



Prevention and Wellness Trust

Ch. 224 of the Acts of 2012

Prevention and Wellness Sustainability Committee

DPH Lobby 1 Conference Room

October 29, 2015

Meeting Minutes

Board Members present:

Jean Zotter (DPH), Maddie Ribble (MPHA), Jeff Stone (MA Health Council), Zachary Crowley (for Sen. Lewis), Abigail Armstrong (for Sen. Lewis), Sarah Sabshon (for Rep. Sanchez)

Board Members not present:

Erika Scibelli (for Rep. Welch), Samantha Pskowski (for Rep. Hogan)

DPH and EOHHS staff in attendance:

Carlene Pavlos, Jenna Roberts, Claudia Van Dusen, Alissa Caron, Jessica Mitchell, Laura Coe, Santhi Hariprasad, Susan Svencer, Liz Moniz

Additional Attendees:

Vaira Harik (Barnstable County), Kim Kelly (Berkshire CHC), Nicole Rioles (BPHC), Rob Schreiber (Harvard Catalyst), Charles Deutsch (Harvard Catalyst), Jennifer Turple, Karen Peterson, Janice Sullivan (Manet), Peter Wilner, Carol Girard, Jodaelle Racine (MPHA)

Introductions and Meeting Overview

- Jean Zotter called meeting to order at 1:06. Meeting is not being recorded.
- Introductions and quorum established.
- Welcome to new PWTF staff.
- Overview of agenda presented by Jean Zotter - consensus of committee for approval
- Discussion of meeting minutes – consensus of committee for review and approval
- Discussion of future Sustainability Committee meeting dates
 - List of dates through march 2016 included in email and in folder
- Discussion of new staffing structure from Jean Zotter and Laura Coe

- Three Technical Advisors as primary point of contact for partnerships, contract management
- Two Quality Advisors to provide more support for health condition implementation

Sustaining the Efforts Set Forth in the Prevention and Wellness Trust Fund

Iyah Romm – MA Health Policy Commission

Presentation – see slides

- We are all communicating at a moment of change. How does ACO certification fit into it all? Where is healthcare reform in 2016, and how does that tie back to public health?
- How do we define value around the health of communities and achieve savings? What is value?
- Over spending on delivery side, underspending on all other supports that impact health.
- What is the next chapter with Ch 224 passed? Sustainability strategy of 224 has to be payment reform.
- MA is an outlier from the rest of the country and the world in health care spending
 - Public health support declining – overspending on most things, under spending on population health supports
 - Across the spectrum the services we use are 9%-15% higher than the national average
 - Approximately 40% of ED visits are non-emergency resulting in large spending
 - Other cost drivers: end of life, readmission, high-cost setting, avoidable hospital visits
- Need whole population interventions for most vulnerable populations with co- and tri-morbidities
 - Small number of people accounting for a huge amount of medical spending
 - Likely the same people who are missing work, have housing instability, substance use, etc
 - Our delivery infrastructure is not designed to provide supports for this complex population
 - All interventions don't work as well without consideration of behavioral health needs
- 4 “levers” to think about payment reform
 - How we deliver care?
 - Reforming how we pay
 - Developing a value-based health care market
 - Engaging purchasers through information and incentives
- How do we engage consumers effectively?
 - Perceptions about community hospitals, preventative care, cost containment hard to battle.
 - Incentive programs lead to belief that lower cost means lower quality
 - *Comment* – We haven't done a good job of helping people understand that our strategy for public health is making people healthier.
 - *Comment* - Our goal is to provide better value, this will improve health outcomes.

Market considerations

- How do price disparities tie into variation in public payer mix?
 - Higher price providers generally care for fewer publicly insured patients.
 - Where we spend \$\$ matters, and we are not spending enough on preventative services and primary care.
 - Who should be spending those dollars? Government? Delivery systems?

- How do we effectively communicate how health care costs tie to direct economic implications on people's ability to get raises, for businesses to grow and add jobs
- There is disconnect among both consumers and providers about what things cost.
 - What about CBOs and delivery system itself?
 - Community health needs national strategy. Role of the individual when considering value?
 - Other challenges: large distrust, power differential
 - *Comment:* Language used to discuss value; disconnect on who is responsible for what in coordinated care
 - *Comment:* Lack of a social support system
 - *Comment:* More emphasis is also needed on data.

Payment models and defining value

- How do we pay people?
 - Need to build incentives more effectively.
 - Progress on payment reform is mostly geared toward global budget, won't change much about how providers and hospitals are being paid
 - How do we empower communities to be involved? What are the policy solutions that assist with preventing disparities? Why is the focus in primary care when cost drivers are ER?
- How does value get paid for? What is value? Challenging to define in both principal and metric.
 - What does patient want? Some organizations look at that as a means to determine value.

The role of HPC in the next several months

- Thinking about investing, testing model payments. If pie is redistributed, should more be going to primary care?
- Real cost savings, where are they? How can we use that with providers, payers, employers?
 - PCMH – Helping to make community based health part of primary care.
 - Enhanced access does not just mean more PCPs.
 - PCMH is a hub for long term services and support. How do we make this an important incremental step in improving the delivery system, focusing on patient?
 - ACO – Provider led entity within health care system accountable for health of population.
 - ACO certification standards are in the process of being created, releasing for public comment in mid- to late-November.
- CHART Phase 1 – some of the same challenges as PWTF. Opportunity to do community-based investment.
 - Did first round investment quickly – process improvement, cross-training for CHWs, tele-medicine to increase BH access, etc.
 - Hospitals and community partners both have challenges in partnership. There are both opportunities and barriers on both sides. Where do we hold hospitals at risk? Are large community based providers willing to assume risk?
- CHART Phase 2 – second round of investment is live now. \$60M. 85 community partners, 28 hospitals.
 - Seek to partner effectively and reduce costs by:
 - Improving behavioral health for known high-cost patients

- Providing support as they go back out in to the community
- Fewer admissions
- Process improvement through lean, 6 sigma for hospitals, other cost reductions
- Enhanced care coordination and enhanced care transitions
- Super-utilizer work – wrapping services around people who are frequent utilizers
- Building community coalitions—understanding network of resources
- Insurance options
- Other service connections—law enforcement
- Primary care access is sometimes not the problem
 - Do not know who to send them to or who to partner with
 - Hospitals are recognizing that the answer is not hospitalization or PCP
 - Need hospitals to act in different ways. We are a hospital centered state—we want them to be integrators.
- For sustainability, the next step is combining a program like this and PWTF in a way that is patient centered, breaks down the fragmentation, and ensures good quality healthcare
 - What really is the role of employers and all the money there? We are going to continue analytics around this
 - Continue aligning our evaluation work with that of PWTF.
 - Trying to invite conversations that are multi-stakeholders

Discussion

Intersection of ACO certification specifications and PWTF

- *Comment/Question* – There are a number of questions around the intersection of how ACO certification specifications are built and PWTF. Identification of high risk patients, referral to community services, infrastructure. Where should they look for overlap so they can comment?
 - *Comment* – Standards built around partnership with long-term services, public health, other CBOs. What you won't see is to meet these standards, you must do a, b, and c. We could use help defining that. Similar input needed on community benefits, risk stratifying populations (clear evidence, best practices are helpful)
- *Question* – Who would you expect in an ACO?
 - We should not specify. Populations of focus can vary (ex. general population vs. aging population). More orientation towards types of ACOs (who they care for, partners reflecting that).
- *Comment* – Communicating in general has always been difficult for public health, haven't done enough to educate patients. We have high expectations, complicated language. This change creates opportunity, but there is a real disconnect between consumers going towards PPO and then us saying we should limit care options.
 - New framework within the next year or so. MassHealth wants to move quickly so we will keep pace with that. On the investment side, we are also going to have a round of innovation investments to spur partnership, opportunity to shift power differential.

Considerations for sustainability of PWTF

- *Question* –What do we need to think about in PWTF in the next 1.5 year for a sustainable strategy?
 - Tell stories of partnerships, patients. If we assume we don't achieve what we want to, we at least have value in demonstrating that models work. Figure out how to scale them up.

- Work with DPH to figure out how we can all support evaluation. Sustainability with tight timelines is a real concern. We have to bring other metrics on a population level, like economic impact, education, community impact into conversation.
- Be willing to talk differentially about grantees' experiences and externalities that impact success or failure. The things that drive success or failure can be as simple as a whether or not leadership is strong. Don't tie everybody's failure to everybody else. Success does not mean hitting 100% of all metrics, but instead have conversations before there are results to understand threshold for success.
- *Question* – PWTF talks about conditions whereas people in the health care setting are not conditions-focused. Has shifted from condition specific interventions to population centric interventions in recent years. Should we have been thinking about a group of kids in a specific zip code rather than asthma?
 - Change from condition specific intervention to population level health will be a challenge for this evaluation. Are PWTF patients' whole needs being met? Trying to tackle that head on and understanding implications - for payment reform and public health - is important. Some things you are doing with PWTF should just be done by the delivery system, other things that public health should tackle. What does sustainability really mean? Is it the partnerships themselves sustaining? Re-funding of the grant? Looking at specific interventions? This is a very different way of thinking about grants. Can you have different effects by pushing partnerships to have these conversations?
 - Being creative about the global impact of these programs in outcomes measurement, but can't wait to fully have the outcomes to tell the story.
- *Comment* – Goals of PWTF are related to changing health care financing system, but they are not exactly the same. Have to coordinate across these domains. Our goal is not to become experts in this, but to engage and align with you. We can't have completely different systems inside and outside of clinic that don't work together. We need to have feet firmly planted in world of public health.
 - *Comment* –Cost is opportunity to make health care better that can't be missed. But access, quality, community engagement also matter.

Closing

- Next meeting Thursday Dec 10th from 1:00-3:30
- Thank you, Iyah.
- *Jean* – Motion to adjourn. *Seconded*. All approved
- *Jean* –Adjourned meeting at 3:09 PM.

Respectfully submitted,
Elizabeth Moniz