

Health Reform: New Models of Care Workgroup
Wednesday, February 23, 2011
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees:

Workgroup Members: Craigan Gray (co-chair), Karen Adams-Gilcrist, Randall Best, Don Bradley, Peter Chauncey, Annaliese Dolph, Beth Lovette, Beth Melcher, Mary Piepenbring, Brenda Sparks, Gina Upchurch, Jack Walker, Neil Williams, Susan Yaggy

Steering Committee Members: Allen Feezor

NCIOM Staff: Thalia Fuller, Pam Silberman, Rachel Williams

Other Interested Persons: Judy Brunger, Sam Cykert, Betty Herbert, Marc Koleman, Rich Lord, Ann Lore, Catherine Moore, Sara Naff-Mio, Lendy Pridgen, Chris Skowronek, Craig Umstead, Elizabeth Walker Kasper, Rebecca Whitaker

Welcome

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

Dr. Gray welcomed everyone to the meeting.

Overview of Appendix I of Health Reform Report

Pam Silberman, JD, DrPH
President and CEO
North Carolina Institute of Medicine

Dr. Silberman updated the workgroup on the status of the interim report on health reform. Hard copies of the report will be available to members of the workgroup and the North Carolina General Assembly. The report will also be posted on the NCIOM website (www.nciom.org). A draft of Appendix I can be found here: [Appendix I—Description of New Models in North Carolina](#).

Subcommittee Updates

Episodes of Care

Valinda Rutledge
President and CEO
CaroMont Health

Betty Herbert
Director, Managed Care
CaroMont Health

The Episodes of Care subcommittee has started to meet and is beginning to discuss several issues, including the criteria to select an episode of care and method of reimbursement. In addition, the subcommittee would like to add additional members and wanted feedback on other members that should be added to the workgroup. The goal of the episode of care model is to reduce fragmentation and costs. A challenge with defining an episode of care, particularly with chronic conditions, is determining where the episode begins and ends. Dr. Randall Best, Medical Director for the NC Division of Medical Assistance, conducted a review of emergency department claims to determine whether an episode of care payment could help reduce unnecessary emergency department utilization. The workgroup also explored other options to test episode of care models across provider settings (i.e., inpatient, outpatient, home health). Theoretically, providers have more of an incentive to work together collaboratively if they are being paid under one global payment for an episode of care. The workgroup members suggested that initial episode of care pilots should focus on more discrete episodes of care (for example, orthopedic surgery) and then move to chronic conditions. This way the providers learn to work together more effectively before moving to more complicated issues. The subcommittee would like to add more members from the provider side (i.e., nurses, specialty providers) and payer representatives (i.e., Blue Cross and Blue Shield) for their next meeting.

Selected questions and comments:

- It would be nice to have a common episode of care definition across the state rather than have a different definition for each payer.
- Patient centered medical homes are better suited to handle chronic conditions than the episode of care model.
- The committee should think about if the state could use episodes of care to drive the creation of ACOs or vice versa.
 - The state could use the episode of care model as a trial to see how to start coordinating care across provider settings and then move to something broader such as ACOs.
 - Maybe models should be tested with volunteer health systems since it is easier to test in an integrated system than in separate systems.

- A lot of hospitals are at work doing episode of care redesigns internally. These designs will vary based on contractual relationships between the hospital and providers. There may not be only one episode of care model to use because of these contractual relationships.

Transitions

Elizabeth Walker Kasper, MSPH
Project Manager
North Carolina Quality Alliance

Sam Cykert, MD
Associate Director
Medical Education and Quality Improvement
North Carolina AHEC Program

Dr. Cykert updated the workgroup on the Transitions of Care subcommittee. The committee consists of members from both the New Models of Care and Quality workgroups. The New Models of Care workgroup charged the committee with exploring the possibility of creating a multipayer demonstration to implement a transition care model, and to determine whether changes were needed in DMA's existing efforts to implement a transition care model. The Quality workgroup charged the committee with discussing strategies to reduce readmissions related to the hospital payment adjustments (ACA, Sec. 3025) and ways to prevent readmissions through successful transitions of care. The committee looked at evidence-based initiatives within inpatient care, care management, and outpatient care and what components make the initiatives successful. The committee developed draft recommendations including improving education of providers and patients, using personal health records, creating partnerships and collaborations between stakeholders, defining essential elements for outpatient intake after discharge, and applying the transitions of care model to all patients regardless of payer. The presentation can be found here: [Update on NCIOM Transitions of Care Subcommittee](#).

A draft report from the committee can be found here: [Transition Subcommittee Summary of Discussions and Recommendations](#).

Selected questions and comments:

- Principles are important, but the solutions will be local. Not everyone has the same resources to implement the same programs. Patient populations are different as well.
- Q: Will Medicare changes to reimbursement related to excess readmissions in 2012 be enough to change the way hospitals do things? A: Yes. There are going to be multiple changes to Medicare hitting at the same time including payment changes regarding readmissions and hospital associated conditions. Small hospitals depend on Medicare income and a 1-2% cut in that income would be significant. There is also anticipation

that private payers will design a system that parallels what is going on in Medicare which would give hospitals even further incentive to change.

Medicaid: Healthy Lifestyle Initiatives

Susan Yaggy

President and CEO

North Carolina Foundation for Advanced Health Programs

The committee is working on a proposal for a federal grant rather than making recommendations or producing a report. The committee was originally looking at Section 4108 of the ACA, which provides grants to states for programs that prevent chronic disease and improve overall health in Medicaid beneficiaries. However, there is no guidance on this section from the federal government.¹ The committee suggested that the state should focus on pediatric obesity as the target for the intervention since it would involve the whole family, work has been done in public health to establish evidence-based practices and materials, weight loss is easy to measure, and losing weight is a good incentive for many people to participate in an initiative. The committee would like to use a patient-centered medical home model and motivational interviewing in the proposed initiative to promote weight loss and healthy lifestyles.

Infrastructure Needed to Support New Models Evaluation Metrics

The workgroup discussed what barriers would need to be addressed or new infrastructure put in place to support new models of care. The workgroup felt it was important to look at state regulations that could promote or hinder new models of care. For example, some members of the workgroup suggested that existing scope of practice laws for pharmacists and non-physician clinicians, including nurse practitioners and physician assistants, may be too limited to support new models. Practices should work to build teams of providers, including non-physician clinicians, to provide care instead of having care provided by siloed health professionals. The workgroup also discussed whether there should be standards and specific outcomes to ensure accountability.

The workgroup would like to hear from those involved in the creation of the state's HIE to make sure what each group is doing does not overlap. Also, the workgroup would like to inform the HIE on what kinds of data should be collected related to new models including evaluation data, behavioral health data, and a continuity of care document (CCD) to facilitate transitions of care.

¹ Note: Subsequent to the February 2011 New Models of Care meeting, CMS issued a competitive grant application to states to test and evaluate the effectiveness of a program to provide financial and nonfinancial incentives to Medicaid beneficiaries who participate in prevention programs and demonstrative changes in health risk and outcomes. The grant announcement is available at: <http://www.cms.gov/MIPCD/>

The workgroup would also like to discuss having a complete database available to practitioners to treat patients and a portal to collect the information needed.

Another issue the workgroup discussed was payment models such as pay-for-performance. Payers could pay more to practices or teams of providers if they reach certain outcome standards.

Public Comment Period

No further public comments were given.