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KHPA Provider Advisory Council Meeting
July 31, 2007, LSOB, Topeka KS
Minutes - Final

KHPA Provider Advisory Council Members Present:

- Janet Williams, Chair
- Susan Bumstead
- Tony Wellever (designee for Karla Finnell)
- Dr. Kevin Hoppock – via teleconference
- David Johnson
- Terry Lambert
- William Mahoney
- Dr. Richard Meidinger
- Randy Peterson
- Elaine Schwartz
- Peter Stern
- Linda Wright

KHPA Provider Advisory Council Members Unable to Attend:

- Brandon Smith Ziph (designee for Kara Bell Fiske)
- Dr. K. Allen A. Greiner
- Dr. Bert Oettmeier

KHPA Board Members Present:

- Connie Hubbell, KHPA Board Chair

KHPA Staff Participants:

- Dr. Barbara Langner, Consultant
- Dr. Andrew Allison, Deputy Director
- Janis DeBoer, Advisory Council Manager

Welcome by Janet Williams, Provider Advisory Council Chair

Chair Williams opened the meeting, welcomed members, the public, and KHPA staff. The agenda was reviewed along with handouts (packet information provided to Advisory Council members is available on the KHPA Advisory Council website). Again this month, the objective of the meeting was to facilitate discussion on health reform policy questions with an emphasis on paying for prevention and primary care and promoting personal responsibility.

"Rising Health Care Costs, Prevention & Primary Care, and Personal Responsibility" – Presented by Dr. Barbara Langner, Consultant

Dr. Langner's presentation focused on the rising costs of health care in the United States and factors that impact our overall health. Dr. Langner recently attended a conference where Dr. Fienberg, President of the Institute of Medicine, presented the IOM's top ten concerns regarding the US health system and stated that "30 to 40% of every dollar spent in the US on health care is spent on overuse, underuse, misuse, duplication, etc." Data from a 1975 study indicate four factors influence our health: medical care; genetic make-up; the environment; and how we live (behavior) which explains 51% of our health outcomes (a member of the Purchaser Council noted that more recent research indicates the percentage of health outcomes related to behavior has increased to 60-70%).

Kansas specific data was presented as it relates to health behavior and chronic disease. In 2003, 60.5% of Kansans were overweight or obese and childhood obesity has increased 36% in the past 20 years in Kansas. Smoking among adults has remained relatively unchanged from 1992-2003 (although youth rates have declined in the recent past). The prevalence of risk factors for coronary artery disease and stroke in Kansas has also increased.

Recommendations from national research institutes were included in the presentation. Dr. Langner noted that the Commonwealth Fund State Scorecard on Health System Performance, 2007, ranks Kansas in the second quartile and we should be proud of that ranking, however, we can do better.

Open Discussion of Policy Questions – Facilitated by Chair Williams:
Chair WIlliams led the discussion on the twelve policy questions as follows:

Prevention and Primary Care – Healthy Lifestyles:

1) **What barriers exist that prevent Kansans from having healthy lifestyles?**

Comments/Input/Feedback from members:

- There is no penalty for having unhealthy lifestyles; our pocketbooks are not negatively impacted.
- Conversely, there is no immediate payoff/reward for healthy lifestyles.
- Income levels impact lifestyle choices; it can be expensive to eat healthier.
- Schools teach healthy behaviors, however, they also contract with vending machine vendors.
- We have created a system of working long hours and "grabbing a bite to eat."
- Communities are not designed to support walking; more walking trails are needed.
- There is a knowledge gap; research results can send confusing message with regard to healthy behaviors

Summary: The general consensus of the Provider Advisory Council members was to acknowledge that the challenges of having healthy lifestyles for Kansans exist at all levels of age, education and income.

Prevention and Primary Care - Interventions:

2) **Do you have examples of interventions in your organization that have improved health behaviors?**

Comments/Input/Feedback from members:

- Employer pays for a health evaluation for employees; this practice has driven patients into physician's offices when they otherwise may not have been seen; this practice promotes a medical home model.
- Provided case managers for one year to employees with high risk behaviors; realized dramatic health improvements.
- Implemented health fairs for employees with screenings available; employee assistance program includes mental health and medical well-being; very successful; now market the program to outside businesses.
- Partnered with public health to teach and educate older adults on how to prepare healthier meals.
- Implemented an incentive at the workplace to walk twice a day, during the work day.
- Provided decals to promote Healthy Kansas; education is the key.
- Provided bathroom scales to individuals in the community through chronic disease management

program.
- Have built a coalition with businesses to promote smoke-free environments.

Summary: The general consensus of the Provider Advisory Council members was interventions can be effective in improving health behaviors, based on successful experiences previously and currently implemented.

Prevention and Primary Care – Health Benefit Designs to Incentivize and Reward Health:

3) **What changes might be included in health benefit designs to incentivize and reward health? (The question was modified to replace "should" with "might.")**

Comments/Input/Feedback from members:

- Change how the dollar is spent; providers should be getting paid for health outcomes.
- Move to a pay for performance system for physicians.
- There needs to be a more generous payment system for prevention and case management.
- Should changes incentivize the system or incentivize individuals? More education is needed to incentivize individuals.
- Consumer-driven health plans could make a difference, but still leery of such an approach.
- Put incentives in health literacy.
- There is a disconnect between hospital and physician payment systems; if the two could work together both systems may see improvements/changes.
- There is also a disconnect between hospitals and home health agencies; case management incentives in health benefit designs could assist.
- More education and collaboration is necessary to realize changes; collaboration between the Department of Health and Department of Education could impact changes for school children.
- Build in changes that support pharmacy management; go back to what pharmacists were taught with regard to managing and optimizing pharmacy management.
- Make changes that help "connect" the current systems and if the hard decisions result in a loss of providers maybe that would be healthier for all; find ways to distribute the dollars better.
- Family care physicians are the lowest paid physicians; specialists are higher paid; change the system to increase reimbursement for preventative care.
- Changing individual behaviors is a complex issue; can health benefit plans have a prerequisite that people must embrace healthy lifestyles in order to enroll?

Summary: The general consensus of the Provider Advisory Council members was recognition that changes to be included in health benefit designs to incentivize and reward health need to address both the current health care delivery system and individual behavior.

Prevention and Primary Care – Decrease Obesity and Tobacco Use:

4) **What policies should Kansas adopt to decrease obesity?**
5) **What policies should Kansas adopt to decrease tobacco use?**

Comments/Input/Feedback from members:

- Policies that support more access to services as opposed to incentives and penalties in a health benefit plan may be a better approach; access to case managers who can assist individuals in coordinating their care may be one way to keep costs down.
- Target children in schools; do we need to require physical education in our schools again?
- Target children; teach nutrition early.
- Tax the heck out of tobacco.
- Support premium differentials in the health plans; design policies with more carrots than sticks.

Summary: The general consensus of the Provider Advisory Council members was support for policies that target children specific to obesity and tobacco use, and consider reinstituting the use of premium differentials

in health plans as policies are developed to decrease obesity and tobacco use overall.

Prevention and Primary Care – Health Benefit Designs to Manage Chronic Disease:

6) **What changes might be included in health plan benefit designs to better manage chronic disease?**

Comments/Inputs/Feedback from members:

- Case management and disease management need to be included in health benefit plans.
- Evidence-based practices need to be covered under health benefit plans.
- Medication therapy management needs to be covered; medication management should also be covered.
- Health Screen Assessments should be mandatory; allows individuals to be followed across the systems.

Summary: The general consensus of the Provider Advisory Council was recognition that to better manage chronic diseases, health plan benefit designs should include health screen assessments, evidence-based practices, case management, disease management, and medication management options.

Prevention and Primary Care – Patient-Centered Medical Home:

7) **What barriers exist that prevent Kansans from having a medical home?**
8) **What changes might be included in health plan benefit designs to drive the delivery of care to a patient-centered medical home?**

Comments/Input/Feedback from members:

- Reimbursement system changes could be made to drive the delivery of care to a medical home model.
- Not enough physicians; need to look at broad-based services.
- Create regionalized centers of excellence; need to be able to get to providers.
- Scope of practice should not impede access to services.
- (Note: there was a request by the group to define a medical home. In response to this request, a July 20, 2007 article titled "Medical Homes Could Improve Care to All," written by Karen Davis and Stever Schoenbaum will be emailed to members. The article defines a medical home as "A medical home is not a building, house or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective."

Summary: The general consensus of the Purchaser Advisory Council members was acknowledgement of the benefits of a medical home and how changes might be included in health benefit plan designs to drive the delivery of care to a patient-centered medical home.

Prevention and Primary Care – Prevention Effort Priorities:

9) **Given the state's limited resources, what prevention efforts should the state focus on first?**

Comments/Input/Feedback from members:

- Focus on children.
- Focus on chronic disease management.

Summary: The general consensus of the Provider Advisory Council members was to focus prevention efforts on children and chronic disease management, given the state's limited resources.

Personal Responsibility:

10) **What policies should Kansas adopt to encourage Kansans to embrace healthy behaviors?**
11) **What policies should Kansas adopt to encourage the use of cost-effective health care services?**
12) **What policies should Kansas adopt to promote contributions to the cost of health insurance, based on ability to pay?**

Comments/Input/Feedback from members:

- Partner with schools/education to adopt policies that encourage Kansans to embrace healthy behaviors.
- The media is powerful tool; develop healthy behavior campaigns.
- Policies need to be culturally sensitive in order to encourage Kansans to embrace healthy behaviors.
- Target the behaviors that are most costly.
- Adopt policies that support healthy schools/ healthy workplaces.
- The buying power of health care services is in the hands of patients.
- Health care services extend beyond a 9:00 – 5:00 world; emergency room utilization reflects this reality.
- The expansion of clinic hours to 9:00 pm resulted in reduction of emergency room utilization.
- Design policies that incentivize new doctors to support extended hours.
- Sliding scale fees should be incorporated into the cost of health insurance; everyone should pay something.

Summary: The questions regarding personal responsibility triggered responses from the Provider Council that support healthy schools and healthy workplaces; encouraging the use of cost-effective health care services by putting the buying power of health care services into the hands of individuals, recognizing the need for health care services to extend beyond 9:00 – 5:00, and promoting contributions to the cost of health insurance based on one's ability to pay.

The group was reminded of the agenda for the August meeting which is to review the summary statements for each of the policy questions presented from the June and July meetings. The summary statements, once consensus is reached, will be reflected in the interim report presented to the Kansas Health Policy Authority Board on August 20 by the Council Chairs.

Dates of the remaining Purchaser Advisory Council meetings are as follows: August 8, and September 5.

Next Steps

- The Advisory Council grid will be used to prioritize the issues that the council will consider for health reform, focusing first on health insurance reform options, as identified by SB 11 (June meeting).
- Other health reform options, such as those developed in collaboration with other agencies, will be considered subsequent to the health insurance reforms (July meeting).
- Advisory councils will begin to "fill in the grid," identifying the advantages and disadvantages of various health reform options (August meeting).
- The KHPA Board and Health for All Kansans Steering Committee will then use the grid to inform their development of health reform options (August meetings).
- The development of health reform options will be iterative, in that the Board and Health for All Kansans steering committee will direct/provide feedback to the Advisory Councils as they consider reform options (September meetings).
- Independent consultants and KHPA staff will analyze various reform options in order to identify the economic costs (to consumers, to business, to state government, to federal government) as well as to identify the number of individuals who will get access to health care under each reform option (September meeting).
- The Joint Oversight Committee for the KHPA will be apprised/consulted on health reform options (September meeting).
- The KHPA Board will present the final health reform options to the legislature (KHPA Oversight Committee and legislative leadership) and Governor on November 1 2007.

Adjournment

Next Meeting: Wednesday, August 15, 1:30 – 3:30 at the LSOB, 9th & Jackson, 1st floor, #106 conference room.