

Health Reform New Models of Care Workgroup
Wednesday, January 19, 2011
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees:

Workgroup Members: Allen Dobson (co-chair), Craigan Gray (co-chair), Deborah Ainsworth, Peter Chauncey, Steve Cline, Chris Collins, Tracy Colvard, Analiese Dolph, Lloyd Michener, Renee Rizzutti, Tom Savidge, Robert Spencer, Torlen Wade, Jack Walker, Neil Williams, Susan Yaggy

Steering Committee Members: Chris Collins, Torlen Wade, Susan Yaggy

NCIOM Staff: Thalia Fuller, Pam Silberman, Rachel Williams

Other Interested Persons: Troy Arnold, Rebecca Carina, Markita Keaton, Tara Larson, Ann Lore, Catherine Moore, Diane Poole, Chris Skowronek, Jeff Spade, Kathy Trotter, Curtis Venable, Judy Walton, Andrew Weniger

Welcome and Introductions

Allen Dobson, MD, FAAFP
Vice President, Clinical Practice Development
Carolinas HealthCare System
Co-chair

Craigan Gray, MD, MBA, JD
Director, Division of Medical Assistance
NC Department of Health and Human Services
Co-chair

Dr. Gray welcomed everyone to the meeting.

Updates from Subcommittees

Subcommittee to more actively engage patients in own self-care
Susan Yaggy, President and CEO, NC Foundation for Advanced Health Programs, Inc.
Chris Collins, MSW, Deputy Director, Office of Rural Health and Community Care

The subcommittee is currently looking at potential opportunities in engaging Medicaid patients in their own care including incentives in prevention and social networking. The subcommittee

would like to design incentives to encourage healthy lifestyles and to use motivational interviewing as a baseline. There is not much known about what incentives work best for prevention in Medicaid patients. The subcommittee is discussing focus groups and structured interviews to begin in order to determine what Medicaid patients view as barriers to healthy behaviors and what they would encourage them to make positive changes in lifestyle choices. The subcommittee is also planning to look at current Medicaid payment codes to see what is already available in terms of prevention.

Selected questions and comments:

- Q: Has the subcommittee discussed combining patient incentives for self-care with telemonitoring processes? A: Yes, there are currently a couple of models in the state to review. Telemonitoring can be used as a secondary or tertiary prevention strategy.
- Incentives that involve waivers, such as payment for services or vouchers have historically caused red flags in political circles.
 - Florida and West Virginia have used incentive models. Florida did see changes in behavior, however the program in West Virginia was not as successful. In the Florida program, patients did not really use the vouchers so there must be another driver behind the behavior changes that were seen.
- There are some reports coming out now showing that most innovations in low-income populations are not cost effective. Therefore, interventions must be low cost.
- Many things are coming out about changing behaviors in social networks instead of just in the individual. There is a shift from making an individual change to making a group change.

Transitions of Care initiative

Allen Dobson

The Beacon Community Grant will be used to try different models that are community specific. The models are tied to what community resources are and where clusters of patients are. The North Carolina multi-payer demonstration, which will be implemented in seven counties, will evaluate allowing patients enrolled in Medicare, Medicaid, Blue Cross Blue Shield, and/or the State Health Plan to receive care in community care networks. The importance of this demonstration is that it is going into an area with high disparities and room for improvement. The demonstration is not just focused on the location of clinics, but also on transitions and remote care.

BCBS/UNC New Model of Care

Troy Arnold

Senior Strategic Advisor

Blue Cross Blue Shield of North Carolina

BCBS and UNC are currently in the early stages of designing a three-year patient-centered medical home facility pilot, which will be located in either Durham or Orange County. The home will serve five thousand BCBS patients with a focus on the chronic care population. The facility will have a pharmacy, lab, and a range of providers, and will offer group health visits and extended hours. The model will include a team based care approach. Evaluation of the model will include patient satisfaction, carrier satisfaction and clinical metrics.

Selected questions and comments:

- Q: Will the patients be assigned to the practice? A: No, patients will have a choice of whether to receive care at the facility. We would like members to view the facility as their medical home. If the patients wish to go elsewhere, they can.
- Q: Will the physicians be employed full time? A: Yes, we are currently working out who the physicians will be employed by (ie, BCBSNC or UNC Health System).
- Q: How did you determine this concept would be a reasonable approach? A: We have done internal research as well as research on past projects. Internal research we have done include focus groups and accessing information on patient diagnoses and where they go for treatment to determine facility location.
- Q: Will you be competing with other physicians in the area? A: Members can choose this practice so we are not ruling out a competitive location.
- Q: If this becomes uniformly successful, will you want to open facilities in other areas? A: We have discussed expansion and how it might look like but we will need to see how the model goes. We have been focusing much more on getting the facility open by the end of this year rather than on future expansion.
- Q: What efforts will be employed to attract patients? A: Marketing efforts that have been discussed include approaching employer groups and financial incentives.
- Q: Will you be evaluating financial sustainability? A: There are many discussions on new funding models deviating from the traditional fee-for-service model. We will be evaluating policy and reimbursement for this facility. Models that have been discussed include salaries for doctors and reimbursement for the practice or a combination of fee-for-service and other models.

ACA Workgroups Legislation

Tara Larson, MAEd

Chief Clinical Operations Officer, Division of Medical Assistance

NC Department of Health and Human Services

Ms. Larson presented information on what legislation DMA may be submitting to the North Carolina General Assembly out of the discussions from the health reform workgroups. Her presentation can be found here: [ACA Workgroup Legislation](#).

Review of Interim Health Reform Report

The workgroup reviewed the New Model sections from a draft of the NCIOM's interim report on implementing the Patient Protection and Affordable Care Act in North Carolina. As a part of the report, the workgroup also reviewed a draft of the principles for the workgroup: [Principles of the New Models Workgroup](#).

Selected questions and comments on the report:

- The workgroup discussed the importance of testing new and better models to improve health outcomes and reduce costs. There is a need to aggressively seek out new models, implement them, and disseminate them across the state.
- The first paragraph of the report should include something about population health. Population health is not stated in the ACA specifically, but the new Center for Medicare and Medicaid Innovation (CMMI) is going to look at population health as a key for funding. Population health will help reduce costs and slow the rise of health care costs.

Selected questions and comments on the principles:

- “Patient-centered” is too narrow. There should be emphasis on not only the individual but also the community and families.
- Data should be available to assess health care needs at the local level to build better systems. Different parts of North Carolina will have different needs and different programs that work.
- There should be an emphasis on dissemination, so that we can disseminate successful interventions to others.
- There needs to be emphasis on the importance of transparency to patients, providers, and communities.

Public Comment Period

No further public comments were given.