Health Innovation Leadership Network

Quarterly Meeting | July 14, 2017

Summary

The second quarterly Health Innovation Leadership Network meeting (held in-person and via webinar) for 2017 provided an opportunity to review, discuss, and understand how to collectively champion the HILN's action agenda to advance value-based models, equity, and consumer engagement. Members also agreed to a strategy to garner further stakeholder commitments to value at the Healthier Washington Symposium on October 18-19, 2017.

At this meeting, Hannah Cheshier, a project manager for MultiCare Health System, captured the meeting, using words, colors and pictures in real-time, to create a visual record of the discussion. This can be seen on the Healthier Washington website.

Opening Remarks

John Wiesman, Healthier Washington Executive Governance Council

- While we can do a lot together as a leadership network, today's meeting and action toward our commitments will serve as a springboard for the Healthier Washington Symposium on Oct. 18-19 in SeaTac. The purpose of the Symposium is to demonstrate the action we have been taking to advance value, and ask other partners to join us in action. HILN's leadership now and at the Symposium speaks to the importance of our roles as ambassadors and accelerators.
- Reminder to group Healthier Washington embodies our commitment as a state, from the governor on down, to improve the health of our people and our communities. Healthier Washington embraces three key strategies to advance the interrelated three-part aim of better care, lower costs, and healthier populations:
    - Paying for value and outcomes over volume of services
    - Ensuring care focuses on the whole person, with a specific focus on physical and behavioral health integration
    - Recognizing health is local, building healthier communities through regional collaboration
- Healthier Washington has multiple implementation mechanisms to transform payment and delivery of care for the entire population of our state: foundational legislation, a $65 million federal grant we are more than halfway through, and a new-this-year Medicaid Transformation Demonstration to advance our strategies and goals specifically for the Medicaid population.

- We've come a long way as a state, and we have further to go. Deliberate, targeted, and collaborative action by HILN over the coming years will continue to demonstrate that transformative, lasting change requires focused, collaborative engagement of the public and private sectors working together toward mutual goals.
- John Wiesman gave an overview of a new resource, a "Voices" guidebook. To demonstrate how far we have come. HILN has encouraged us to tell stories about how we're collectively advancing a healthier Washington for the people we serve. In the materials packet is a "Voices of a Healthier Washington" Story Bank Guidebook and Talking Points to help you serve as ambassadors for Healthier Washington. The online story bank—which features many organizations represented in the room—was in response from a HILN request to provide stories HILN members could use in speaking engagements.

Bill Robertson, Health Innovation Leadership Network Co-Chair

- Provided level-setting of HILN's commitment to value, value-based goals, and Symposium, to help members better understand where we are going.
- HILN shifted in 2017 to an advanced acceleration role. HILN committed this year to focus in an even more concerted way on spreading and sustaining the Healthier Washington strategies and vision. A key lever in sustaining and spreading successes will be ongoing HILN leadership committed to value.
- Specifically, HILN supports an action agenda to achieve Healthier Washington goal of 80 percent value-based payment in state-financed contracts by 2019 (30 percent by the conclusion of 2017), and 50 percent value-based payment in the commercial market by 2019. This aligns with the national framework for value-based payment.
- While the measureable outcomes are oriented toward payment, HILN members have a role to play in achieving value—whether it be through measurement, public health levers, changes to clinical delivery, collaboration with social health sectors, person and family engagement, application of an equity lens, and more.
- When this year concludes, HILN members will point to a specific action to advance value in Washington State. Additionally, in October, Healthier Washington will convene hundreds of partners at the HILN-led symposium and ask them to commit to specific actions.

Lou McDermott, Acting Director of HCA

- Former HCA PEBB Director, now serving as Acting Director of HCA. HCA is committed to VBP, and advancing value and value-based purchasing through the "state as a first mover" concept. Recognize importance of partnership across the public and private sectors and HILN commitment to this leadership forum.

Advancing the HILN Action Agenda

Laura Zaichkin, Healthier Washington Deputy Coordinator

- Meeting transitioned into dialogue-based session, graphically recorded by Hannah, with examples of select commitments (e.g., Communities & Equity Accelerator Committee) to frame each of the three agenda items:
    - Adopt/spread VBP
    - Equity
    - Consumer engagement/literacy
- HILN is a forum and members were invited to speak up, discuss some key questions:
    - What do we need to do to get this done?
    - What's in our way?
    - Goals of discussion:
        - Offer, request, and partner in the advancement of the HILN action agenda
        - Understand the commitments and how they reinforce one another
        - Illustrate how the actions and agendas fit together to advance value
        - Learn something new about what's happening in the field
        - Identify partnerships for action—particularly uncommon partnerships
        - Identify who/what else we need to advance our value-based aim
- Adopt/spread VBP discussion
    - *WA Health Alliance*: partnering with HCA to advance VBP. Will purchasers insert common measure set into contracts? Work with Business Roundtable. Challenge within that organization (policy-driven), but hope to make progress. Purchaser Affinity Group: one-on-one meetings with purchasers. Having conversations with purchasers. Regence, Aetna, Cigna, United HC, Kaiser. Dialogue is happening. Actively seeking two speaking engagements a month to expand visibility of VBP. Established important partnership with brokers, focusing on VBP. Purchasers want to look at cost data (total cost of care standpoint). Alliance's database now has price information. Payers: need to create plans with value-design. Providers: need to take the leap from fee-for-service to value-based. Barriers: lack of understanding that health care variation exists. Higher costs are not correlated to higher quality. Need more transparency in cost and quality.
    - "Flipping the whole thing" – purchasers have to become altruistic. Yet the goal of any MCO is to make money. Struggle with how to flip the mission. Also struggle with hospitals – organizational survival is paramount in any entity. 61 hospitals have closed and more anticipated. How to manage or adjust those systems currently in place to suddenly become altruistic. When you change the expectation or economic incentives, most organizations involved in health care are mission-oriented, their job is to operate to their mission. They will adjust (see Maryland). When your incentives change, your behavior changes. When you switch economic incentives, organizations adjust. Optimistic for human capacity to adjust.
    - Another perspective – labor. From labor perspective, hospital closings may be right-sizing. Second may be that hospitals are like dinosaurs, resistant to change for many years. Didn't work together to adjust to new economics. Labor needs place at the table, not just C-suite. VBP – albatross around the neck are high-

deductible health plans. Conflict with moving toward VBP to have high-deductible health plans.

- Opportunity with Healthier Washington by focusing on value as patient experience, outcomes, and cost. Free ourselves from profitability and focus on outcomes and paying for outcomes; providers can take a leadership position to go to payers. Cooperation to become an Accountable Care Organization. Stop having conversations about protecting own interests. Take larger view to protect citizens. Also need to consider appropriateness of care – work of Bree Collaborative. Leadership and culture change, what are the mechanisms – incentives, policy, or otherwise – to get us there.
- Social determinants – need to deal with these to reduce cost of care – current system not set up to deal with this. Allow plans to do agency credentialing of peers. Allow CPT management of peer counselors to help people address the social determinants of care. Making that change to commercial plans will provide continuity for purchasers or providers at no cost.
- Four years in to an investment of staff making connections between housing and health. Housing organizations can play a big role and have resources to bring.
- Accelerate the use of data – especially around social determinants – housing, child care, nutrition, exercise, etc. Use data to drive decision-making around where the value sits population by population. Any organization that's turning data into analytics? Resources required to drive data and analytics are few and far between. E-science, DSHS, HCA. But complicated and not inexpensive exercise.
- Cambia Grove is exploring building this type of data sandbox. Pathway = using data in meaningful ways. Pick up population heath aspects as well as quality measures.
- Prior to making big shifts need to look at what's currently in the system. Two requirements from HCA = barrier. Requirement that all Medicaid enrollees have to be seen at least once a year. Shouldn't force us to do that. Another: MCOs are required to do managed care contracts but won't pass on savings to us. As a provider, once we succeed in managed care, then we have a margin that supports things that aren't reimbursed and are badly needed to do social determinants. EHRs are Wild West. Making it difficult to have inter-operability.
- Providence/Swedish: Data – over 400 for ambulatory and 380 for inpatient. Inventoried all measures. Lack of interrelation among all the requirements and who's requiring them. Are the common measures heavy hitters? Do they touch MACRA? Do they touch MIPS?
- *Ann Christian - WA Council for Behavioral Health:* Serve primarily low-income and Medicaid population. Goal of 80 percent VBP 2018 and 90 percent by 2021. How to support practitioners on the ground:
  Learning community focused on behavioral health industry. Operate between clinical and social determinants.
    - VBP/Practice Transformation Academy under the PT Support Hub
    - Customized curriculum to WA and Demonstration, Common Measure Set and ACH transformation projects

- Working with community-based behavioral health agencies. on fast track to start in September
- VBP guidebook for behavioral health settings

- Equity Discussion
  - *Winfried Danke* – accelerator committee on health equity. Settled on areas:
    - Data – disaggregate data
    - Voices of those into our decision making world who are most affected by disparities
    - Have a workforce that mirrors real-world demographics and who we serve
    - Connect health equity to financing. Can't talk about VBP without talking about health disparities.

    How to come up with common measures? How do you stratify your populations? Can we have a conversation about that and come to an agreement about how we measure it? Develop partnership where we could test a set of core metrics? Scale up to better handle the picture of health inequalities. How do we all make sure to bring in the voices of those who experience health disparities?
  - How to measure institutional racism? How is that perpetuated in the workplace re: job opportunities, moving up career ladder? Hope to have those data sets that we hope will speak to this.
  - Underscore data and importance of acquiring data on populations served. Kaiser – example and possible mentorship. It's been 10 or 15 year journey. Rate of joint replacements in black population is lower than white population. SDM – people engaged in SDM had higher rate of getting joint replacement. One way (small piece) is to incorporate SDM strategies at point of care.
  - Tribes, migrant health workers - let's be able to drill down data by geography.
  - EMS System: when nurses are not present, EMS calls go up.
  - Hotspotting – identify highest cyclers through system. Data-driven.
  - What if we identified the top need (not cost) and targeted assistance toward those?
  - Don't need same intervention for everyone. Risk stratify and need stratify.
  - Health/wellness consultancy industry. This has been internalized so it's not top-down driven. Health champions in the workplace who earn points toward a premium discount. Reduced smoking from 10% to 5%. Chronic disease mgmt. program has more than doubled. Will have by end of 2017 to measure hypertension to the previous year. Medical cost inflation at 3%.
  - Hospitals, law enforcement, etc. all have data. Fund a data person. Met with silos and get permission to aggregate the data to identify the frequent fliers. Work with them to drive down the cost of care.
- Consumer Engagement/Literacy Discussion

Next Steps

- Members listened to Hannah explain her visual capture of the meeting's discussions.
- Reminder that HILN plays a leadership role at the Symposium. Please plan on attending at least Oct. 19 (the second day), with encouragement for purchasers, plans and providers to attend the first day (Oct. 18) as well.

- HILN's next is scheduled for January 19 at Cambia Grove, to celebrate our accomplishments and identify next steps.