Provider Focus Group Summary

October/November 2011
Facilitator: Kelly Foster, Project Manager, Heath Care Authority

Locations: Seattle (13 participants), Yakima (11 participants), Bellingham (12 participants), Spokane (6 participants), and Wenatchee (6 participants)

Targeted Audience: The following entities were asked to send representatives:
- Association of County Human Services for Area Agencies on Aging, Regional Support Network, County Developmental Disabilities and Chemical Dependency
- Washington State Mental Health Council
- Federally Qualified Health Centers
- Nursing Home Associations (Washington Health Care and Aging Services of Washington)
- Hospitals through the Washington State Hospital Association and Washington Rural Health Association)

In October and November of 2011 five provider focus groups were conducted. The purpose of the focus groups was to explore ways to integrate care, improve outcomes, and reduce costs for the dually eligible population in Washington. Specific topics included ways to create accountability, improve care coordination, and reduce fragmentation among services including medical, long-term care, developmental disabilities, and behavioral health. Below is a summary of the common key strategies shared by the focus group members. Although the goal was to gather ideas and solutions, not to reach consensus, there were many commonalities across the State.

How can we improve coordination of care?
- Focus on successful transitions from hospital settings including:
  - building strong relationships with hospitals
  - having staff in hospitals when possible
  - timely notification of admit to care coordinator, ideally this would be an electronic alert
  - set up follow-up appointments prior to discharge, preferably to be seen within 7 days of discharge.
- Integrated, seamless, non-duplicative system of care that informs beneficiaries of options
  - 1 assessment (consistently used across the state)
  - 1 coordinated care plan
  - 1 membership card
  - 1 phone number
  - 1 person to contact
  - 1 benefit package
- Care Coordination that uses a beneficiary centered approach to determine where care coordination takes place

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- Must be able to predict who will be the high risk/high cost beneficiaries (Use Predictive Risk Intelligence System -- PRISM)
- Care Coordinator has a specialized skill set including
  - Flexibility
  - Knowledge of motivational interviewing (possibly credentialed in this)
  - Knowledge of behavioral activation
  - Training for behavioral aspects-medical, mental health, developmental disabilities, long term care, chemical dependency
  - Not health plan based, health home based
- Expand successful models to have a multidisciplinary approach (example, chronic care management has worked well in the Area Agencies on Aging (AAA))
- Regular communication of care team (weekly or daily) to triage and care plan, could be done via conference calls
- Interdisciplinary team should be based upon beneficiary need (access to dietician, physician, therapists, social worker, registered nurse, mental health specialist, chemical dependency specialist, community based providers)
- Use of telehealth to support health outcomes and care coordination, beneficiary enters daily stats (example, Health Buddy System)
- Increase accountability and self management ability of beneficiaries by:
  - Making them accountable to use preventative services
  - Use of self-management courses to support lifestyle changes including Chronic Disease Self Management
- Providers could be dually certified (Medicaid and Medicare, mental health and chemical dependency)
- Integrate the Washington Administrative Code where possible
- Integrate the funding for all systems
- Use a fully risk bearing model
- Capitated model of care
- Leverage electronic systems to exchange info
- Link hospital with clinics electronically
- Unified and centralized utilization management system

How can reduce fragmentation of the system?

- Accountable entity responsible for service delivery; that entity decides who takes the role of care coordinator
- NOTE: it was stressed several times that the entity that carried the risk would need to be "smart and experienced" enough to know how to run the program

- Benefit package should the same for all dual eligible's
  - Best of both Medicaid and Medicare
  - Housing*
  - Living skills
  - Employment
  - Transportation
  - Adaptive technology
  - Preventative care
  - Care Coordinator as a benefit

    *housing is not a benefit covered by Medicare or Medicaid. Affordable and accessible housing is frequently identified in these and other stakeholder sessions as critical to the overall health outcomes of beneficiaries)
- Identify strategies used by successful models to achieve outcomes (Caremore in California and Wenatchee Medical Clinic were identified as examples)
  - Adaptive technology
  - Chronic care/disease management
  - Care coordinator makes home visits
  - Interdisciplinary team

How can we improve accountability? What incentives should be used?
- Foundationally that there has to be parity across all systems in capitated model
- Managed care implies controls, utilization management
- Whoever takes on the risk needs to be ready to meet the individual needs
- Opt out is important
- Build criteria including prevention
- Preventive services should be free
- Whoever holds risk should chose provider that can provide most culturally competent services AND allow client to choose providers
- Incentives to reduce hospital days
- Look at shared savings; be offered gains at the end of the year

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- Regulatory reform to reduce burden with technology
- Use Program for All-inclusive Care for the Elderly (PACE) financial model but not primary care based, make it behavioral health based
- Incentives for clinical outcomes and reductions of hospital stays, use of avoidable ER
- Track these outcomes and use for performance
    o Least restrictive setting
    o Hospital days
    o Health status
    o Beneficiary sense of how they feel?
- Managed fee for service potentially could end up with the same silos
- Money should go into one bucket
- Pay rates that will incentivize quality care
- Clients have incentive up front for prevention
- Financial model that supports prevention, do not use fee for service
- Single entity would manage system, don't have too many administrative layers
- Have a financial incentive to not cost shift
- Have encounter info from state and CMS in real time
- Additional regulatory oversight would be a waste
- Need something streamlined
- Eliminate duplication of oversight

What is the first step?
- Use pilots and expand
- Use models that provide good outcomes
- Identify what community partners need to be at the table to be incentivized
- Communities should have conversation, community assessment, and design for community
- Assess what works well
- Develop map of service

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- Make sure Accountable Care Organization or Managed Care Organization knows what the map of community is
- Look at infrastructure at provider level; some should go some should stay
- Do strategic analysis of system SWOT: Strengths Weaknesses, Opportunities, and Threats
- Indentify where duplication is
- Managed Care Organization does not need to recreate provider structure
- Look at Patient Activation Measure and Predictive Risk Intelligence System to what has been saved and outcomes
- Make sure you use what has worked well in Long Term Care and Mental Health Program of Assertive Community Treatment (PACT)
- What are the care pathways and options in communities
- Phase in across state, be able to make adjustments
- Shouldn't carve out services, put all services into one system
- Don't underestimate the importance of electronic medical record sharing
- Try rural area, lots of opportunity to streamline