

STATE OF WEST VIRGINIA

Mountain Health Choices

Presented by Martha Yeager Walker

Joe Manchin III, Governor July 2006



West Virginia Department of Health and Human Resources

Goals of West Virginia Medicaid Redesign

- Streamline administration
- Tailor benefits to population needs
- Coordinate care, especially for members with chronic conditions
- Provide members with the opportunity and incentives to maintain and improve their health

Key Components of Redesign

- 🚀 Prevention
- 🚀 Personal Responsibility
- 🚀 Care Management
- 🚀 Establishment of a Medical Home
- 🚀 Electronic Health Records

Member Agreements

- ✦ **Outlines member rights and responsibilities.**
- ✦ **An educational tool.**

Implementation

- 🚀 4 year implementation plan.
- 🚀 Starting small to build on successes.
- 🚀 Children and adults with children first target population.

Mountain Health Choices

The West Virginia Health Improvement Initiative
for Medicaid Members

Dr. Sarah Chouinard, MD

Chief Medical Advisor of the Community Health
Network of WV (CHN WV) & Medical Director
for Primary Care Systems, Inc.

7/11/06

“Every system is perfectly designed to achieve the results it achieves”

*Don Berwick, MD Co-author,
IOM's Crossing the Quality Chasm*

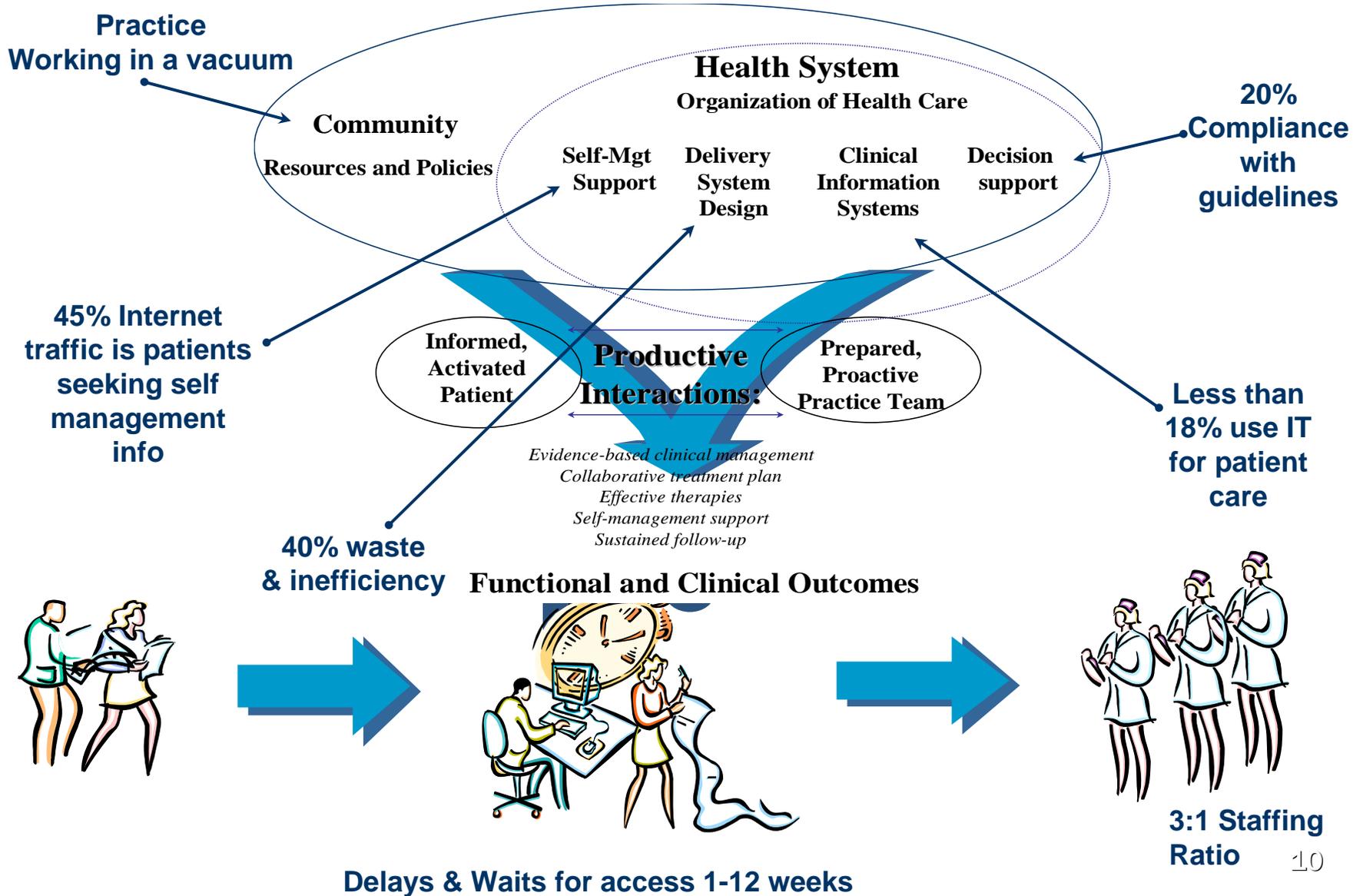
Population Forces Driving Change

- 📌 85% of Medicaid patients have or are at-risk for a chronic condition
- 📌 70% prevalence rate of overweight or obese
- 📌 70% are sedentary
- 📌 Located in rural, geographically and economically isolated areas
- 📌 Fatalistic approach to health status
- 📌 Patients do not access care unless ill

Health Care System Forces Driving Change

- 🚧 Rising costs, rising numbers of uninsured, limited resources.
- 🚧 Misperception of “Disease Management” as a silver bullet. There are some gains, but continued fragmentation.
- 🚧 Ill-defined Medical Home. A house is not a home—the medical home concept as a routine place to receive care alone is not enough

THE PREVALENT SYSTEM OF CARE DELIVERY



Results

- 🚩 Fragmented system
- 🚩 Patients feeling powerless
- 🚩 Reactive care model
- 🚩 Poor outcomes— less than 55% adherence to evidence based clinical guidelines
- 🚩 Frustration throughout the system
- 🚩 Providers and policymakers wrestling rather than collaborating
- 🚩 Costs keep going up

“No. 1 dissatisfaction of primary care physicians is the time pressure...We can’t talk faster, and patients can’t learn faster.” –Fred Kelsey, MD

Alignment of Interests: A Natural Collaboration

STATE'S AIMS

- Contain costs/growth
- Improve outcomes
- Establish a advanced medical home for each beneficiary
- Promote prevention and adoption of evidence –based care
- Imbed care management practices in the system
- Personal accountability for
 - all beneficiaries
- Incentives to influence behaviors

HEALTH CENTERS' AIMS

- Optimize resources to serve > #
- Improve outcomes
- Create an Advanced Medical Home
- Establish best practices
- Coordinate care seamlessly
- Empower and self-activate patients through Planned Care
- Self-activation breeds success

The Advanced Medical Home

“The advanced medical home acknowledges that the best quality care is provided not in episodic, illness-oriented, complaint-based care—but through patient-centered, physician-guided, cost-efficient, longitudinal care that encompasses and values both the art and science of medicine.”

–The American College of Physicians

TransforMed

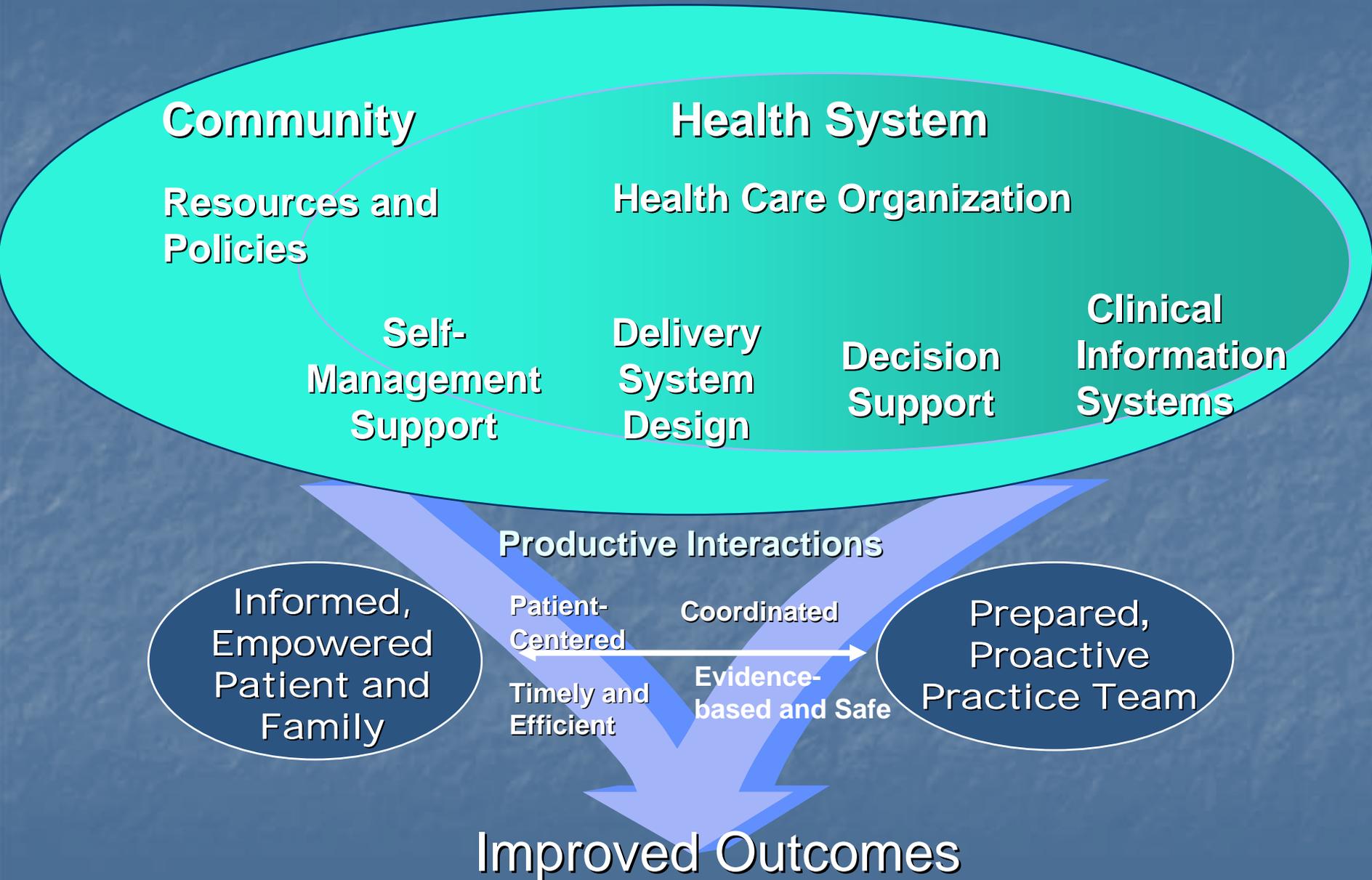
“A team approach to care is proposed in this new model, utilizing advanced information systems (including a standardized electronic health record); redesigned, more functional offices, and a whole-person orientation that focuses on quality, safety and care provided in a community context.”

–American Academy of Family Practice

What are we doing that is different?

- 👉 Care is delivered by a *team (4:1)*
- 👉 Patient-centered (e.g. open access schedule, self management)
- 👉 Integrated behavioral health
- 👉 Shared care plan (patient responsibility)
- 👉 Continuity of preventive and wellness care
- 👉 EHR supports the Care Model for monitoring and feedback
- 👉 Community Context
- 👉 Portability of information...*semi-smart* cards

Care Model



Patient Health Management Plan...

A Shared Care Plan

- “Year-at-a-glance”
- Each patient receives a unique personal care plan
- Patients are held accountable for its content.
- Care plans aim to educate, structure, and coordinate care throughout the practice

EHR Infrastructure and Reporting

- 📌 Common clinical outcomes reporting system
- 📌 Common clinical information system
- 📌 Predictive Modeling and claims-based analytics
- 📌 Provider performance monitoring and feedback
- 📌 Shared care plan development

A *clinician-centric* EHR is...

- ✿ An integrated patient health record *for provider use*
- ✿ Traditional goal of HIT is to e- display what you already should know in a more usable format
 - Health Summary
 - Reminders
 - Lab and Reference Lab Interface data
 - Immunizations and State Immunization Sharing data
 - Pharmacy
 - Allergies

A population and patient-centered EHR is...

- ✪ Software views/applications that allow for ‘on the fly’ extraction data for analysis, evaluation, and improved performance
- ✪ More powerful than chart auditing
- ✪ Includes population and public health measures
- ✪ Can be used for P4P
- ✪ One example: IHS Clinical Reporting System

MedLynks...our EHR

- 📌 This entire program is not possible without an electronic health record (beyond an e-chart)
- 📌 Our EHR leverages the work that Indian Health Services has done with their system, RPMS, which is based on a VistA platform, with support from Medsphere System Corporation
- 📌 Our network of CHCs is using and adapting that software for our practice setting

MedLynks (or *any* EHR) Disclaimer

- 🔑 Software is **not** a solution
- 🔑 Software is **only** a *tool* to assist clinicians (and their facility) in better serving their patients
- 🔑 Software can **help** clinicians (and patients) identify problems
 - with clinical documentation process
 - with clinical care and quality measures
 - with populations/communities

Reimbursement to support the Advanced Medical Home/Chronic Care Model

- 👉 The current system largely does not provide the support for adoption of the proposed model. It instead pays for volume-based, episodic, fee-for-service care...not outcomes.
- 👉 Reimbursement needs to be realigned to support the Advanced Medical Home Model including: use of HIT for QI enhanced communications (email, telephone); telemedicine; and P4P reporting

A Community-wide Effort

- 🏠 Pedometers in the schools
- 🏠 Weight management classes on site
- 🏠 Happy Birthday Letters
- 🏠 Static Education Mailings
- 🏠 Collaboration with the local Health Dept.
- 🏠 Lay education with “model patients”

Summary

- 📌 **Community focused**
- 📌 **Patient centered**
- 📌 **Continuity of Care (not episodic)**
- 📌 **Integrated EHR**
- 📌 **Partnership of patients, clinicians, and state agencies**
- 📌 **Realignment of reimbursement to create incentives**

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