

Working Group for Healthcare Innovation  
December 1, 2015  
4:00pm – 6:00pm  
Meeting Minutes

Attendees:

Working Group Members: Ted Almon, Al Charbonneau, Peter Andruskiewicz, Al Ayers, Dale Klatzker, Neil Steinberg, Steve Brown, Patrice Cooper (for Stephen Farrell), Rebecca Kislak (for Jane Hayward), Sam Salganik, Lester Schindel, Mark Montella (for Tim Babineau), Peter Marino, John Simmons, Mayor Avedisian, Elizabeth Lange, Reginald Tucker-Seeley, Al Puerini, Pablo Rodriguez, Diana Franchitto, Al Kurose, Senator Miller, Paul Larrat

I. Welcome

Secretary Roberts thanks everyone for joining us today, at this meeting in which we will discuss a report of the work we have been doing since this past August. The Secretary presented PowerPoint slides which gave an overview of the agenda, and principles and goals that were outlined by the Governor in her charge. The presentation slides are available online, and upon request via email to [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov)

II. Report of the Working Group for Healthcare Innovation

The Secretary continued to present slides, which reviewed an overview of the content of the report of the Working Group. She thanked everyone for their comments over these past few months, and their specific report input and remarks over the past couple of weeks. The presentation slides are available online, and upon request via email to [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov)

Secretary Roberts stated that the goal with this report was to get as much input as possible. It is not expected that everyone will agree with everything there, but it is very reflective of input that many of the members have shared.

III. Working Group Discussion

Neil Steinberg: A global health spending target is that recommendation sufficient or do we need to come up with a set target, and if not what gets to that six or nine months to get to that target?

Secretary Roberts: You are not. This recommendation goes to the Governor, and she will make a final decision. Then that the Health Policy Office would oversee that as it is tied to the economics of the state. The Governor would likely be on a shorter than six month timeline to consider this, as she has been thinking about this since receiving the Whitehouse Steinberg

John Simmons: Can you speak more about the office of health policy? We like the idea, but if it's just another layer, then I may not be as excited.

Secretary Roberts: Our recommendation is that it would be a quasi-layer, not more bureaucracy. Align across agencies, but also be an access point for the community to talk about programs. Still would use a lot of the resources of existing health policy staff. Our suggestion is to start with this recommendations and then review if this is where we need to be. We will say let's try and coordinate and see what we can get done, aligning and using existing resources.

John Simmons: Why did you pick EOHHS for the home?

Secretary Roberts: I will look to Senator Miller, as we looked to his legislation from last year for guidance and this recommendation. There is no perfect place, but with the exception of commercial health insurance all of the health system are within EOHHS. We also don't want to leave out social health determinants, which do live within EOHHS. There is an opportunity here, and feels like the most natural fit and the least likely to create a new infrastructure.

Pablo Rodriguez: Can this all be driven through the executive branch, or will it need to go to the legislature?

Secretary Roberts: There is no question we want the engagement of the legislature. The structural changes here that we discuss do not require legislation unless we decide down the line to move authority from one agency to another. We want to move, but in a judicious way, and start to drive change.

Sen Miller: We identified EOHHS as Switzerland. Components as we were trying to consolidate the legislation, we didn't expect it to be the end all, but rather that it would evolve into something like this recommendation.

Al Charbonneau: Are you saying that the office of health policy will be established with little or no cost?

Secretary Roberts: Yes, that would be my expectation. We might want one coordinating staff member, but we are discovering under the EOHHS staff umbrella and OHIC, we have the chance to coordinate effectively between agencies so as not to duplicate that ability elsewhere. Our goal would be to pull together.

Al Charbonneau: Why couldn't the Governor just say work together?

Secretary Roberts: If you create it without statute that is what is being said.

Senator Miller: Yet not that easy, but certain components of what we want to do here would need statutory changes in existing offices. All the components that should be involved in the policy and development can now be in one area.

Secretary Roberts: We do have the ability within EOHHS to pull people together, but what you have said is right, that the governor has said work together, but you need also to ponder that you don't want to live and die by every admin being different, so there is an advantage to creating an office as it may tend to exist beyond one administration.

Peter Andruskiewicz: This set of recommendations as currently crafted requires no legislative change?

Secretary Roberts: Transparency issues, we have a lot of what we need, but if we need to mandate we MAY need some legislative authority, but we believe most can be done without leg change. Again, though we will not be successful without input from the leg.

Mayor Avedisian: It seems to me setting up another exec order for the policy office, and then come back with more recommendations for what to do?

Secretary Roberts: I would like to somewhat get to work, and then as we work see where we need to go. Look at where we are with CON, etc. I haven't talked to the Governor about another Executive Order, but I am expecting there to be a lot of community input. We need to create something that links, works together and does not duplicate other work. There will be links to the changes in the community with changes in government and policy.

Pablo Rodriguez: I noticed some language changes... when we started talking about 80% of payments tied to quality, whereas now we ended up with value. Is it semantics?

Secretary Roberts: I think it is semantics, to me value is the marriage of cost and value. You are correct.

Pablo Rodriguez: I ask as any time I speak to providers the question is how do we get 80% of payments tied to quality how do we do it.

Secretary Roberts: That is it, which is the work, how do we really move it.

Al Kurose: Truly non FFS payments are 1.5% of the total revenues.

Secretary Roberts: there is a lot of alignment here, using some of those resources here to help with that, will help build the systems to move in that direction. How we measure value is a central issue.

Sam Salganik: First thank you, a lot of these proposals make a lot of sense. I especially appreciate the focus on public health goals. I see there is a very robust public reporting process for the office of health policy. Is there an intention to include public health goals there?

Secretary Roberts: My hope as a citizen and an official is that we as a state will start to report, monitor and work towards improvements in public health goals on at least an annual basis. One of the best things I heard today was that there appears to be a significant drop in diabetes in the country, and it sounded in the report as it came from cutting sugar, increasing exercise – things we all need to do. Improving health. Director Alexander-Scott, what is your

Director Alexander-Scott: From the department's standpoint we have the full expectation that we will have clear metrics, follow them and work to align them around public health goals. Now we want to achieve. We have also offered, with laying out these pop health goals, is a framework from which our SIM process can choose from these current goals to decide these are the things to strategize and put forth from the state. There maybe state level ones based on the ultimate outcomes that really publicizes and pushes metrics and how to address them. From a dept. standpoint we tend to address all of them.

Secretary Roberts: I think this is an area around which the public also has a huge value to bring in terms of consumer engagement and input. We need to live lives focused on improved health, and bringing that conversation into the health reform conversation.

Dale Klatzker: This is a lot of good work. The older I get, the more impatient I get, and as more of a comment – I would like to believe we would be able to accomplish all this because

it makes sense, and that people will intrinsically do the right thing. I have been amazed in my tenure in RI how we use the carrot and not the stick to get people to change. So what is the stick?

Secretary Roberts: Information can be a powerful stick, actually. As we create a target to look at and see what is driving costs, and how we want people to be accountable for change, there was a conversation about what happens if unsuccessful. I share your impatience in some sense, but mind is around shared vision. We need to get there. We at the state can create resources, but we need to come together or other people will create a vision for us. We have two locally based mission driven health insurers, we have a national partner who has made a commitment here, we have a big Medicaid program (number one for quality for kids in the country). How do we take those strengths and build on them, when in the past we have not been as effective as we could be. Perhaps sticks with some padding on them. I am not naïve enough to think that some of these will not be easy to do.

Reginal Tucker Seeley: Out of pocket trends tracking

Cory King: In our total cost of care report we track those, and the APCD will break those down as well.

Secretary Roberts: As you know there is a lot of conversations right now about what is out of pocket.

Pablo Rodriguez: Risk adjustment, how will you compare my practice that is 30% Medicaid 40% urban with one that is 60%suburban, and no Medicaid. How do you reward providers taking that risk?

Secretary Roberts: Good question. We are not the first state with an APCD, which is where we will do some comparison. That question is outside my realm of comment at this time, but we don't want to have a lack of perfect data be the reason we cannot answer.

Al Charbonneau: You talked about the hospital capacity study talked about over the past few years – I got the impression that you would wait to from the office of health policy and then charge the HCPACC – is that the case? If there is impatience why not just have HCPAAC go at it?

Secretary Roberts: They commissioned the study, so they do have it. One of the questions that came out was how do we go at it.

Al Charbonneau: That was two years ago, yet it was never on the agenda.

Kim Paull: I know years ago at HCPAAC we did produce the Hospital Capacity study report, through the council's work we identified potential overcapacity in hospital work per person. When I was staffing the council under Commissioner Koller we had decided to move it to a council agenda item.

Kathleen Hittner: I recall it then being discussed, and the Dept. of Health reviewed and made some recommendations from the study.

Al Charbonneau: Perhaps I am misstating, that was discussed, you are right, but the follow up there was not present.

Commissioner Hittner: It did occur not necessarily at those meetings.

Secretary Roberts: There is a good point there that we have a lot of studies, but we haven't used them yet as a platform to drive change. The first four studies there were required by, and funded by the General Assembly and transmitted to them. We haven't had a place with the political authority to drive that change with the public engagement. We can use these reports to say what do we need and how do we get there.

Director Alexander-Scott: If I may add we do have plans now to use those studies to augment the work we are getting underway. We refer to the state health inventory, and these studies to talk about the population health/behavioral health plan.

Commissioner Hittner: I would add to that, to emphasize these studies have not been put on a shelf and we are frequently reviewing and using their results to inform our work.

Reginald Tucker Seeley: Cost transparency issue you mentioned there are several places its valuable, can you speak to that?

Secretary Roberts: Important that we share appropriate data on things like out of pocket cost, but also a need for the provider community to have adequate information to take on accountability. It will need to be in different formats for different use but there is need in more than one place.

Senator Miller: To re-emphasize it I think the conversation leads to two things that have been discussed. Designing a health policy office, designed either by the leg or the Governor or whoever, it requires that you have data that rises to the level that requires action be taken on that data. That can be a stick of follow through.

Peter Andruskiewicz: To that point, I thought in an earlier draft of some of this work, we discussed in MA they have a health policy commission, independent appointed by the governor, healthcare experts that oversee the office of health policy in Mass – I do not see that here.

Secretary Roberts: You are correct, you see an office with advisory capacity. If we want one with executive authority we will go to the legislature but at this point it is not in the recommendation.

Peter Andruskiewicz: They have an annual process where all the data and the output from the prior year for all the AEs to come to roost.

Secretary Roberts: Right, and the goal is to have that kind of reporting, engagement, but then see what people do with it. Massachusetts has made info available but I would say their Attorney General has done more to drive provider change. This gives me a moment to also mention that we are open for comment now – if you want to write up that recommendation we can accept that.

Steve Brown: How do you propose or think the different responsibilities and work pan out?

Secretary Roberts: I think the APCD will have that kind of data and provider costs – not quality so much – there should not be an expectation that we will be reaching in and pulling a provider out to review individual characteristics. We will look at types of service, types of systems. Look at what the system drivers are in terms of cost and quality; although it is available now to go in and look at what a provider has been paid for. We do that more for

oversight, not a good use of analytic capacity.

Steve Brown: How does this relate to specialties – how will it affect the way I practice, to attract providers here?

Secretary Roberts: I will tell you as a policy and program person in government is to use a lot of this data around improved quality and coordination of care. In the specialty and subspecialty world, it's about linking you into that system, and impact on health in the community. We haven't had a good way to make that link – I think AEs and total cost of care can help us do that. Having clinical and cost information about where you fit and the value is huge. An organized quality system is big. I am hoping it will be about having a system on a shared mission with appropriate levels of reimbursement working together to improve health.

John Simmons: What's next?

Secretary Roberts: We will let you all speak to use some more for a few days, given the holiday last week. It will be submitted later this week to the governor. She will need to make some decisions, and I'm sure many here will be consulted. You can have your commented appended to the report as a public document, so if you would like something attached as a formal appendix please write specifically and let us know. Then I think we need to get to work on the government side to begin coordinated work that is ongoing. We will have to get to this discussion of the shared vision. How do we make sure we have regulations that support that on the government side, how do we come together around the shared mission. I will need to speak with the Governor about how she wants to take that work forward.

Neil Steinberg: How transparent will this be? Public?

Secretary Roberts: This is absolutely a public document, completely open recommendations. And that's why if anyone wants to put their comments as a formal appendix they may. If you want to be a part of this work going forward, then there will be opportunity to do that. Not one of us can solve this alone. This is where we need to challenge some of the impatience coming through. We are a diverse group with diverse and divergent monetary interests but with a common goal to improve the health of those we serve.

- IV. Public Comment – No comment offered by the public at this time.
- V. Adjourn – Secretary Roberts thanked all the Working Group members for their time and input on this important process, and thanked the public for their interest and input as well.