GOVERNMENT OF THE DISTRICT OF COLUMBIA

SERVICE DELIVERY SUBCOMMITTEE

HEALTH REFORM IMPLEMENTATION COMMITTEE

Thursday, July 7, 2011, 2:00 pm – 4:00 pm
Department of Health Care Finance
Conference Room 1, Room 6130

AGENDA

I. Introductions

II. Purpose and Goals of Service Delivery Subcommittee

III. Overview of D.C. Health Reform Efforts Currently Underway

IV. Focus on Service Delivery
   a. Health Homes
   b. Accountable Care Organizations

V. Service Delivery Subcommittee Charge

VI. Committee Discussion

VII. Adjournment

Next Health Reform Implementation Committee Meeting:
August 4, 2011, 2:00-3:30pm

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HEALTH REFORM IMPLEMENTATION COMMITTEE

MEETING MINUTES

Attendees

Amy Brooks, RCM at Washington
Angela Katsakis, DHCF
Anne Sturtz, DMH
Anthony Proctor, DHCF
Bruce Griffin, Home Health Care Assoc.
Cathy R. Anderson, DDS/DDA
Danielle Darby
Danielle Lewis, DHCF
Diane Lewis, DC Coalition of DSP
Dionne, Brown, ANC
Ernest Brown.
Elaine A. Crider, The Crider Group
Francis Smith, DC Chartered HP
Howard Webers, DCPCA
Janelle Goetcheus, United Health Core
Julianka A. Bell, DHCF
Karen Johnson, United Healthcare
Karen Williamson, The Crider Group
Laura L. Nuss, DDS
Mary L. Meccariello The Arc of DC
Micahel Williams, DCPCA
Orriel Richardson, DHCF
Robert Axelrod, Kaiser Permanente
Ron Swanda
Shannon Hall, DC Behavioral Health Assoc.
Sharon Baskerville, DC Primary Care Assoc.
Steve Baron, DMH
Tonya Kinlow, Care First BCBS

Dr. Linda Elam, Vice-Chair of the Health Reform Implementation Committee, called the meeting to order. Introductions were conducted and Dr. Elam made opening comments, including the purpose and goals of the service delivery subcommittee. An overview of D.C. health reform efforts, service delivery, including health homes and accountable care organizations (ACOs) and service delivery subcommittee charges were presented by Dr. Elam.

Questions

Are accountable care organizations operationalized? What is the energy behind it?
ACOs are still in development. As of yet, no groups have come together to create one. Providers are looking at organizing themselves in a way that hospitals can include more provider care services.

Is it care managed?
The Federal government has issued rules related to Medicare only. Camden, New Jersey is the only location that has passed laws specifically allowing HCOs to occur.

Continuity of care is driven my primary care. The concern with primary care is that hospitals are beginning to purchase primary care which isn't standard. The committee should come up with ideas that work specifically for the District. The federal rules on ACOs are restrictive because it only relates to Medicare. However, separate groups may try to demonstrate savings (i.e. GW Hospital can become an ACO because they are self-sustaining)

Other populations (i.e. disable, long term care, etc.), need a solid plan for care to ensure that there are cost savings (i.e. making sure that there are no re-admissions before 30 days). The idea

is to make sure that share savings are at the provider level and are going to primary care. This is very similar to the managed care models of the 1980s. By providing incentives, there is an opportunity for relationships between carriers and providers.

Health homes vs. medical homes
Medical home- A broader term
Health home- A more specific term that specifies the criteria in terms of health conditions. It is designated by DHCF for the purposes of legislation and is specific to health reform.

What are the plans for prevention?
The Department of Mental Health emphasizes prevention for kids and substance abusers. 20% of the block grant award is for prevention. The public school mental health program has a huge program for preventative health. There is early screening in every child care center. In addition, public school children in pre-kindergarten through 3rd grade receive screenings.

The challenges of prevention are demonstrating cost savings- the value of prevention without it being tied to a dollar amount. In addition, although mental health risk factors are being addressed and most primary care providers are screening along a wide range of ages, is intervention taking place?

In health homes, the provider has to agree on a health standard. An amalgamation of services are created in alignment with the standard service of care. Health homes are one level of coordination, with the ACO being the overall standard.

What are the primary problematic populations? Are we able to run data sets on the individuals that we can't locate? How frequently? How prevalent is it?
We're working on getting data runs and trying to find out what the behavioral health spending expenditures are for this group. The issue is that agencies don't always get timely notification of patient admittance in the ER; thus, we can't intervene if we can't locate the individuals.

Committee Discussion

ACOs vs. MCOs

- The ACO concept differs from the MCO one. With ACOs, the provider is responsible for the complete care of the patient. The concept behind the idea is to save money by keeping patients healthy, whereas MCOs are aimed at making money. The service providers' goal is to make sure that every point of contact agrees on the same idea of service. (i.e. Kaiser Permanente)

Health Information Exchange

- An advantage is that the District is operating on a health insurance exchange already. As a result, service providers have the ability to view patients that are in the system. Thus, showing the efficacy of the program will capitalize on the positives of the HIE.

- Disability Services:
    - Issue: Coordination of care and the exchange of information between physicians.
    - Consequence: Cost drivers are constantly in the emergency room and the cost of hospitalization is increasing.
    - Solution: Need electronic health records.
        - HIE will allow non-EMR equipped providers the ability to exchange information. Providers need to adapt to the changes in order to build an all inclusive service model for all populations. We need to get providers to see the benefits of a single point of entry system. In addition, we need a State health insurance exchange plan that will guide continuity of care.

- Behavioral Health Providers:
    - Issue: The federal incentive doesn't give money to behavioral health providers. As a result, agencies are running on multiple systems. HIE is critical for continuity and efficiency between agencies. As of now, there are four different technology systems, all of which create behavioral health treatment plans. Patients are overlapping systems, making it difficult for providers to coordinate care.
    - Solution: Vendors should create a care coordination system that will integrate pharmacies, reduce hospitalization and elicit proactive care coordination.
        - In order to provide these services, capitalization is required. Providers need to move from volume to value- "high technology, high touch". There needs to be low cost interventions to generate savings (i.e. employing people to check on patients, making sure that they don't end up in the hospital again).

Hospitals

- Issue: The model for the new reimbursement system isn't in alignment with the current reimbursement system.
- Hospitals are considering having managed care within the hospital. When looking at prevention and planning and defining models, the hospital has to be aware of the implementation (i.e. In the system, children are tagged as needing assessment, yet they don't get assessed in other groupings).

Substance Abuse Treatment

- Issue: Integrating new models for the drug seeking, problem population
- Solution: HIE will allow for predictive modeling (i.e. Knowledge of drug seeking patients in the ER will notify the MCO/caregiver allowing them to generate savings that they can reinvest).
    - Examine the best practices from other States to come up with a treatment component that everyone agrees on.

Take Home

There are more issues to talk about with regards to delivery and changes within the District. This is an opportunity to address the distinctiveness of the District. What are the primary problematic areas? What are the characteristics of the population? What are examples from other States that work for this population? What resources will help individuals manage their illness?

Meeting adjourned at 3:30 pm