GOVERNMENT OF THE DISTRICT OF COLUMBIA

HEALTH SYSTEM DELIVERY SUBCOMMITTEE

HEALTH REFORM IMPLEMENTATION COMMITTEE

Wayne Turnage, MPA, Chair *Linda Elam, PhD, MPH, Vice-Chair*

ATTENDEES

Angela Katsakis, DHCF
Anne Sturtz, DMH
Anthony Proctor, DHCF
Diane Fields, DHCF
Diane Lewis, DC Coalition – DSP
Ernest Brown
Frances Kanach, DHCF
Francis Smith, DC Chartered
James Cobey, Medical Society
Laura Nuss, DDS
Linda Elam, DHCF
Lisa Alexander, GWUMC
Lisa Proctor, Specialty Hospital
Karen Williamson, The Crider Group
Mary Bernstein, Coalition on LTC
Matt Rosen, Arc of DC
Mike Thompson, Providence Hospital
Nina Marshall, DHCF
Orriel Richardson, DHCF
Robert Axelrod, Kaiser Permanente
Roopa Chakkappan, DHCF
Roula Sweis, APRA
Susan A. Walker, DC Coalition on LTC
Tonya Vidal Kinlow, CareFirst

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1) **Introductions**
2) **Review Approval of August 4, 2011 Minutes & Attendance Record**

Dr. Elam, Vice-Chair of the Health Care Service Delivery (HCSD) Subcommittee, called the meeting to order at 2:06pm, and introductions were conducted. The minutes from August were approved with changes. Dr. Cobey moved they be approved. Ms. Richardson seconded.

3) **Subcommittee charge for September 2011**

Dr. Elam informed the subcommittee about timelines established by the Mayor's Health Reform Implementation Committee. Director Turnage, chair of HRIC, has requested subcommittees begin to develop work plans to govern their work. The HCSD Subcommittee is charged with developing recommendations for new demonstration projects and waiver programs, funded through the Patient Protection and Affordable Care Act of 2010.

4) **Discussion**

a. CMS Demonstrations/Waivers: Target Populations & Conditions

Dr. Elam reviewed the handouts provided to frame the discussion about target populations, conditions, and opportunities to create demonstrations and waivers to address their health concerns.

1. Income inequality -- deep pockets of high poverty and an affluent higher-end skews data that represents health outcomes (i.e., the more affluent and higher educated population's health outcomes mitigate the severity of the poor outcomes among the impoverished)

High rates of insurance coverage exist in D.C., and the benefit package offered by the District's public programs is more generous than in in many other jurisdictions. Given the investment in health care (particularly insurance), why do the District's outcomes remain poor?

2. Mr. F. Smith – A recent study questioned what are the cost drivers. The study said that in D.C. the cost of care itself was higher. The District's benefits are far above the national average.

3. Dr. Cobey – Transportation is an issue, but because of the high option (BCBS), providers in this area demand more from the health system in general. Medical malpractice accounts for approximately 20% of each health care dollar.

4. Advent of concierge medical service prices many out of the system and removes providers from pool available to public programs.

5. How much of the expenditures are due to misuse of emergency departments? Traditionally, the District's ED use will be higher than the national average (primarily based on the unique aspects of the District). Financial incentives to dissuade overuse are not in place, and for the Medicaid eligible population, there is little/no education on proper ED use.

6. Ms. L. Nuss - Disabled population issues were discussed, and an emphasis on care coordination among specialty and primary care providers. This encourages ED misuse. If the District tackles care coordination and electronic health records (EHR), then outcomes may be improved.

7. Has the District examined cost differences between FFS and managed-care populations? Are there other managed-care like systems that have mastered the care coordination concept from which we could glean ideas?

8. Unreimbursed services (i.e., phone calls to coordinate care) are problematic

9. What about patient education? Individual responsibility is key in making real strides in coordination and improving outcomes.

10. Mr. F. Smith – Though we have improper ED use, the numbers are still respectable given some of the other issues in the District (e.g., behavioral health problems). When the behavioral health system is broken, the wheels begin the fall-off (i.e., social workers asked to assist above and beyond the call of duty).

    a. The EHR would go leaps and bounds toward establishing a better system. For example, approximately 40% of mail is returned, and many individuals are otherwise "missing" from record. EHR would improve this.

b. Any steps should include considerations for improving the tracking system, particularly for children.

11. Dr. Brown – How is the care coordination funded? Unity had house calls that were funded for four years, and in that time, there were great improvements in outcomes. The issue is how to make these initiatives sustainable.

12. Ms. Katsakis – It is important to include all considerations toward empowering our population to self-manage their conditions. Issues for consideration include literacy, language barriers, and the like.

13. Dr. Kanach – DCPCA-funded study (Brookings) covered focus groups about those things that are not working in the District. A prevailing theme is patient-centric care.

    a. Communication is not just about coordination among providers, but the adequacy of communication to patients.

    b. DHS awarded $44 million for health departments to develop strategies for communities advocating for themselves.

    c. Communication issues could also underlie bases for disparities. Is information appropriately communicated?

14. Dr. Sweis – Prioritizing care coordination and EHR for improved health outcomes is critical. Poverty level as an indicator in the District should remain at the forefront of our considerations. Because of the poverty level, the prioritization of health is low on the priority list, and by the time those individuals reach the health system, treatment is in crisis mode. Prioritizing wellness and valuing health are critical considerations. APRA is grappling with this.

15. Residents of Ward 8 want input into health reform. They want focus groups for input from residents. The survey for stakeholder input for health insurance exchange planning asks lots of questions, but not the right ones.

16. Mr. F. Smith - The District should tackle difficult social issues to address disparities and improve outcomes.

17. Ms. Sturtz - Prevention and wellness do have a place here. There do seem to be things that can be done to mitigate the impact. (Again, burden of competing demands).

    There are things that can be done to improve prevention. e.g., Understanding low-income Black women and rates of depression. Being able to make these kinds of connections is critical. Financing streams that allow integration of care are pivotal.

18. Dr. Alexander – At Bread for the City, their tagline relates to treating "clients" with dignity and respect. This is a consideration because having-not does not mean these residents do not have an expectation to be treated the same as others.

    a. Ophthalmology is a specialty that is needed, and volunteers have stepped-up to provide the service (the Alliance does not cover this).

    b. Critical to incorporate "caring" bedside manor at the graduate medical educational level

b & c. Health Homes and Accountable Care Organizations (ACOs)

1. Some opportunities in the Affordable Care Act have helped frame early discussions: 1) Health Homes and 2) ACOs.

    a. Enhanced match lasts for two-years
    b. PACE in the District?
    c. Letter of Intent (LOI) is intended to give the District funds to conduct research and develop the best model for health homes in D.C.
    d. Ms. Nuss – DDS briefed Dr. Akhter regarding health homes. In July, CMS was open to efforts targeted to the developmentally disabled population. The care coordination and behavioral health overlay report will be shared with District agencies soon.

2. ACOs – Members discussed the validity of the hospital-based model for the District.

    a. Dr. Cobey – The idea will not work when patients are free to roll into and out of the system.

    b. Mr. F. Smith – Another consideration is that the hospitals are interested ways to sustain revenue. At least three hospitals in the District would suffer greatly based on cuts to ED utilization.

    c. Dr. Kanach – In the current system, hospitals recognize they cannot continue the status quo.

    d. What DRIVES good medical practice? Competing needs of physicians can result in overutilization to drive-up revenues rather than patient-centric treatment.

    e. Are the ACOs a priority for the District? DC Primary Care Association is preparing briefings on this issue.

    f. Is there a difference between what is happening in Ward 1 and Wards 7 and 8? The community centered approach is great for some wards, but would the same

approach work west of the river? We need to be careful to ask appropriate questions so that we address the city's needs, not just most disadvantaged or most affluent.

i. Dr. Alexander - There is a sense of abandonment among residents in Wards 7 and 8; Unity has established a strong presence, and the population is familiar with this.

ii. Ms. Proctor – Specialty Hospital is engaged in some initiatives to assess and address holistic health. Wards 7 and 8 need more clinics and need to ensure choice of providers. The hospitals met with the community through the ANCs. In essence, maintaining a community-centered approach.

iii. Ms. Sturtz – Many opportunities in D.C. are not appropriately used; for example, the program to strengthen the family unit. The United Planning Organization (UPO) is also expressing interest in the health system, particularly on the behavioral health side.

    1. Dr. Elam - The delivery piece does not have to reinvent the wheel. Leveraging existing resources is essential to maximizing new opportunities that are available.

    2. Ms. Nuss - Mayor Gray is rolling-out a new approach to TANF. This will require collaboration among all agencies that touch this population. This could coincide with a unified data system for social and physical health. DOH could end up with the role that IMA currently holds exclusively. Also, understanding that being mentally well is a precursor to higher education, employment, etc.

iv. Dr. Sweis – The more work we do behind the scenes, the better the continuum of care the District can present to its residents. We need to get away from asking "Do you have insurance?" as the precursor to care.

v. Ms. Katsakis – In regard to working through the Medicaid-specific approach to ACOs, DC should consider the Mayo Clinic model

vi. Mr. F. Smith - Are there ways to improve the transparency of grants, projects, demonstrations, etc. that are related to the health care system?

    1. Also, Chartered is working to have providers extend hours of operation.

    2. The focus should be how to establish the health home.

d. Health Care Workforce

1. GW tested care coordination, medical homes, and physician extenders (physician assistants) – among those with intellectual disabilities (ID) outcomes improved and ED use dropped dramatically.
2. Dr. Brown/Dr. Elam - What are some current barriers in the District that preclude using physician extenders?

    a. Health Workforce Strategic Plan recommended the District reconcile scope of practice issues for physician extenders.

    b. Currently working with the medical board to relax some of the restrictions for physician assistants

    c. Some physicians are averse to hiring the physician extenders. Physician extenders often see populations of patients that physicians will not.

    d. The District does have a nurse practitioner practice.

3. Ms. Sturtz – DMH is trying to get primary care incorporated into their system of care. Is it possible to get providers some seed money to incentivize hiring of physician extenders. But also, it is important to consider non-clinicians (e.g., social workers, substance abuse counselors, etc). Care teams (i.e., led by clinicians but staffed by various professionals)

5) Recap Decision & Action Items

a. Revisiting scope of practice issues for physician extenders

b. Research on dual eligible populations

6) Adjournment - Dr. Elam adjourned the meeting at 3:32pm.