

State Innovation Model (SIM) Better Care Workgroup

Tuesday, July 21st 2015 - 1:00 p.m. – 4:00 p.m.
Marshall University Graduate College – South Charleston Campus – Room 116

MEETING SUMMARY NOTES

Today's Expected Results:

- Develop a clear understanding of the SIM project and workgroup member's role in developing the WV State Health System Innovation Plan (SHSIP)
- Strengthen working relationships among workgroup members
- Review and apply baseline documents ("Workgroup Charter," "Mutual Understandings and Assumptions" and "Baseline Trend Assumptions")
- Begin to address "Workgroup Charter" topics and key questions
- Select preliminary strategies around the focus areas of obesity, tobacco and behavioral health based on selected criteria
- Identify additional workgroup members, next steps and materials and expertise needed for future sessions

Co-Chairs: Dr. Arnie Hassen and Nancy Sullivan

Facilitator: Bruce Decker

Participants: 29 people – 20 in person and 9 electronically

TOPIC	OVERVIEW/DISCUSSION/DECISIONS
<p>Welcome, Introductions and Opening Remarks</p>	<p>The session opened with a welcome and opening remarks indicating that this is the first meeting to launch SIM workgroups, building on work that has been done through the WV Health Innovation Collaborative. Roles of the facilitator, co-chairs and workgroup members were reviewed. Joshua Austin, SIM grant project coordinator, was recognized for his role as liaison among the workgroups. The agenda with expected results for the meeting and ground rules were reviewed with workgroup members. A sign in sheet was distributed for any needed revisions.</p> <p>Workgroup members recorded on index cards their response to the following question: “If you had a Magic Wand and could change <u>one thing</u> that would significantly improve or transform ‘<u>your piece</u>’ of the health care system in West Virginia, what would that be?” Workgroup members were asked to identify what “their piece” of the health care system is and the one thing they would change. Workgroup members then found someone in the room that they did not know or did not know well and shared who they are, what entity they represent and their response to the Magic Wand question.</p> <ul style="list-style-type: none"> • Integrated data collection and analytics • Transparent quality reporting by all providers that is scientific and consumer friendly • Sufficient services and support to allow seniors to live at home or place of their choice • Effective communication between all health care participants • Transparency of costs, more transparent health care system • Health care transparency: costs, providers, quality, procedures • Effective communication • Health system partners would continue these types of collaborations • Undertake complete review of WV Medicaid program • Expand HCBS for aging and people with disabilities – expand scope of practice to expand care and meet demand • Have a three-pronged approach: coaching and tobacco cessation for all, 100% comprehensive smoke free, increase tobacco tax • Better care coordination between all providers • Zero waiting time for access to medical care

	<ul style="list-style-type: none"> • Transparency of care costs • Minimizing duplication of efforts with regard to quality improvement • Seamless sharing of information among professionals and patients – systems do not speak to one another • Value the nursing profession • Coordinated, community care teams • Universal health care, education of what is to come for each consumer given individual behaviors • Full utilization of all health care providers to get “all hands on deck” • Seed funding to invest in an integrated and aligned delivery system which would lower costs to improve population outcomes for WV
<p>Setting the Context for Our Work: SIM Overview</p>	<p>A PowerPoint presentation was shared with workgroup members to set the context for their work. “Workgroup Charters” and “Mutual Understandings and Assumptions” documents were briefly reviewed with participants.</p>
<p>Review of Baseline Trend Assumptions: Small Group Discussion</p>	<p>In small groups, workgroup members discussed the “Baseline Trend Assumptions” document and recorded their responses to three (3) questions related to the document on flipchart paper. Small group discussion guidelines were provided to help direct workgroup interaction. Small groups provided a brief report to the larger group.</p> <p>The questions and verbatim responses follow:</p> <p>Is anything missing?</p> <ul style="list-style-type: none"> • Needs of aging population <ul style="list-style-type: none"> ○ Physical ○ Cognitive ○ Living / human service • Breakout of age demographics • Infrastructure for healthy lifestyle is lacking • Expanded baseline information regarding lifestyle characteristics • Nutritionists and alternative providers are not included

- Added cost of good health and nutrition
- Cultural resistance to change and personal responsibility
- Trend information from other health issues
- Analysis
- Information on complementary and other scope of service
- Communication structure
- Identified coverage gaps
- Disabilities
- Access to services
- Silo - integrate obesity / tobacco / behavioral health
- Coordination
 - Funding
 - Services
 - Data / shared info
- Assumptions will continue without intervention
- Not “just” a health issue! (many elements not integrated) – there are a number of facilitating factors

The following answers provided are grouped into themes based on the small group discussion / output:

What do you see as the top three (3) strengths to transforming our current health care system?

- West Virginia has engaged, well-connected health care stakeholders
- West Virginia is undertaking multiple collaborative efforts to improve its health care system, including but not limited to the “Try This” campaign, the WV Health Innovation Collaborative and the SIM grant itself
- Changes at the federal level in how health care is paid for and budgetary constraints at the state level have created a climate in which health care system change might be possible
- Health technologies are improving and becoming more cost effective

- West Virginia is a relatively small state in terms of population and size, as well as tight-knit, so people can easily be brought together to effectuate change in the health care system
- West Virginia has many resources at its disposal to make health care system change, including state and federal experts and academic medical schools
- The Secretary of the U.S. Department of Health and Human Services is a native West Virginian
- On the whole, West Virginia has a high insurance coverage rate, especially after opting to expand Medicaid under the Affordable Care Act
- West Virginia has a strong network of community health centers and community-based health care delivery mechanisms, such as FQHCs, health departments, etc.

What do you see as the top three (3) challenges to transforming our current health care system?

- Political leaders in West Virginia have not made health care and health care system reform a priority
- West Virginia has a culture that does not place a high priority on public health, healthy living and wellness
- Any changes to West Virginia's current health care system will have to come from savings achieved, as there is no money presently committed from the federal government to pay for wholesale change
- West Virginia lacks the basic technical infrastructure to make significant changes to its health care system
- West Virginia's rural geography makes it a challenge for consumers to access health care, especially experts or specialists
- West Virginia's consumers often receive fragmented and uncoordinated health care
- West Virginia has not settled on a model to coordinate the care of patients with chronic disease(s)
- Transitioning from the current fee-for-service to a value-based health care system could negatively impact the health and access to health care of West Virginia's patients / consumers
- There is a lack of education and outreach to patient populations to explain the new value-based health care model that is likely to be implemented during the next several years in West Virginia and throughout the country

**Workgroup Charter
Key Questions: Small
Group Discussion**

In small groups, workgroup members discussed “Workgroup Charter” Key Questions and recorded their responses on flipchart paper. Small group discussion guidelines were provided to help direct workgroup interaction. Small groups provided a brief report to the larger group.

The answers provided below are grouped into themes based on the small group discussion / output:

1. What does “Establish a highly coordinated care delivery system built upon a comprehensive primary care model” mean? What is the function of such a system? What are the components of such a system? How do we transition to such a system?
 - There is “no wrong door” with which to access health care—providers and community partners should have seamless communication
 - Ideally health care is coordinated by linking to single database / electronic health record with uniform measures; providers treat the underlying disease and not just the symptoms and incentives / payments are aligned to encourage the delivery model
 - Health care is integrated to include medical and behavioral health, with an emphasis on connecting patients to community-based resources to meet not just their medical but socio-economic needs
 - The health care system includes a continuum of care that also incorporates access to telehealth, especially for expert, specialist and behavioral health care
 - To transition to this system, the payors should compensate providers for care coordination, education of patients on how to appropriately access care and for meeting agreed upon measures / benchmarks
 - This system requires a community care team consisting of, at a minimum: a primary care provider, a care coordinator, health educators for chronic disease(s) and a telehealth specialist to extend the reach of the care coordination team
2. How can current integrated and coordinated care models in West Virginia (Medicaid MCOs, PCMHs, value-based reimbursement) be leveraged in development of the SHSIP plan?

- West Virginia should leverage its advanced primary care model to deliver coordinated care to health care super utilizers and supplement this infrastructure (e.g., telehealth)
- West Virginia has disparate care coordination models; it should pick one and make it a key focus for public / private payors
- West Virginia needs an inventory of its currently deployed care coordination models so it can analyze and identify best practices

3. What would be good measures for our six target areas of obesity, tobacco, behavioral health, preventable care and avoidable costs, data / measureable outcomes, and community engagement, collaboration and infrastructure?

- **Recurrent theme:** Health care delivery in West Virginia is episodic and often focuses on treating symptoms and not the underlying disease—need a more whole-person orientation to health care
- **Recurrent theme:** West Virginia should choose a uniform set of quality and outcome measures and establish attainable goals, then gradually increase these goals
- **Recurrent theme:** West Virginia should create an All Payer Claims Database as developed legislatively three years ago or another centralized depository of claims information, such as the data warehouse used by the WV Bureau for Medical Services
- West Virginia should increase its tobacco tax to decrease the number of smokers and measure the decreased prevalence of smoking
- West Virginia should set a specific target from its current baseline to improve the state’s ranking (i.e. obesity from 49th to 39th by 2020; prevalence of tobacco use from 50th to 40th by 2020)
- West Virginia should focus the preponderance of its time and resources on decreasing the prevalence of chronic conditions that share comorbidity, such as obesity, diabetes, heart disease and tobacco use
- West Virginia must value the quality of life indicators that contribute to health and wellbeing, such as the amount of greenspace and walkable / bikeable communities

<p>Potential Strategies Around Areas of Focus: Small Group Discussion</p>	<p>In small groups, workgroup members discussed and identified potential key strategies for each of the three (3) State Health Improvement Plan areas of focus (1) obesity, (2) tobacco use and (3) behavioral health and recorded their responses on flipchart paper. Small group discussion guidelines were provided to help direct workgroup interaction. Small groups provided a brief report to the larger group.</p> <p>The answers provided below are grouped into themes based on the small group discussion / output:</p> <p>For All Focus Areas</p> <ul style="list-style-type: none"> • Select the most obtainable outcomes from each of our focus areas and make those early goals, then build on those successes • Increase the use of telehealth—requiring it to be covered by payors and included as a health quality measure • Expand and bolster community-based initiatives such as the “Try This” campaign to develop local solutions to local health problems <p>Obesity</p> <ul style="list-style-type: none"> • Work with grocers and other sellers of foodstuffs to encourage healthier options for consumers • Incorporate obesity best practices into the training of providers so they know what works • Develop a community care team that includes an obesity specialist <p>Tobacco Use</p> <ul style="list-style-type: none"> • Increase the excise tax on tobacco products • Expand clean air ban scope to other types of places and to each county in West Virginia • Ban tobacco advertising • Incorporate tobacco cessation best practices into the training of providers so they know what works • Develop a community care team that includes a tobacco cessation specialist
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	<ul style="list-style-type: none"> • Discourage pharmacies and wellness-related locations from carrying / selling tobacco products (Ex. CVS no longer carries tobacco products at its stores) <p>Behavioral Health</p> <ul style="list-style-type: none"> • Integrate behavioral health with primary care • Children / adolescent early identification and treatment of mental illness • Patient-Centered Medical Home models for those with mental illness • Expanding telehealth pilots that integrate primary care with mental health care • Incorporate behavioral health best practices into the training of providers so they know what works • Explore programs in schools to help kids under stress / suffering with behavioral health issues • Further develop clean needle exchange programs • Develop a community care team that includes a behavioral health specialist • Substance Abuse / Behavioral Health <ul style="list-style-type: none"> ○ Governor supports and advocates for prescription drug take back / amnesty programs ○ Limit the ability to prescribe painkillers in emergency rooms to curb abuse ○ Require regional pain center visits by patients ○ Require physicians and pharmacists to use of the Prescription Drug Monitoring Program
Public Comments	None
Next Steps, Action Items and Assignments	The next Better Care Workgroup meeting will be held on Tuesday, August 18 th from 1 p.m. – 4 p.m. at the West Virginia University Health Science Center in Charleston, West Virginia.
Parking Lot	<p>Items / questions identified at the workgroup session that need further attention are:</p> <ul style="list-style-type: none"> • Where are the community-based individuals? <ul style="list-style-type: none"> ○ County Commissioners ○ City Council ○ Family Resource Networks ○ Behavioral Health

Suggested Ideas for Additional Workgroup Members:

- Department of Education (EL-HI)
- Educators of our children (K-12)
- Chiropractic Association
- Behavioral Health
- Alzheimer's Association
- Medicaid/BMS
- WV Medical Association
- Dental representatives and groups
- Civic organizations (Rotary, etc.)
- Grassroots community members.
- WV Legislature
- American Heart Association
- Medicine and Osteopathic representatives
- Industry – Walmart, Sheetz
- Pharmacy companies
- Consumers
- County / city level individuals – county commissioners, city councils, Family Resource Networks