Report: Meeting One

Colorado State Innovation Model (SIM) Project

Health Care Provider Workgroup

JUNE 5, 2013

Overview

Processing and sharing electronic medical information in real time. A right-sized health care workforce with the latest and best training. State and federal regulations that smooth innovation rather than block it. Payment systems that do the same. A clear picture of the state's current health care landscape and measurable indicators to chart its progress.

These were top-of-mind thoughts and ideas, among many others, that emerged when a group of health care providers gathered for the first time in June to discuss the Colorado Health Care Innovation Plan.

The health care provider workgroup is part of the stakeholder process supporting the State Innovation Model (SIM) project. After two more meetings, the group's goal is to make its final recommendations and sign off on Colorado's strategic plan.

Summary

The health care provider workgroup is focused on issues of concern to primary care providers, behavioral health care providers and others in the statewide health care community. Questions about the adequacy and training of the state's health care workforce are a top priority, but this group is also addressing the provider experience with the state's efforts around health homes, IT, payment design, benefit design, quality improvement, quality measurement, the consumer experience and other issues.

At the first meeting, 17 stakeholders were on hand representing academia and workforce training programs, mental/behavioral health clinics and advocates, several statewide provider associations, as well as a representative from the private sector and a representative from philanthropy. [A full list of attendees is included as Appendix A to this report.]

Attendees reviewed the purpose, organization and goals of the state innovation plan project and stakeholder engagement efforts. They asked questions about the scope of the innovation plan as well as the planned focus on integrating behavioral and physical health. There was some confusion about the type of model that the state would be submitting for accelerated implementation as well as how the work for the 2013 federal SIM grant related to the first round of efforts in 2012. The discussion served as an opportunity to reach common understandings and provided a platform for the rest of the meeting.

Draft SIM Vision:

Build on Colorado's robust foundation of primary care and collaboration to create an integrated system of physical health, behavioral health, community prevention and clinical care.

Draft SIM Goal:

Ensure that 80 percent of Coloradans have access to integrated physical and behavioral health care.

Recommendations

The group made 20 recommendations to advance innovation and support the SIM project. These recommendations included structure and composition of the innovation plan, requests for research around barriers to innovation, and identifying actions that could streamline care.

Recommendations: *Access to Integrated Care*

Recommendation 1: *All Coloradans will have the opportunity to access a robust integrated system of care to support health.*

Recommendation 2: *Establish a consistent definition of health home and integrated primary care health home.*

Recommendation 3: *Establish an integrated physical/behavioral primary care health home baseline to use in comparison to the 80 percent goal.*

Stakeholders recommended changes to the draft SIM goal, incorporating their views of Colorado's current health care system and attributes of the system they hope to see following innovation. They asked that the vision acknowledge that primary care in Colorado is strong in some areas of the state or within certain systems but that, overall, it may not be as robust statewide as it should be. The group supports building a robust system that is accessible to all Coloradans. The group noted that the current goal spells out specific health interfaces in the state, such as physical health, behavioral health, community prevention and clinical care, and shared a desire that rather than separate the health care system into these components they would like to see the document refer solely to health. Naming distinctions in health specialty or orientation was seen as perpetuating silos rather than bringing the system together.

The group also:

- Said that the SIM vision should encompass the reasons that Colorado wants a robust and integrated system. For example, the goal of developing such a system would support a healthier Colorado population, improve satisfaction with the system and lower health care costs.
- Agreed that a robust, integrated system accessible to all Coloradans would likely improve health outcomes and increase satisfaction based on research. However, the impact on cost is not well understood.
- Requested that the goal be in plain language for both a policy audience and a non-health policy audience, and that it uses terms and objectives that would make sense to any Coloradan.
- Scrutinized the SIM goal of having 80 percent of Coloradans with access to integrated physical and behavioral health homes. The group acknowledged that there is no public agreement on what our baseline is for health homes generally or integrated health homes in particular. It recommended establishing a common definition of primary care health home as well as a baseline so that the goal can be measured. This context is important if Colorado is to evaluate the aspirational extent of the goal and the resources that could be necessary to achieve it over a time frame of five to 10 years, members noted.

Recommendation 4: *Develop a plan for change management before, during and after the innovation roll-out that will engage health administrators, providers and educators.*

Concerns raised by the group about the goal of ensuring that 80 percent of Coloradans have access to an integrated primary/behavioral health home included:

- How do we organize a disorganized system to reach such an ambitious goal?
- How do we ensure as many payers and providers as possible are working to achieve the goal?
- Is a system-wide approach to integrated care versus a more targeted approach a better use of scarce resources?
- Do we have the workforce necessary to achieve this goal?
- Where does community and public health prevention fit into this goal?

- Who is in the 20 percent who will not have access to an integrated health home?
- Should a mental health clinic be able to serve as the health home rather than a primary care site?

The group generally came to consensus on pursuing a system-wide approach to integrated care versus a targeted approach.

Recommendations: *The Colorado Health Care Innovation Plan*

Recommendation 5: *Colorado State Health Care Innovation Plan chapters should include: Health Homes; Integration of Behavioral and Physical Health; Workforce; IT Infrastructure; Payment Models; Benefit Design; Quality Improvements; Consumer Engagement; and Bridging Clinical Care with Community Prevention/Public Health.*

Recommendation 6: *Explicitly acknowledge that physical/behavioral health integration is the chosen accelerator in Colorado's innovation plan but it also should serve as a platform for broader integration of the system, including oral health.*

Recommendation 7: *Include a chapter on consumer engagement that evaluates the extent to which Coloradans understand and appreciate the development of health homes, how they would like to experience a transformed system, and whether there are ways to move consumers to the driver's seat in establishing the care they will receive and how they will receive it.*

Stakeholders spent much of their time together discussing health homes. The conversation brought forward different interpretations of what a health home is and where it is centered. The group came to a common agreement that there must be a baseline study of where Colorado is in order to fully understand what it will take to expand health homes statewide. For example, is a medical home different from a health home and should we use such terminology to suggest that a patient can expect integrated care regardless of where he or she generally seeks that care. The group suggested looking at the ACA definition of health home, HCPF's definition or IOM's definition or another as long as it is agreed to and used consistently.

Without a common definition and baseline metrics, stakeholders struggled to describe where Colorado is today. General descriptions of Colorado's current landscape included:

- Fragmented: Within physical health and certainly with regard to mental health.
- Low Consumer Awareness: Consumers do not necessarily see and feel the health home concept. Often, consumers just assume providers are collaborating and communicating.
- Location or necessity: Consumers often seek care outside of a primary care setting depending on insurance status, incarceration, citizenship and other factors. Also, they often seek care outside of conventional hours. These actions result in overuse of emergency room services and no connectivity to the mainstream health home concept.
- Dynamic: Transforming into a comprehensive health home is an evolutionary process and requires ongoing support, culture change, and new ways of doing business.

Recommendation 8: *Study workforce requirements to achieve a goal of access to an integrated health home for 80 percent of Coloradans with a particular focus on clinical needs vs. non-clinical needs. For example, assessments of IT, administration and billing, discharge planners and health navigators may be needed to support the system.*

Stakeholders identified numerous barriers to achieving a greatly expanded health home system. Some of these barriers already have had a dampening effect on innovation. They include:

- Insufficient workforce to meet behavioral health demands.
- Significant costs to establish an integrated health home, including expanded hours of care and administrative staff support.
- Insufficient data to staff health homes based on patient panel characteristics.

Recommendations: ***Regulatory Barriers***

Recommendation 9: *Assess and identify Colorado regulations, funding and governance structures that are not aligned with the goal of integration and expansion of health homes. Develop recommendations and an action plan to align state governance and funding in support of the SIM goals. The assessment should include the opportunity for cost savings based on streamlined governance.*

Stakeholders recounted many examples of running into regulations that limited or even stopped innovative efforts to integrate care. Group members agreed that this is an important area to be addressed if Colorado is to set the stage for true care integration. The discussion focused on:

- Regulations that limit progress. At least five state agencies govern behavioral health and physical health as well as the workforce that supports these types of care. The issue is further compounded by federal governance. This result is often duplicated administrative costs and audit criteria, multiple and competing regulations and contradictory guidance, all of which discourage system innovation.
    - An example cited: Western Slope Psychiatric Hospital opened its doors prepared to serve an integrated substance abuse and behavioral health client population. It had been planning this for years. But, after opening, the state licensing agency raised flags and made Western Slope split out substance abuse and behavioral health. This occurred because it did not fit with current licensing regulations and the various agencies were not fully engaged in the process.

Recommendation: ***Best Practices***

Recommendation 10: *Conduct a study of the health homes across Colorado that are working well to determine if their lessons could be taken to scale across the state.*

Stakeholders said there is much innovative work being done across Colorado that can help us do a better job of figuring out where to take the system. Examples cited:

- Federally Qualified Health Centers (FQHCs): These organizations are often innovative when it comes to integration and health homes. Examples include Clinica Family Health Services and Metro Community Provider Network
- Memorandums of Understanding (MOU) and hot spotter meetings: In Greeley, MOUs to help share data and hot spotter meetings between care coordinators help identify nutrition assistance, transportation and other important considerations.
- Coaching: Health Teamworks is having success in helping practices evolve into medical homes.
- Nurse resource lines: Children's Hospital is using a nurse resource line to extend hours and capacity for care. At the same time, it is taking care to connect directly back to the pediatric provider.

Recommendations: ***Information Sharing***

Recommendation 11: *Consider adopting innovative, proven approaches into the model for accelerating integrated health homes.*

Recommendation 12: *The discussion of IT Infrastructure should include capturing patient data in electronic health records, sharing records across all patient providers as necessary, and also developing the ability to extract reliable data for analysis, shared learning, and system improvement while protecting privacy.*

Recommendation 13: *Study and identify broader concerns with IT and health information. Develop recommendations to address barriers to sharing health IT across state lines.*

Recommendation 14: *Develop training programs to address privacy and legal myths and facts around health IT and minimal standards. Work with state and federal agencies to create guidelines.*

Recommendation 15: *Identify options for how we should use data to measure health goals and make improvements.*

Recommendation 16: *Empower consumers to share in electronic health information. Create protocols and training for providers to share EHR's with patients and make joint decisions about records.*

Recommendation 17: *Develop case studies of FQHCs and a few other clinics that have found ways to expand their use of IT.*

Stakeholders affirmed that IT is a necessary component

of integrated care. They also agreed that IT can and should serve many functions. Observations included:

- IT is necessary for success in integration but Colorado has not achieved an interoperable IT system.
- Colorado is littered with islands of integrated IT systems. These systems are limited to certain closed circuits of care and often do not cross types of care such as mental and physical.
- Smaller practices or clinics often find it hard to know what type of IT to invest in and share concerns about cost.
- Privacy is a stumbling block for interoperable IT. Many users have fears surrounding HIPPAA requirements and legal liability.
- Rural areas are both opportunities and challenges for IT.
- IT can be a factor in some older physicians leaving the system.
- The technology is perhaps not even developed to handle the demands of an integrated care system.

Recommendations: ***Payment Reform***

Recommendation 18: *In the current fee-for-service system, assess Medicaid payment for preventive behavioral codes. Recommend changes to incentivize care.*

Recommendation 19: *Transition system to more global payments with an eye to accountability.*

Recommendation 20: *Assess payment barriers to delegation and coordination of care. Make recommendations to pay for team-based patient-centered care.*

Stakeholders agreed that payment is a key component of transformation. The group recognized that there are numerous payment models in the public and private sectors but also in the delivery of behavioral health and other types of care. The group highlighted several important points:

- Certain payment models that are working well today may not be well served by wholesale changes. For example, Medicaid behavioral health capitation payments have been shown to be cost effective.
- Enhanced payments to FQHCs do incentivize primary care and integration to an extent. It is important to keep funding protections for the safety net.
- Medicaid payment rules can be a disincentive to strategic care approaches. For example, Medicaid won't pay for acute inpatient work as well as behavioral health work. So more hospitals let psych beds go.
- Alignment and standardization across payers would save administrative burden and facilitate better care management.
- New payment models must support small practices if they are moving away from volume-based models.

Next steps and Wrap-up

The provider stakeholder group will next meet on Friday, July 12, from 9 a.m. to noon. The discussion will focus on Colorado's proposed model to integrate behavioral and physical health. Participants were asked to recommend stakeholders who might join the group. One recommendation is to ensure that clinic CEOs and field-based providers are at the table.

The group will be asked to provide comments on this report and adopt it as a record of their participation.

Appendix A: Participation List

Chet Seward, Senior Director, *Health Care Policy, Colorado Medical Society*

Mary Weber, Associate Professor, *University of Colorado Denver College of Nursing*

Nicole McWhirter, Director, Engagement, *Colorado Association for School-Based Health Care (CASBHC)*

Colleen Church, Senior Program Officer, *Caring for Colorado Foundation*

Ledy Garcia-Eckstein, Acting Director, *Denver Office of Economic Development (OED) Division of Workforce Development*

Bill Ray, Communications Consultant for CDA, *Colorado Dental Association*

Dianne Brunson, Director of Public Health and Community Outreach, *CU Denver School of Dental Medicine*

Terri Hurst, Director of Public Policy, *Colorado Behavioral Healthcare Council*

Gretchen Hammer, Executive Director, *Colorado Coalition for the Medically Underserved*

Polly Anderson, Policy Director, *Colorado Community Health Network*

Harriet Hall, President/CEO, *Jefferson Center for Mental Health*

Carol Saylor, Chief Operating Office, *Rocky Mountain Youth Clinics*

Rebecca Kurz, Legislative Liaison, *Colorado Access*

Kristin Paulson, Policy Coordinator, *Center for Improving Value in Health Care (CIVHC)*

Ben Miller, Assistant Professor, Director, Office of Integrated Healthcare Research and Policy, *CU Denver School of Medicine, Department of Family Medicine*

Larry Pottorff, Executive Director, *North Range Behavioral Health*

Gail Finley, Vice President, Rural Health and Hospitals, *Colorado Hospital Association*

Anna Vigran, Senior Analyst and Communications Specialist, *Colorado Health Institute*

Deborah Goeken, Senior Director of Operations and Communications, *Colorado Health Institute*

Michele Lueck, President and CEO, *Colorado Health Institute*

Rebecca Alderfer, Senior Analyst, *Colorado Health Institute*

Appendix B: Slide Presentation

coloradosim.org/sim-kick-off-meeting/sim-kick-off-presentation/