

State Innovation Model (SIM) Better Value Workgroup

Thursday, July 23rd 2015 - 9:00 a.m. – 12:00 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: Jeremiah Samples and Jeff Wiseman

Facilitator: Becky King

Participants: 26 people – 24 in person and 2 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> <p>Verbatim responses recorded on the index cards follow:</p> <ul style="list-style-type: none"> • To get patients to take a more proactive role in their health care • Engaged, educated consumers • Primary Care Coordination • Fully-integrated health care system • Better Long-Term Care / Post-Acute Care Management Financing, “Systems-Based Practice” • Neonatal Abstinence Syndrome (NAS) addicted babies issue in WV, resulting in few NAS births • To improve the health and well-being of all West Virginians • Universal Quality Measures and Reporting • Have policymakers be more willing to support policies that would have a beneficial impact on health – tobacco tax increase, soft drinks and Supplemental Nutrition Assistance Program (SNAP) • Reduce inappropriate Medicaid visits to the hospital emergency room – provide enhanced care management, keep Certificate of Need (CON) |

| | |
|--|---|
| | <ul style="list-style-type: none"> • WV obesity is less than 10% of the population • Insurance payors recognize and reimburse for preventive services • Improve children’s health – overall status • Better understanding of the work of managed care and outreach done for better health • Universal EHR • Access to affordable care and education, especially in rural areas • Provider reimbursement models and strategies • No ideologies |
| <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> <ul style="list-style-type: none"> • Following the PowerPoint presentation, a question was raised regarding the availability of implementation funds. Currently, there is no CMS implementation funding earmarked; however, funding might be available from other federal sources. • As part of the review and discussion of the “Mutual Understandings and Assumptions” document, there was a concern raised that the restrictions imposed by CMS could overly limit the changes / reforms available under the SIM grant. The need to take a strategic approach and develop a larger strategic vision under the auspices of the SIM grant was emphasized by other members of the Better Value Workgroup, in addition to taking advantage of other available resources, future funding opportunities and cost savings. The importance of reaching consensus on collecting “low hanging fruit” in terms of cost-savings was also stressed. |
| <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> |

Is anything missing?

- Lack of attention to long-term care
 - Dual eligibles
- Drug abuse
- Poverty
- Health education
 - Public resources geared toward younger population, insurance
- State specific data
 - Social determinants of health
- Tobacco – not emphasized
- Behavioral health / substance abuse
- Common data warehouse (cannot determine NAS data) to do analysis
- Per capita health care consumption costs
- Provider shortages (comparison with other states)
- Lack of focus on children
- Return on Investment (ROI) data on various initiatives (successful and not successful)
- Evaluation baseline
- Gauging population understanding of concepts of integrated systems of care and value-based health care delivery and payment
- Evaluation of impact of low health literacy and education attainment levels on implementation strategies
- Understanding of social determinants of health and impact on implementation strategies

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 three academic health centers

- West Virginia has a strong federally-qualified health center system and school-based health center system
- West Virginia is a small state with engaged, collaborative health care stakeholders
- West Virginia elected to expand Medicaid coverage under the Affordable Care Act
- West Virginia has a comparatively low uninsured population
- West Virginia has a good framework for collaboration initiated by the state's Health Innovation Collaborative; it can help implement / sustain future efforts
- West Virginia ranks at or near the bottom in many health care metrics; this creates opportunities for improvement and significant impact from efforts
- West Virginia is leveraging other health care delivery change activities, such as the Public Health Task Force review led by the West Virginia Bureau for Public Health, into the SIM project

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

- West Virginia lacks placements for graduate medical education
- There is no identifiable source of funding to pay for transforming the health care system
- Lack of consensus and lack of perception of complex health care system issues
- West Virginia's public health status frequently ranks at or near the bottom in most measures, such as heart disease, obesity and tobacco use (**also listed as an opportunity / strength**)
- West Virginia's level of poverty and weak economy are roadblocks to changing the health care system
- West Virginia's Legislature and regulatory environment must adapt to new models and concepts, which will require substantial educational efforts to inform and align processes
- West Virginians can frequently have a fatalistic attitude—that is, nothing can be done to change a problem—and this perspective can create a road block to changing unhealthy behavior(s)
- There are a wide variety of programs, approaches, methods and data at the payor level; there must be a push to align incentives, data and outcome measures to facilitate orderly change at the patient and provider levels

| | |
|---|--|
| | <ul style="list-style-type: none"> • There is a disconnect from ideas to action in implementing any health care system re-design plan |
| <p>Workgroup Charter Key Questions: Small Group Discussion</p> | <p>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.</p> <p>The answers provided below are grouped into themes based on the small group discussion / output:</p> <ol style="list-style-type: none"> 1. From a payment perspective, how will the state implement care coordinators? <ul style="list-style-type: none"> • West Virginia needs to pilot different care coordination models to see what works best • West Virginia should deploy the community care team coordination model in a regional capacity (i.e., similar to Community Care of North Carolina) • West Virginia still needs to decide on its care coordination model; the SIM process will assist with that 2. What populations are currently uninsured and what strategies exist to cover these populations? <ul style="list-style-type: none"> • Medicaid expansion in West Virginia addressed the vast majority of the uninsured population; the focus should now be on linking the Medicaid population to a Patient-Centered Medical Home 3. What quality measures do providers and payors feel should be incentivized to improve population health? <ul style="list-style-type: none"> • Measure follow ups after discharge • Measure readmissions rates • Aligning measures—whatever they are determined to be—among all payors • Targeting and limiting the number of measures • Determining the return on investment of the measures themselves (i.e., is collecting this measure cost effective) |

- Making return on investment part of measurement (i.e, was that intervention / procedure / program cost effective)
 - The standardized measures should be what the workgroups decide as part of the SIM process
4. What new strategies could the State look to adopt to help with cost containment in the health care system?
- Standardize quality measures
 - Identify the super utilizers of health care and transition them to a per member per month for managing care
 - Integrate physical / mental / dental health care
 - Standardize the definition of care coordination
5. What specific strategies can be implemented to change West Virginia’s culture of poor health?
- Build a vision / mission / value statement to try to build a brand of change that is the focus of mass communication
 - Expand the “Try This” initiative
6. From a payment perspective, what is the best model to drive coordination of care and improve population health outcomes? What are the components of such a system? How do we transition to such a system?
- Provide incentives for performance-based systems
 - Reward improvements in measurable results
 - Encourage cooperation between providers and payors, recognizing that there is a long-term financial win for improving population health
 - Provide incentives for the purchase of healthy foods
 - Integrate the delivery model with quality measures and care coordination with shared risk
 - Move toward a single payor system

| | |
|---|--|
| | <ul style="list-style-type: none"> • Move toward a fully-capitated model • Continually work to refine the managed care approach to mirror Medicare (e.g., bundled payments and pay for performance) |
| <p>Potential Strategies Around Areas of Focus 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>Obesity</p> <ul style="list-style-type: none"> • Recurrent theme: Align SNAP guidelines with nutritional outcomes • Expand the “Try This” initiative • Study the motivating factors that affect obesity, especially in the economically disadvantaged, then build focused strategies • Farmers market initiatives • Fund community recreation facilities, walking trails, etc. • Deploy community care teams • Standardize weight control / low-cost reimbursable model (hone in on the “low hanging” fruit) • Primary care collects data on BMI / standardized waist circumference • Focus on children – keeping children from continuing the obesity cycle • Disease management for pre-diabetes • Building on the National Diabetes Prevention Program implementation being coordinated by the West Virginia Bureau for Public Health Office of Health Promotion • Standardize care coordination for pre-diabetes / diabetes across the primary care system • Offer an incentive for the purchase of healthy foods • Develop more obesity and wellness educational programs (Pre-K – 12) • Enhance physical education in the public school curriculum • Address behavioral health related issues connected to obesity |

| | |
|---|---|
| | <p>Tobacco Use</p> <ul style="list-style-type: none"> • Increase the state excise tax on tobacco • Further expand “smoke free” locations, including “vaping” in the smoking discussion • Encouraging retailers to stop carrying tobacco products (e.g, CVS) • Expand incentives for not using tobacco and quitting and increase penalties for users (e.g., higher insurance premiums) • Encourage / incentivize employers to hire non-tobacco users <p>Behavioral Health</p> <ul style="list-style-type: none"> • Integrate primary care with mental health • Allow adult Medicaid population to access free standing psychiatric hospitals • Expand utilization of telepsychology and telepsychiatry • The most complex behavioral health population(s) receive no type of care coordination; enroll in care coordination |
| Public Comments | None |
| Next Steps, Action Items and Assignments | The next SIM-related Better Value Workgroup meeting will be held on Wednesday, August 26 th from 2 p.m. until 5 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"> • None |

Suggested Ideas for Additional Better Value Workgroup Members:

- A primary care physician
- FQHCs
- Payor groups for lower cost representation – Medicaid especially
- Insurance executives
- PEIA
- WV Hospital Association
- WV Medical Association
- Free clinics
- WV Department of Education
- Marshall University representatives
- Behavioral health providers