

Provider Advisory Group
Meeting Minutes
Wednesday December 9, 2015
6:30-8:00pm

Attendees: Claire Nadeau, Donald Murphy, Peter Karczmar, Steve Ferra, Elaine Jones, David Kroessler, Sarah Fessler, Cory King, Marti Rosenberg, Lynn Hob, Karen Dalton, Steven Montaquila, Peter Hollman, Lateial (Medical Resident), Megan Ramney, Steve Brown, Phil Salko, Gary Bubly, Sam Marullo, Lauren Lapolla, Steve Detoy, Newell Warde, Secretary Roberts

I. **Welcome – Secretary Roberts**

Strategic Plan on addiction and overdose.

At the next meeting we will also hope to address the issue of patient/consumer engagement and responsibility (concern about cherry picking as discussions about quality payments go further) Paying for outcomes what things are we held responsible for things outside provider control. Think about if others in your networks should be involved.

II. **Presentation on the State Innovation Model Project (Marti Rosenberg, SIM Project Director w Cory King, OHIC)**

Slides were handed out in hard copy, and will be available upon request via email to lauren.lapolla@ohhs.i.gov.

Questions during Presentations:

Steve Detoy: Fourth Aim, Provider Satisfaction

Marti Rosenberg: Okay thank you we can add that.

Steve Detoy: When you mentioned the community health planning it brings me back to another meeting about health care planning, so how do those go together?

Marti Rosenberg: Population health plan will look at eleven areas of health, with a set of metrics around those eleven areas. It will look at that and then with the vendors we bring on board to do that we will have the conversations in the community to see what we will do about that, which goes back to the SIM theory of change. It is within SIM's purview to look at infrastructure and capacity. We are going to make decision together that may have some technical infrastructure, some technical capacity; we need to make the right choices for what is not that much money –granted it is more than we had in the past, but still not a ton.

Lynn Hob: Do you think you will measure twelve pieces of information?

Cory King: We have a tentatively endorsed list of measures, still combing through; it won't be twelve – right now at a menu of 47.

Peter Hollman: But those 47 are not all at physician level.

Cory King: Number required are yet to be determined.

Pete Karczmar: These will be standardized across all third party payers, will this be directed from OHIC, or...?

Cory King: Leadership hasn't had this discussion yet but I would imagine OHIC may write regulations over the commercial set, and Medicaid likewise over their set.

David Kroessler: Within each would be quality indicators?

Cory King: Yes that's the idea.

Megan Ramney: Does this take into consideration CMS measures?

Cory King: How well aligned our measure set is with measures we do not have control over; looked at Medicare Shared Savings and the five star and worked on a crosswalk. That is a consideration.

Steve Ferra: You haven't made a mention of specialties. Are these basically directed at primary care, are they generic, or defined by specialty?

Cory King: I would say we are not there yet, largely because primary care and hospitals have been the focus of value based payments and specialists have been largely out of that. Our existing measures have largely been executed through primary care contracts and hospital contracts. Regulators like OHIC are very interested in value based payments for specialists but accommodations and reviews will be done.

Steve Ferra: How does this ensure that physician's quality of care extends beyond what is being measured? Is there a danger of that if you select certain things?

Sarah Fessler: You will measure health status and function status which would give us a clue.

Cory King: The work group reviewed that it would be representative of the array of services provide to a population; representative of diverse services needed; broadly address population health.

Secretary Roberts: At the moment, no one is measured on anything. I am happy to have a test that maybe doesn't cover everything but does cover things that we know are important to improving health. And we know that this will always be changing, as practices change and medical care changes.

Steven Montaquila: There are a lot of dovetails, example: general practitioner measured on diabetics if patient had an eye exam. I can see subsets you are looking at, how do we make sure everyone and data are connected in the correct way?

Cory King: Then the question is back to you – are there incentives in contracts to ensure that you do? That's a good thought. Also open the floor to Dr. Hollman who is an expert on this.

Peter Hollman: I would look at this as a start with a focus on populations. Some population measures come down to what providers do, but this is not another PQRS. This committee's sole charge is to look at measurement within those agreed upon in the contracts. Still have other things that you want to measure but must be those that were chosen respectively in each category. I would also say that a lot of things are being measured, if in an ACO. Can't really have alternative payment models unless you measure outcomes.

Secretary Roberts: There is some truth that we haven't done much with the specialty

provider community. I think that goes to Cory's comment that it has been primary care and hospital focused, thus how we start to think about those.

Elaine Jones: I have found on the national level reporting on items that have nothing to do with neurology, and it is very frustrating.

Cory King: OHIC has particularly been focused this fall on ways to incorporate specialty care into payment models. We finished a round of meetings, the commissioner convened this alternative payment advisory committee, but if there is interest for us to tell you more about that work I am happy to come back at another time.

Karen Dalton: [re: common provider directory] I don't know if patients will understand what they are looking at and why that physician is held to reporting.

Steven Montaquila: Want to be sure that the docs aren't inappropriately penalized by the system.

Marti Rosenberg: There are examples around the country, Maine is well used by employers and purchasers; we want to not make it like Yelp. Here we think your input will be crucial. Will providers use it, if not is this a place for the dollars.

Lynn Hob: My practice is like that, and numbers are up on the website. I think it's good – if looking at broad quality metrics, its reasonable. If you have a number of surveys, then outliers are discounted.

Elaine Jones: I know that neurology groups are doing this, ophthalmology is, cardiology – may not need to duplicate.

Steve Detoy: Will this not overlap w APCD?

Cory King: No, that is de-identified data.

Lynn Hob: Also there is a system called Trio, a quality measurement tool you can purchase, it measures quality and helps calculate risk. It compares you statewide. Used in Iowa.

Sarah Fessler: Feedback as our model uses an SBIRT – our SBIRT clinician is against where she refers to. We need to look at beefing up our Psych outpatient services in the state.

David Kroessler: It falls under access. When you have someone in the Emergency Department (ED) who needs naloxone, they need it now, but not all ED docs are not naloxone providers.

Megan Ramney: We see a disproportionate number of behavioral health clients. There is a lack of referral options, particularly for Medicaid patients. Even if you are dual diagnosis. Need somewhere to send. We have done a lot of work around SBIRT and it works, but where it fails is when people are not comfortable answering questions. Technology can help here. Telehealth; innovative solutions to deliver more effectively. As an ED physician, if I have five minutes with a patient that is good, so it is not always feasible to implement. SBIRT, the follow through, and innovative ways to implement.

David Kroessler: Additional issue is the huge majority of psychiatrists do not take health insurance.

Steve Deto: We met with quality institute this afternoon and they have a new grant that sounds like that practice assistance program. Look around at other areas for partnership.

Secretary Roberts: I would like to add that rather than do 15 things lightly, we try to go much deeper on 3 or 4 things. How can those investments make the most difference, and it is why we want to engage people to ensure that where the gaps are is where we are filling and spending those resources.

III. **Provider Input and Discussion**

Elaine Jones: I think one of the biggest things you can do is the interoperability, the communications between systems. That would help to carry us so far, to have our systems speak to each other.

Secretary Roberts: This is now to the point where I almost wish there was regulation, because the companies involved are not cooperating. Either the providers will walk away at some point because of costs, or the government will have to say to the IT providers that kind of cost is not allowed. That is recognized as a major issue.

Peter Karczmar: This is an area the consumers can engage a lot - the patients who come in and are amazed that I don't have info from a physician down the block, despite having EMRs is high.

Marti Rosenberg: We may be able to get employers involved too.

Secretary Roberts: It will have to be a national solution as these are national companies.

Phil Salko: What about a discussion between CareNE and Lifespan to talk to each other?

Gary Bubby: They do talk easily – Care NE is not fully implemented yet, but what is there, I can get. SouthCoast has set up a privacy barrier for what they will share.

Lynn Hob: But why not use CurrentCare

Megan Ramney: Because Currentcare doesn't have notes or EKGs, for example.

Lynn Hob: Not notes, but EKGs, why not use what is there.

Gary Bubby: I am a fan of Currentcare, but I would say it is a failure. One of the major problems is that it was set up as opt-in. It is very limited, and any drug seeker will opt out of any system; makes it difficult to see high utilizer people. I did want to mention there is another system out there, used in Washington State, Oregon, parts of California and parts of Ohio. There is a system called EDIE, an opt out system, takes feeds from the PMP as long as you have a legislative body to let that happen. It produces a thinner slice, too much on CurrentCare. I want a very thin slice of useful information, and I would love to have that PMP pushed to me directly. One of the barriers to using PMP is the login, its one more step. Putting the information directly in front of you. That cost is \$200,000 per year in a state like this. Reduced ER visits, saved state of Washington by about \$6.8million on their Medicaid budget. It may be more helpful.

Lynn Hob: For me, Currentcare is helpful as I have 95% of my patients enrolled. Once there,

it is great.

David Kroessler: As an aside, with PMP I login once, keep it on my desktop and have it up all day.

Megan Ramney: That doesn't work in the ED, or anywhere that you are bouncing from stations.

Steve Detoy: We are changing PMP vendors soon. I know you and Dr. McDonald were talking about this.

Secretary Roberts: The reason we have an opt-in is a state law, you have to ask people to enroll. I do say providers will have to get people to enroll I am sure there are a group of people no matter the practice will choose not to enroll. That is the law for the RIO, not for Info exchanges.

Lynn Hob: And that happened from a strong patient group who did not want an opt out program.

Secretary Roberts: The goal for the state is to have a lot more people enroll. Doesn't have to be the physician, can be someone in the office, but need to ask the patient if they want to enroll and why they should. The higher percentage of people in it, will drive use, will drive data.

Steve Ferra: The ideal time to have people enroll is when they sign up.

Secretary Roberts: Yes we will have a trigger for that, but some people do not trust their insurers.

Karen Dalton: Is that being addressed at CVS minute clinics?

Secretary Roberts: At the moment there is no requirement to ask people to encourage sign up. We need to find new ways to encourage that.

Megan Ramney: Listening to the various perspectives here, brings up a huge issue, but goes to that fourth aim of provider satisfaction. That is the workflow issue. Appreciate that you try to standardize measures, but each additional thing takes away from providers' time to provide care. Just ask that you keep that under consideration as you work on this – think to that.

Secretary Roberts: I am interested in whether there are other ways to changing the practice patterns. Thinking about what best practices are in the flow that perhaps someone else on the team can do, build relationships on the team. There are some practices which have made real progress around that, whereas others have not.

Megan Ramney: Almost physician detailing.

Peter Hollman: When you talk about a major aspect of the SIM getting to alternative payments, I think especially with specialists, it is vague. A couple things may help change that: One, when the federal government talks about what happens with the fee schedule it is fairly specific. The health plans have not been very specific, it remains almost a mystery. I think it is hard for people to prepare, and a vague threat has the impact that some get nervous, others find it old hat. Secondly, is it also hard for those who want to do many

things for them to respond. There were some specialists at a recent SIM meeting, when there was a discussion about some of these aspects it was really almost impossible for folks to sound anything but defensive. Some may be defensive by nature, but it is hard to react to something that is completely nebulous. Even if I was willing to be a part of something, how do I fit into that situation? Need to create an environment where more of that can be discussed. The challenge you have with specialties is to find meaningful way to get them in, and which specialties. If you set up rules ... a challenge w PQRS is that every specialty had to have a set rule. I think it is a real challenge, but if can begin to set up a dialogue amongst specialists, and also have health plans be upfront about what they are planning to do, that would be helpful.

Steve Ferra: On a national level there are many lobbying efforts going on for the Medicare rates. The better we, cardiologists, did the more we were costing Medicare for longer term care. How about starting at the other end: Preventing the diseases from starting before it gets to an expensive care. It seems like we should make sure our children are practicing the best health we can so as not to grapple the best cost we can. Let's stop the cost early on; I know the grant has a timetable associated, and we have to do that too but do not look at just one segment.

Lynn Hob: Here is a disruptive idea – providers complain often about too much work, so why not have the patients do some of the work? Have the patients do some of the measurement; patient experience of care survey. Patient gathered.

Peter Hollman: On the quality measures, yes, on the side 'How's Your Health' has been mentioned, and CAPS, those which may not be as efficient, are on the radar.

Lynn Hob: If you had a very low cost tool, where patients measure some of the quality for you, can we include that in this system? It is cheap, it keeps the work down.

Sarah Fessler: I think it would be tough for certain populations, i.e. health center populations, and often those cost systems a lot of money.

Secretary Roberts: I will argue with you a little there, our kids and families are fairly low cost (Rite Care). As we think savings, we need to look at the people who are in many ways over utilizing the system as it is not meeting their needs. Some are not as they have multiple illnesses, but some there are upstream questions and are over-utilizing as they are in and out of all the places you are. Some by their own doing, some by 911's doing, and we need to try to impact those patterns as they are not driving improved health for the most part.

Gary Bubly: Linking a bit to Lyn's idea – Scribes. Scribes bring happiness to ED docs. That could be piloted in Primary Care. Have as many metrics as you want and these scribes would be trained to follow up and find that. It could potential increase to the PCP workforce in the state.

Lynn Hob: I have an e-scribe (instant medical history), and everyone who comes to my office uses it. It pulls so much out – could go electronically with your scribe too – relieves the burden.

Gary Bubly: I am not familiar with that, but even with voice recognition, not as effective as a

scribe.

Sarah Fessler: I dream of that, but that is a barrier of cost. Perhaps with enhanced payment that is something primary care can do.

Gary Bubly: I know OHIC has talked about barriers to cost there. When we say we need more primary care in the state, it is a way to do it. I would pilot it to see if you enhance capacity. It works in the emergency room, but need to extend to PCP. Out of our 110 ED docs there are 3 that prefer to work not with the scribes, but the rest rely on them.

Sarah Fessler: How does the hospital pay for it?

Megan Ramney: We pay for it ourselves, but it is a high return on investment.

Gary Bubly: You can try to pass it to the patient but is hard to do with difficult patients.

Lynn Hob: The problem with having the practice write the quality metrics it is often hooley. What did the patient get, what did they bring home. When you ask the patient, you actually find out.

Megan Ramney: I agree with you, I think that there are logistical difficulties. There are a lot of IT, HIPPA, high tech act concerns. I am a huge fan of using new tech to improve patient care, but sometimes they are two separate things. It is key to say what we are doing, but also patient outcomes. I wouldn't say patient reported outcomes obviates clinician reported metrics. Sometimes they merge, but not overall.

IV. Public Comment – No additional comments at this time.

V. Adjourn – 2016 meeting schedule to be shared in the next week.