## Large Group Discussion – General (Responses Lightly Edited for Clarity)

### Super-Utilizers

- Chronic disease management.
- “Access” over utilizers (i.e., ER, etc.).
- Mental/Behavioral Health.
- Poly pharmacy/medication adherence.
- Palliative/end of life care.
- Wrong place, wrong time patients.
- Post-acute care management.

What do we need to work collectively?

- Data – build upon WVHIN and health information exchange capabilities.
  - Access in real time.
  - Sharing and workflow tools.
  - Centralized
- Team
  - Identification of who is on the team, PCPs and the team leader.
  - Communication among the team members.
  - Coordination of the team/care.
- Attribution?
- Identification of population segments.
- Build upon existing super-utilizer lists (e.g., National Governors Association Medicaid Complex Care initiative)

Other models in West Virginia

- NAS (Neonatal Abstinence Syndrome)
- Complex Care.

**Group Checkout (Responses Lightly Edited for Clarity)**

<i>What worked well today?</i>	<i>What would you change for the next meeting?</i>
<ul style="list-style-type: none"> <li>• All players are in the room</li> <li>• Engaged group</li> <li>• Incredible participant panel</li> <li>• Excellent facilitation by Dr. Weaver</li> <li>• Breakout session</li> <li>• Open atmosphere</li> <li>• Group breakout</li> <li>• Good discussion on conceptual issues</li> <li>• Level of participation</li> <li>• Payors willingness to be creative</li> <li>• Good to hear what is happening across U.S.</li> <li>• Monday’s facilitators</li> <li>• Breakout sessions</li> <li>• Dr. Weaver did a good job at summaries</li> <li>• Kept discussion moving and people thinking</li> <li>• Brought together strong group of stakeholders to begin to grapple with reality of moving forward</li> <li>• Generally positive facilitation</li> <li>• Topics/goals clearly understood/defined</li> <li>• Level-setting approach at beginning was positive</li> <li>• Reasonably positive open exchange</li> <li>• Competent facilitation</li> <li>• Getting the group together</li> <li>• Break out smaller groups</li> <li>• Engagement level</li> <li>• Baseline education</li> <li>• Dr. Weaver facilitation</li> <li>• Focus good</li> </ul>	<ul style="list-style-type: none"> <li>• Propose ideas and ask for a vote</li> <li>• Less discussion, more decision about actionable steps</li> <li>• Difficulty moving from theoretical to practical</li> <li>• Small group deliverables unclear</li> <li>• Provide one longer break to allow time to attend to our real job duties – 30 minutes</li> <li>• Continue to focus us on what SIM can be spent to accomplish</li> <li>• Keep us focused</li> <li>• Dragged out some points</li> <li>• Not as much discussion on specific consensus components</li> <li>• I think that the critical presentation on PCMH and models around nation was weak and too late for people to absorb</li> <li>• Inability to set basic parameters, like who to serve, what to do, how to do it</li> <li>• The introduction of Medicaid ideas and programs that were not in the book!</li> <li>• Sunday meeting</li> <li>• Would suggest fewer consultants which would lead to a smaller group</li> <li>• Ability to have a discussion with <u>lead</u> facilitators before the meeting</li> <li>• Room a little too large and AC not very comfortable</li> <li>• No more Sunday evening discussions during holidays (not because I do not want Sundays, but people lose focus)</li> <li>• Is this about Medicaid/or other insurance products? Each of the MCO/insurance companies has vested interests in gaining market – needs clarifying</li> <li>• If this is about cost containment, let’s talk about that</li> <li>• Good to hear about other states’ models but all portrayed as</li> </ul>

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	<p>good and effective - what does the evidence say about what works?</p> <ul style="list-style-type: none"><li>• More specific questions to the group</li><li>• Make some assumptions about direction</li><li>• Provide some real data from payors</li><li>• We need more time together to discuss amongst ourselves what is happening - I would suggest two full days</li><li>• Meeting individually not all that helpful</li><li>• Too large of a group</li><li>• Complexity – need a baseline model</li><li>• Need more practitioners in the room</li><li>• Need more detail on other states’ models and whether or not they are working – Maryland saved \$100 million last year – how?</li><li>• Need to find out if there is <u>any</u> change the payors are willing to make or <u>any</u> investment in PCMH or <u>any</u> PMPM that they would do</li><li>• Sunday presentation too long</li><li>• May need to refer back to goals when meeting gets bogged down or adrift</li></ul>
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**Task Force Meeting Notes Submitted by:** Bruce Decker and Denina Bautti-Cascio, December 17, 2015

**Task Force Meeting Notes Revised by:** Joshua Austin, January 19, 2016