



Better Care Workgroup

Tuesday, September 15th 2015 - 1:00 p.m. – 4 p.m.
West Virginia University Health Science Center – Charleston, West Virginia

MEETING SUMMARY NOTES

Today's Expected Results:

- Strengthen working relationships among workgroup members
- Develop an increased understanding of the state of tobacco in West Virginia
- Provide recommendations for the design of a system that delivers coordinated and integrated care in West Virginia
- Identify next steps, materials and expertise needed for our next session, unresolved issues regarding the proposed system of coordinated care and preparation for October's focus on behavioral health

Co-Chairs: Arnie Hassen and Nancy Sullivan

Facilitator: 19 people – 12 in person and 7 electronically

TOPIC	OVERVIEW/DISCUSSION/DECISIONS
Welcome, Introductions and Opening Remarks	The third SIM Better Care Workgroup meeting opened with welcoming remarks. Joshua Austin, SIM Project Coordinator, was recognized for his role as liaison between all workgroups. The agenda with expected results for the meeting and ground rules were reviewed with workgroup members.
Review of Workgroup Meeting Results to Date	<p>Mr. Austin provided a PowerPoint presentation summarizing the results of all SIM workgroups to date. Five key themes for the SIM model design have emerged. These are as follows:</p> <ol style="list-style-type: none"> 1. Must include care coordination / coordinators 2. Must be an integration of behavioral health and physical health 3. Must be alignment of provider and payor quality measures 4. Must include telehealth / telemedicine 5. HIT must be a backbone, aid to this model design and its deployment
West Virginia Tobacco Prevention Plan Proposal	This agenda item was not addressed at the meeting. A handout of the tobacco section of the State Health Improvement Plan (SHIP) will be shared with participants.
Designing a System that Delivers Coordinated and Integrated Care in West Virginia	<p>In small groups, participants discussed the following questions and reported their discussion to the whole workgroup.</p> <p>The responses below have been lightly edited for clarity.</p> <ol style="list-style-type: none"> 1. <i>Are we designing a health system (network) or a medical system (network)? What is the significance of the choice?</i> <ul style="list-style-type: none"> • Health System <ul style="list-style-type: none"> ○ Addressing more than just absence of disease, includes more than what has been considered by traditional care providers ○ Looks at well-being, vitality and ability to contribute to society

- Health System
 - Proper resources for most complex conditions
 - Other components required, such as education and wellness
 - Regional approach assures adequate resources for each part of the state
 - Meshing of public health and communities
 - The system will require a navigator – someone to guide members through the system

- Medical v. Health
 - Medical home structure that incorporates social determinants, environment, lifestyle choices and cultural components
 - The current care model is medical-based, and we need to better incorporate the social determinants of health.

- 2. *What services or service lines need to be available in the desired system?*
 - Behavioral, oral, physical, primary care spiritual, transportation, care coordination, educational, financial, environmental, long-term, specialty, life-style coaching, palliative / grief and loss, support and life cycle services
 - Focus on function; do not label deliverers of function
 - Within regions, there must be all the services that would ensure whole-person care
 - Care coordination
 - Human services / social service
 - Vocational
 - Education
 - The Medical system / model has to alter to support the wellness and more holistic components
 - Expanding physician services – e.g., telehealth; determine what types of services are available currently to decide the areas of greatest need (e.g., diabetes, obesity, etc.)
 - Need to determine how to get current resources to less accessible areas of the state

- Education, patient engagement, health coaching – based on the composition of the state these services must be regionally accessed

Environment	Traditional medical
Lifestyle	Social determinants

3. *How should Public Health, including local health departments, private care, communities and enabling resources be integrated and coordinated?*

- Keep care coordinated and integrated
 - By mutual formal working relationship(s), or by a virtual means
 - There is responsibility for coordination, asset management, outcomes, etc.
- These should be integrated and coordinated in every way possible
 - Integration – involvement of local health department in the system
 - Build a whole care network with a community core
 - Shifting local health department infrastructure from communicable to chronic diseases, which will require a strategic refocus
 - Informatics system to enhance communication among different types and levels of providers
 - Supportive role – including inventory data / resources for referral of services and care
- Co-location of facilities
- Provide some services offered by local health departments, and coordinate with the health network to offer those services
- As a medical neighborhood, we should know what the available resources are, and how we can leverage them to less accessible areas of the state
- Coordinating the resources between each main enabler needs to occur before integration can occur

- Improving health through better informatics can be possible if there is a coordination of data sources – need interoperability of data

4. *What is meant by accountability?*

- **Accountability is interconnected for all of the components because accountability for one of the components depends on the flexibility of the entire system and also the separate flexibility of each component.**
 - a. How is the patient accountable?
 - Patient – motivational interviewing to encourage the patient to work toward change
 - Patient – need education first and specific to individual (value-driven) education – avoid “paternal” tone to patients and from there build accountability with information to act, incentives to act and ongoing ENGAGEMENT
 - Must respond to what the provider says – treatment, medications and follow-up
 - Need to understand what the provider is saying, reinforce with motivational interviewing to actually provide ways for the patients to become more accountable
 - Community health workers may be able to get through to the patients better and help to build their accountability more appropriately
 - Greater flexibility at the patient-level allows for a more productive system because it permits the provider to have a more active part in the patient’s treatment plan
 - Needs to re-address what is controllable and changeable
 - b. How is the system accountable?
 - System – accountability for well-services, primary care and tertiary care at individual and population levels
 - c. How is the payor accountable?

	<ul style="list-style-type: none"> ○ Payor – pay for care to drive value-based and quality of care ○ Need to grant flexibility in payment redesign <p>d. How is the community accountable?</p> <ul style="list-style-type: none"> ○ Community – must come together to make healthy choices (e.g., environment, sidewalks, safe community, physical activity for children / school programs, etc.) <p>5. <i>How would desired outcomes and quality measures be identified and tracked?</i></p> <ul style="list-style-type: none"> ● Uniform outcome measures; limited to address specific outcomes of the community or state <ul style="list-style-type: none"> ○ To collect ○ To analyze and report back to the community (i.e. <i>Vital Signs</i> by Institute of Medicine) ● Identification – focus on a few key goals to address on the state-level to streamline efforts ● Admired the measurements / goals approach adopted by kyhealthnow (See more at http://governor.ky.gov/healthierky/kyhealthnow/pages/default.aspx) ● Tracking <ul style="list-style-type: none"> ○ Ensure baseline values established and need(s) / access in all communities ○ EHRs, claims and other data sources need to be utilized ● Currently we track different aspects, so if the new system is more consistent, simple to use and able to communicate across payors, it will be an improvement. ● Identify what we are trying to change exactly <p>6. <i>What questions might the other workgroups have about a coordinated and integrated system of care in West Virginia (refer to workgroup aims)?</i></p>
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	<ul style="list-style-type: none"> • Qualifications of providers (i.e., care coordinators / navigators, etc.) Workforce Development • Who gets access to data? (i.e., integrated mental / medical) HIT • How is health measured? Better Health • Developing a standard curriculum or type of education to be implemented in all health care degree programs would help tremendously. The proper form of education alongside appropriate social skills for care coordinators / health educators, etc. would improve the quality of care but would take time to improve care coordination. <ul style="list-style-type: none"> ○ We will need to re-train patients on the new delivery / value-based system because they are accustomed to the current system Workforce Development • Over time we would need to develop the skills to work in the proposed medical neighborhood or medical homes—building into the system support from the payors as well
Final Comments, Next Steps, Action Items, Assignments and Check Out	<ul style="list-style-type: none"> • For October, the Better Care Workgroup meeting time and agenda are still to be determined. The workgroup will be notified as soon as final arrangements are made.
Parking Lot	<ul style="list-style-type: none"> • Better Value – need to identify priorities for Medicaid, WV CHIP and PEIA (top two to five priorities) • Better Care – take elements identified today to design concrete system addressing priorities • HIT and Workforce Development – use draft model / system to determine HIT and workforce needs • Perhaps intermesh groups around specific topic areas

Group Checkout (Verbatim Responses)

<i>What worked well today?</i>	<i>What would you change for the next meeting?</i>
<ul style="list-style-type: none"> • Good discussion • Good mixing of groups and discussion • Next steps are good • Good participation of group 	<ul style="list-style-type: none"> • More attendees for more discussion • Combine workgroups • Tell us the truth about what we are really able to do with this plan versus ideal

<ul style="list-style-type: none"> • Small groups useful • Introductions • Facilitated discussion • Snacks • Appreciate snacks 	<ul style="list-style-type: none"> • Nothing • Time to bring workgroups together as suggested • Communication with phone people • Joint meeting like Arnie said • Attendee list with contact info • Speed up process • Integrate other workgroups • Fill in more details about “how” • Location • How are we going to prioritize workgroups? (i.e., is Better Value really the most important to tell us how much money and what they are willing to do with money, or is care or health and their ideas driving where money should go?) • Parking is hard
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Suggested Ideas for Additional Workgroup Members

- Dr. Dick Meckstroth, WVU School of Dentistry
- Community dental representative