

SIM Workgroup Update

September WVHIC Quarterly Meeting



West Virginia
STATE INNOVATION
MODEL GRANT

July Workgroup Meeting Themes and Exercises

- * **Meeting Theme** – ‘Level Setting’
- * **Small Group Exercises**
 - * Review and comment on “Baseline Trend Assumptions”
 - * Identifying strengths and weaknesses affecting transformation
 - * Address questions about workgroup charter concepts
 - * Address workgroup specific questions related to the ‘Level Setting’ theme

July Workgroup Consensus – High Scores

- * **9.26 Score** - West Virginia should supplement its advanced primary care model with additional infrastructure (e.g., telehealth)
- * **9.22 Score** - Payors should compensate providers for care coordination, education of patients on how to appropriately access care and for meeting agreed upon measures / benchmarks
- * **9.04 Score** - West Virginia needs to focus on a whole-person orientation to health care

July Workgroup Consensus – High Scores

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- * **8.70 Score** - Aligning measures—whatever they are determined to be—among all payors
- * **8.50 Score** - Determining the return on investment of the measures themselves (i.e., is collecting this measure cost effective)
- * **8.43 Score** - Integrate physical / mental / dental care
- * **7.60 Score** - West Virginia still needs to decide on its care coordination model; the SIM process will assist with that

July Workgroup Consensus – High Scores

- * **8.68 Score** - West Virginia's care coordination model should seek to link patients to community-based resources
- * **8.65 Score - West Virginia typically separates mental health diagnoses and treatment from primary care, making it difficult to coordinate care and adequately address the health care needs of that population**
- * **8.65 Score** - West Virginians often have poor diet, nutritional habits

July Workgroup Consensus – High Scores

- * **9.39 Score** - Defined data governance: integrity / standardization of data
- * **9.28 Score** - Defined data governance: filtering of sensitive patient health information
- * **9.22 Score** - We must address the HIT infrastructure needs of the rural community
- * **9.11 Score** - Have a shared vision of security / confidential data

July Workgroup Consensus – High Scores

W O R K F O R C E

- * **9.06 Score** - Care coordinator training is needed
- * **8.94 Score** - West Virginia should make inter-professional training a priority
- * **8.76 Score** - Loan repayment strategies should be tied to recruitment / retention of health care professionals

WV SIM SOAR Chart (Post-July Meetings)

Strengths	Opportunities
<ul style="list-style-type: none"> ○ Engaged, well-connected health care stakeholders ○ Multiple collaborative efforts such as the State Innovation Model grant, the WV Health Innovation Collaborative and “Try This” initiative ○ Robust primary care center and school-based health center system ○ Comparatively low uninsured population 	<ul style="list-style-type: none"> ○ Adopting a value-based approach to health care payment at the federal level encourages / requires change(s) at the state level ○ Biggest opportunity to improve population health due to poor rankings and position compared to other states ○ Have adequate health care infrastructure / programs in place to improve outcomes—need to change how it is encountered and accessed
Aspirations	Results
<ul style="list-style-type: none"> ○ To move from a fatalistic attitude to one that places a high priority on health and wellness ○ To end fragmented and episodic health care that does not treat the “whole person” ○ To integrate primary care with behavioral health 	<ul style="list-style-type: none"> ○ Standardize and align health care quality measures among all payors ○ Make return on investment a bigger part of health care delivery assessment and design ○ Better leverage telehealth, health information technology ○ Determine a care coordination model through the SIM grant process

August Workgroup Meeting Themes and Exercises

- * **Meeting Theme** – ‘Obesity’
- * **Small Group Exercises**
 - * Discuss the Hypothetical Vignette, asking:
 - * What are the strengths of the elements / components in this proposal?
 - * What are the challenges of implementing the elements / components of this proposal?
 - * What elements / components of this proposal would you strongly recommend that we keep?
 - * What recommended changes would you suggest for a revised proposal?

August Workgroup Survey Results

What are the challenges of implementing the elements / components of this proposal?

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Answer	Order of Importance (1=most important; 2=second most; etc.) - Mean Rank
It is unclear how providers and payors will “share risk” in the Medical Neighborhood	1.33
Not all services considered under the Medical Neighborhood are available throughout the entire state (i.e., there are care gaps)	2.36
Getting agreement from payors to share in the costs of creating regional Medical Neighborhoods	2.4
Much of the success under a Medical Neighborhood will depend on the level of patient engagement and willingness to change	2.43
Some services are left out of this Medical Neighborhood (i.e., motivational interviewing and behavioral change services, especially)	2.5
Providers “buying in” to the Medical Neighborhood concept	2.56
There is a question about who controls the care coordinator in a Medical Neighborhood (i.e., provider v. payor)	3.4
Knowing how to staff the Medical Neighborhood care team with appropriate team members	3.67
There might need to be a different approach used to allow for behavioral health interventions	3.67
As the population of those receiving care coordination increases, the greater the chance that the care coordinator is ineffective (read as: could “drop the ball”)	4.33
It is unclear who is incentivized under this model (i.e., the provider, the payor and / or the patient)	4.4

August Workgroup Survey Results

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What elements / components of this proposal would you strongly recommend that we keep?

<u>Answer</u>	Order of Importance (1=most important; 2=second most; etc.) - Mean Rank
<u>Care coordination is key to the Medical Neighborhood</u>	<u>1.5</u>
Shared responsibility of the patient among providers / team members	2.63
<u>Integrations and connecting of behavioral health with medical care</u>	<u>2.73</u>
Access to health improvement resources, such as diabetic educators	3
The ability to localize, or tailor, the Medical Neighborhood to a community	3.13
The number of services identified in the Medical Neighborhood are critical: these are primary care, behavioral health, oral health, pharmacy and care management	3.22
The emphasis on improved HIT and its role in enhancing health care delivery	3.78

August Workgroup Survey Results

What recommended changes would you suggest for a revised proposal?

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Answer	Order of Importance (1=most important; 2=second most; etc.) - Mean Rank
Adopt a regional approach rather than establishing a patient-centered medical home in each county	1.33
How care teams are staffed will depend on the way regions are separated and identified as delivery regions	2
Identify common priorities from community needs assessments and pick a few commonalities and integrate those needs into the Medical Neighborhood	2.4
Establish a set of required services that all care teams must offer, then give flexibility to add other types of services	2.63
Utilize community needs assessments from sources such as local health departments, critical access hospitals and family resource networks to identify common needs among a region	2.83
Establish a method for piloting / assessing programs that have either modified intervention(s) or are started from scratch	3
<u>Emphasis on data sharing to encourage continuous improvement in the delivery system</u>	3
A patient engagement / educational component is needed to inform them about what these care teams are and what they can do	3.25
Incorporation of social services to address social determinants of health, such as poverty	3.6
Establish risk tiers based on how complicated the patient population is to manage through a Medical Neighborhood	3.75

August Workgroup Survey Results

(Recurrent Cross-Workgroup Theme)

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For the purposes of SIM, do you believe the model should be medical- or health-oriented?

Broad Agreement – Health-Oriented!

- * Better Care, Better Health and Better Value are spending a considerable amount of time defining what is meant by a “health-oriented” model in September. For example, in the Better Value Workgroup, participants will discuss:

How does WV ensure that regional care coordination models focus on a comprehensive health approach and not simply a medical approach?

August Workgroup Consensus – Interventions / Goals Verbatim from WV SHIP

Question asked because of repeated, substantive workgroup discussion

- * **9.25 Score** - SNAP benefits should be aligned with nutritional goals

Innovative Patient-Centered Care and / or Community Linkages

- * **8.88 Score** - Increase awareness of self-management programs
- * **8.71 Score** - Increase built environment / grassroots support to reinforce healthy behaviors for community policy changes (# community mini grant recipients) (Baseline: 103 FY2015)

Traditional Clinical Approaches

- * **8.79 Score** - Increase the proportion of health care systems that utilize team based care
- * **8.33 Score** - Increase referrals to self-management programs (ex. Diabetes Self-Management Program)

August Workgroup Consensus – Interventions / Goals Verbatim from WV SHIP

Community-Wide Strategies

- * **9.08 Score** - Enact policies and regulations to support insurance coverage for counseling and self-management programs and CDC recognized lifestyle change programs (i.e. National Diabetes Prevention Program)
- * **8.75 Score** - Enact policies and regulations to support insurance coverage for counseling and self-management programs

August Workgroup Consensus – SWOT

Strengths	Weaknesses
<ul style="list-style-type: none">Existing technology and a governance structure is in place to leverage data, including WVHIN, the Medicaid Data Warehouse and the hospital system infrastructureHealth Information Technology (HIT) framework is being created to facilitate capture, exchange and utilization of clinical and outcome data to drive health improvement and incentivize value-based paymentEnhanced funding available to continue onboarding other areas of needFew burdensome state / federal regulations for the successful deployment of telehealthTechnical platform for state health information exchange (i.e., WVHIN)Significant advancement in the adoption and use of HIT systems enhanced by incentives from the Centers for Medicare and Medicaid Services and technical support from the Office of the National Coordinator for HIT	<ul style="list-style-type: none">There is lacking interoperability among current HIT infrastructure—a problem that is not unique to West VirginiaA sustainability model or plan is not in place for WVHIN (also a threat)Provider HIT fatigue, increased costs and lost time with systemic changes and additional requirements (e.g., HIPPA compliance audits and ICD-10 implementation requirements)Due to business operating rules, data quality is at riskData governance structure needs to be reinforcedLimited system and business resources to support adoption and use of HIT, particularly in small and rural practice settingsRural HIT infrastructure (e.g., lacking broadband and connectivity)Have yet to develop a shared vision of security / confidential dataEarly stages of data integration and use for health transformation under traditional practice / payment modelsCosts to adopt, implement and upgrade EHR systems and use the health information exchangeLimitations on reimbursement / payment for telehealth and remote patient care



August Workgroup Consensus – SWOT

Opportunities	Threats
<ul style="list-style-type: none">○ Identify the value and return on investment of HIT to both patients and providers○ Progress that has been made with electronic health records provides a foundation to strategically define clinical data needs○ Build a lateral, equitable system of data access and sharing across data systems to address population health○ Ability to create new business process efficiencies across programs by integrating new sources of data○ Reduction in time to deliver reports across enterprise regarding clients, providers, employers, etc.○ Leverage the WVHIN to facilitate HIT support for transitioning to a value-based model○ Telehealth and mobile / remote tools can be extended to provide needed specialty care in underserved areas of the state and to engage patients at home or work○ Make the Medicaid Data Warehouse the de facto All Payer Claims Database	<ul style="list-style-type: none">○ A sustainability model for WVHIN is not in place○ A significant number of providers are retiring and leaving the health care system, which impacts both access to care and quality of care○ Protecting data from security breach○ Behavioral health care information can be shared in an EHR, but it triggers more robust privacy protections○ Legal misunderstandings, ambiguities in what PHI can be shared among primary care and behavioral health providers○ Providers not seeing the benefit or additional value of an EHR○ Patients not seeing the benefit or value of a PHR○ EHR mission creep (e.g., adding data that are not germane or that trigger additional regulatory burdens with little return on investment)



August Workgroup Survey Results

What workforce challenges do you expect to encounter in transitioning to this type of health care delivery system?

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Answer	Order of Importance (1=most important; 2=second most; etc.) - Mean Rank
The model does not keep the priority and focus on managing the entire population; it still looks at health care segments	1
Unsure if West Virginia has the supply of workers to staff the basic elements of the model	1
<u>The “health” focus of the model is lacking; at present it does not address root cause drivers and social determinants of health</u>	<u>1</u>
Regional collaboration could be challenging, especially when there is risk	1.5
The system is focused on medical and symptom treatment – not a holistic approach to health and general wellness	2
There is a question about whether this model can reach all West Virginians, notably those in rural areas	2
Lacks one-on-one connections with patients, particularly the elderly – need to identify and train people for these roles	2.5
This model potentially consolidates control of the health insurance market	2.5
Unsure if medical professionals are adequately trained to staff and participate in this model	3
Uncertain if patients / consumers will accept being part of this model	3
Potential loss of interpersonal relationships as health care becomes virtual	0
Possibility that primary care could become little more than a referral conduit to various specialists	0
No clear definition of care coordination – Who works as one? What is their training and preparation? What do they do?	0
Smaller and rural providers will find it difficult to survive under this model	0

Themes for Model Design After July and August

- * **Must include care coordination / coordinators**

Still to be defined and roles to be determined

- * **Must be an integration of behavioral health and physical health**

October standalone, specialized stakeholder meeting to be held to focus on this issue to better frame efforts for all the workgroups later in October or early November

- * **Must be alignment of provider and payor quality measures**

September - work is beginning in earnest with the help of West Virginia Medicaid and Highmark BCBS WV in Better Value Workgroup

- * **Must include telehealth / telemedicine**

Still to be determined are the type of specialties and policy / payment barriers that may exist

- * **HIT must be a backbone, aid to this model design and its deployment**

Early stage: recall the weaknesses and threats in the HIT Workgroup SWOT Analysis