The Ohio MEDTAPP Summit:
Transforming Healthcare through State-University Partnerships

September 23, 2014
8:00 am–4:35 pm
The Blackwell Hotel and Conference Center
Columbus, Ohio
#OHMedtapp
Welcome

Mina Chang, PhD, Chief
Health Research & Program Development
Ohio Department of Medicaid
Opening Remarks

Mary Applegate, MD
Medical Director
Ohio Department of Medicaid
Presentation Outline

• Purpose and Research Areas
• Partners and Benefits
• Results
  o Quality Improvement to Advance Care Delivery
    ▪ Behavioral Health
    ▪ Maternal and Infant Health
  o Interdisciplinary Patient Centered Team Models of Care
  o Using Data to Identify and Improve Care Delivery for Ohio’s Medicaid Population
• Future Direction
MEDTAPP Purpose

• The Medicaid Technical Assistance and Policy Program (MEDTAPP) is a Medicaid state-university research partnership dedicated to supporting the efficient and effective administration of Ohio’s Medicaid Program
MEDTAPP Policy and Research Areas

- Health services program evaluation and research
- Healthcare quality improvement and patient safety
- Healthcare and human services workforce development
- Policy and data analysis
- Rapid clinical consultation and technical assistance
- Ohio Medicaid Quality Strategy areas
- Other projects per Ohio Medicaid’s request
MEDTAPP Overview

- Upon the Ohio Department of Medicaid’s (ODM) request, Ohio’s colleges and universities provide technical assistance to achieve ODM’s strategic objectives, including:
  - Data Analytics
  - Quality improvement research and technical assistance
  - Medicaid-focused health and healthcare improvement initiatives
MEDTAPP Initiatives

- MEDTAPP initiatives and projects may:
  - Involve university programs already in progress, and/or existing faculty expertise
  - Enable the use of federal Medicaid administrative funds
  - Leverage health and human services agencies’ support
  - Engage support from state and national experts, healthcare providers, and advocates

- The Ohio Colleges of Medicine Government Resource Center (GRC) assists ODM in MEDTAPP administration
MEDTAPP State Agency Partners

- Ohio Department of Medicaid
- Ohio Governor’s Office of Health Transformation
- Ohio Department of Aging
- Ohio Department of Mental Health and Addiction Services
- Ohio Department of Health
- Ohio Department of Developmental Disabilities
- Ohio Department of Job and Family Services
- Ohio Board of Regents
MEDTAPP College of Medicine Partners

- Northeast Ohio Medical University
- University of Cincinnati College of Medicine
- Wright State University Boonshoft School of Medicine
- Case Western Reserve University School of Medicine
- The Ohio State University College of Medicine
- Ohio University Heritage College of Osteopathic Medicine
- University of Toledo College of Medicine and Life Sciences
MEDTAPP State-University Partnership Benefits

• Increasing the state’s health services and research capabilities for:
  • Policy and data analysis
  • Program planning and design
  • Cost savings/cost avoidance
  • Improved use of technology

• Improving care for Ohio’s vulnerable populations, including:
  • Effective and efficient service
  • Use of evidence-based quality improvement science
  • Attracting, training and retaining a healthcare workforce
  • Consumer Empowerment
MEDTAPP Project Accomplishments
MEDTAPP
Quality Improvement
Outcomes and Results
Behavioral Health Quality Improvement

**Goal:**
- Advance standard of care for children with social-emotional and behavioral issues

**Focus:**
- Integrating family-centered mental health services, anticipatory guidance, and related interventions in pediatric and family practice settings
- Implementing standards and guidelines for safe and effective prescribing of psychotropic medications

**Outcomes:**
- Increased anticipatory guidance to caregivers regarding their children’s social-emotional development from less than 20% to nearly 85% during the first 8 months
- Built resilience to withstand trauma
- 18% improvement in prescribing of psychotropic medications soon after Ohio Minds Matter launch. Aim of 25% reduction in use of atypical antipsychotics among preschoolers and polypharmacy
MEDTAPP Maternal Opiate Medical Support (MOMS)

Purpose:
• Improve maternal and fetal outcomes, family stability, and reduce costs of Neonatal Abstinence Syndrome (NAS) due to opiate abuse during pregnancy

Focus:
• Design and test a maternal care home model to integrate addiction treatment and behavioral health services with traditional prenatal care and extending postpartum care

Expected Outcomes:
• Reduce the length of stay of the opiate addicted babies in Neonatal Intensive Care Units (NICUs) by 30%
• Reduce neonatal care costs
Maternal and Infant Health
Quality Improvement

Goal:
• Advance standard of care for high risk pregnancy among hard to reach Medicaid populations and reduce infant morbidity and mortality

Focus:
• Determine efficiency and effectiveness of two maternity care intervention models, Centering Group Care (CGC) and Maternity Care Homes (MCH), in addressing complex behavioral and physical health needs
• Decrease scheduled deliveries between 36 and 38 weeks gestation without medical indication

Outcomes:
• Reduced non-medically indicated scheduled births prior to 39 weeks gestation across the state of Ohio to 5%!!
• Aim to reduce Ohio Medicaid preterm births and adverse outcomes, and improve racial, ethnic and regional disparities in birth outcomes
Purpose:
• Determine efficiency and effectiveness of two maternity care intervention models, Centering Group Care (CGC) and Maternity Care Homes (MCH), in addressing complex behavioral and physical health needs during pregnancy

Project Aims:
• Reduce Ohio Medicaid preterm birth and adverse outcomes
• Improve racial, ethnic, and regional disparities in birth outcomes

Focus:
• Early identification and outreach intervention for high-risk pregnancy among hard to reach Medicaid populations
• Examine the viability, cost effectiveness, and lessons learned
• Develop strategies to scale the tested changes statewide
Ohio Perinatal Quality Collaborative (OPQC)

- OPQC is a statewide, multi-stakeholder network dedicated to improving perinatal health in the state of Ohio.

- Partners include the Ohio Department of Medicaid, Ohio Department of Health, Ohio’s 6 Regional Perinatal Centers, The Ohio AAP, Ohio ACOG, March of Dimes, OCPIM, OBBO, and the Government Resource Center (GRC).
Ongoing OPQC Projects

Obstetrical:
• 39 Weeks
  o Build on existing efforts to decrease scheduled deliveries between 36 and 38 weeks gestation without medical indication

• Antenatal Corticosteroids (ANCS)
  o Reduce perinatal morbidity and mortality by ensuring over 90 percent of infants born between weeks 24 and 34 receive ANCS

Neonatology:
• Decreasing Blood Stream Infection (BSI)
  o The Catheter Care Maintenance Bundle project engaged 24 NICU teams to decrease late onset bloodstream infections in premature infants between 22 and 29 weeks gestation

• Human Milk
  o 23 NICUs to ensure that preterm infants receive human milk to reduce late onset bloodstream infections.
Reducing non-medically indicated scheduled deliveries prior to 39 weeks gestation from 16.68% in 2008 to less than 5% in 2013
Ensuring more than 95% of infants receive 100ml/kg/day of human milk in level 2 and 3 NICUs, avoiding an estimated 24 cases of Necrotizing Enterocolitis (NEC), saving to 12 lives
Reducing the risk of having a bloodstream infection from 1 in 5 in 2009 to 1 in 12 in 2013
Progesterone

Purpose:
• A statewide quality improvement project to reduce Ohio preterm births before 37, (35), and 32 weeks’ gestation by identifying and treating pregnant women eligible for progesterone supplementation

Global Aim:
• To reduce infant mortality in Ohio by reducing preterm birth

SMART Aim:
• By July 1, 2016, decrease the Rate of Preterm Birth before 37 Weeks’ and before 32 weeks’ by 10%
Percent of Deliveries for Women with Qualifying Diagnoses that Used 17P, Linear Trend By Perinatal Region and Month of Delivery, Ohio Medicaid
Neonatal Abstinence Syndrome (NAS)

**Purpose:**
- An 18-month quality improvement initiative to increase the identification of and evidence-informed treatment for Medicaid infants born with Neonatal Abstinence Syndrome (NAS) and reduce their length of stay by 20%

**Focus:**
- Engage 24 Level 2 and 3 Neonatal Intensive Care Units (NICUs) and extend educational offerings to Level 1 maternity hospitals across Ohio

**Expected Outcomes:**
- Improve treatment for infants with NAS and reduce the length of NICU stay for these infants by 20% by June 30, 2015
MEDTAPP
Interdisciplinary Patient Centered Team Models
Outcomes and Results
• **Purpose:**
  • Attracting, training, and retaining healthcare providers to serve Ohio’s Medicaid population

• **Focus:**
  • 20+ interdisciplinary curriculum, training, and placement models to serve Ohio’s Medicaid population, including:
    - Development of an Advanced Practice Nurse online Behavioral Health Training and Certification Program
    - Creation of a Dental fellows training program that provides specialty training to serve children with Developmental Disabilities
    - Establishment of a multi-disciplinary student and residency placement site program that trains future primary care providers to serve vulnerable populations within a Patient-Centered Medical Home (PCMH) model
• **Results:**
  o **1,500** current and future healthcare providers committed to serving Ohio’s Medicaid population, including:
    - Child and Adolescent Psychiatrists
    - Community Psychiatrists
    - Pediatricians
    - Primary Care Providers
    - Advanced Practice Nurses
    - Social Workers
    - Community Health Workers
    - Dieticians
    - Physical Therapists
    - Dentists
    - Other Health and Rehabilitation Sciences Service Providers

• To overcome health disparities, participating MEDTAPP Healthcare Access Initiative students, residents, fellows, and MEDTAPP scholars are recruited from the communities in which they serve, including both rural and inner city communities
MEDTAPP
Using Data to Identify and Improve Care for Ohio Medicaid’s Vulnerable Populations

Outcomes and Results
Building Data Analytics Infrastructure and Capacity

**Purpose:**
Extending capacity to use Medicaid data to measure the impact of policy initiatives and quality improvement efforts for the Ohio Medicaid program.
MEDTAPP Data Analytics

Focus:

• Provide necessary data to measure the impact of health care reform over time, especially for Ohio’s Medicaid and Medicaid-eligible population

• Design analytic tools for identifying gaps in health service needs, targeting strategies to increase health service capacity, and for monitoring the health status and health risks of Ohio’s Medicaid population
Examining the Impact of Ohio’s Medicaid Expansion-Health Improvements for Ohio’s Women and Children

• Research Question 1. Are women with a Medicaid delivery post- vs. pre-ACA more likely to enter prenatal care at an earlier gestational age (during the 1st trimester) and to receive (timely) evidence-based prenatal care?

• Research Question 2. For pregnant women with chronic conditions, are those covered by Medicaid more likely to utilize indicated primary and preventive care post- vs. pre-ACA? Did the 2010 ACA provision regarding coverage of smoking cessation services, including counseling, without co-pay increase use of these services?

• Research Question 3. Are women of reproductive age with income at or below 138% FPL more likely to receive preventive health services, screening and advice regarding health risk behaviors (e.g., smoking, diet, exercise) post- vs. pre-ACA? Subset to those with chronic medical conditions, including diabetes and hypertension?

• Research Question 4. Are women with a Medicaid delivery post- vs. pre-ACA more likely to receive Tier I or LARC contraceptive services or methods (within 60 days of delivery, within 6-months of delivery)?

• Research Question 5. Did women with a Medicaid paid first birth post- vs. pre-ACA have an increase in age at first birth, an increase in intended births, and improvements in birth weight and gestational age?
MEDTAPP Data Profiles

Focus:
• Establish clinical profiles of Medicaid’s high risk populations and identify hotspots for targeted interventions. Targeted populations have included pregnant women, children with severe emotional conditions in multiple systems of care, people with developmental disabilities, patients with chronic pain, and neonates and infants with hospital readmissions.

• Assist health care provider efforts to implement innovative best practices to support the federal and state Medicaid partnership.
Integration of Public Health into Healthcare
**Population Streams**

- **Smart data to target special populations**
  - High risk maternity
  - Mental Health
  - Chronic Conditions

**Community Coordination**

- **PCMH**
- **Improved Population Health Outcomes**

**Disparate population neighborhood filter**

- **Safety net ODH services**
  - Education focus on personal behaviors

**Innovation**

**Data Support**

**State and Agency Strategic Vision**

- **Personal Health Sessions**
- **Education**
- **HC Coverage – physical and mental**
- **Basic needs met**
Plenary: State Agency Policy Priorities & Academic Medicine Collaboration

Keynote and Facilitator: Greg Moody, MPA, Director, Governor’s Office of Health Transformation

- John McCarthy, MA, Director, Ohio Department of Medicaid
- Tracy Plouck, MPA, Director, Ohio Department of Mental Health & Addiction Services
- Jeffrey Susman, MD, Chair of Medical School Deans, and Dean, Northeast Ohio Medical University College of Medicine (NEOMED)
- Audience and Panel Dialogue
Accelerating Ohio’s Health Transformation

Greg Moody, Director
Governor’s Office of Health Transformation

Medicaid Technical Assistance and Policy Program Summit
September 23, 2014

### 2011 Ohio Crisis

- $8 billion state budget shortfall
- 89-cents in the rainy day fund
- Nearly dead last (48th) in job creation (2007-2009)
- Medicaid spending increased 9% annually (2009-2011)
- Medicaid over-spending required multiple budget corrections
- Ohio Medicaid stuck in the past and in need of reform
- More than 1.5 million uninsured Ohioans (75% of them working)
## Modernize Medicaid

**Initiate in 2011**

- Advance the Governor Kasich’s Medicaid modernization and cost containment priorities

**Initiate in 2012**

- Share services to increase efficiency, right-size state and local service capacity, and streamline governance

**Initiate in 2013**

- Pay for value instead of volume (State Innovation Model Grant)
  - Provide access to medical homes for most Ohioans
  - Use episode-based payments for acute events
  - Coordinate health information infrastructure
  - Coordinate health sector workforce programs
  - Report and measure system performance

## Streamline Health and Human Services

- Extend Medicaid coverage to more low-income Ohioans
- Eliminate fraud and abuse
- Prioritize home and community services
- Reform nursing facility payment
- Enhance community DD services
- Integrate Medicare and Medicaid benefits
- Rebuild community behavioral health system capacity
- Create health homes for people with mental illness
- Restructure behavioral health system financing
- Improve Medicaid managed care plan performance

## Pay for Value

- Engage private sector partners to set clear expectations for better health, better care and cost savings through improvement

- Participate in Catalyst for Payment Reform
- Support regional payment reform initiatives
- Pay for value instead of volume (State Innovation Model Grant)
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# Innovation Framework

## Modernize Medicaid

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- Create the Office of Health Transformation (2011)
- Implement a new Medicaid claims payment system (2011)
- Create a unified Medicaid budget and accounting system (2013)
- Create a cabinet-level Medicaid Department (July 2013)
- Consolidate mental health and addiction services (July 2013)
- Simplify and replace Ohio’s 34-year-old eligibility system
- Coordinate programs for children
- Share services across local jurisdictions
- Recommend a permanent HHS governance structure

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<th>Results Today</th>
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Ohio Medicaid and Insurance Exchange Eligibility (as of January 2014 without Medicaid expansion)

Private Insurance

- **Ohio Medicaid**:
  - Children 0-18
  - Parents
  - Childless Adults
  - Disabled Workers
  - Disabled Under Age 65

- **Federal Health Insurance Exchange**:
  - $94,200 (family of four)
  - $11,490 (individual)

SOURCE: Ohio Medicaid; Medicaid eligibility as of February 2013; Federal Health Insurance Exchange eligibility as of January 2014; 2013 poverty level is $11,490 for an individual and $23,550 for a family of 4; over age 65 coverage is through Medicare, not the exchange.
# Innovation Framework

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  - Coordinate health sector workforce programs
  - Report and measure system performance
Health Care Spending per Capita by State (2011) in order of resident health outcomes (2009)

Ohioans spend more per person on health care than residents in all but 17 states

36 states have a healthier workforce than Ohio

Sources: CMS Health Expenditures by State of Residence (2011); The Commonwealth Fund, Aiming Higher: Results from a State Scorecard on Health System Performance (October 2009).
Ohio’s State Innovation Model (SIM) Test Grant Application

- Population Health Plan
- Delivery System Transformation Plan, including better care coordination, particularly for the most complicated patients
- Payment Innovation Models, including patient-centered medical home and episode-based payment models
- Regulatory Plan, including health sector workforce development
- Health Information Technology Plan
- Stakeholder Engagement
- Quality Measurement

Source: Ohio’s State Innovation Model (SIM) Test Grant Application (July 2014).
Colleges of Medicine Priority: “Leveraging existing appropriations focused on workforce development and training innovation”

<table>
<thead>
<tr>
<th>Line Item</th>
<th>University or Program</th>
<th>SFY 2015</th>
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<tbody>
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<td>235-536</td>
<td>OSU Clinical Teaching</td>
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<tr>
<td>235-572</td>
<td>OSU Clinic Support</td>
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<td>235-537</td>
<td>University of Cincinnati Clinical Teaching</td>
<td>$7,952,573</td>
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<td>235-474</td>
<td>Area Health Education Centers</td>
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<td>235-538</td>
<td>University of Toledo Clinical Teaching</td>
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<td>235-519</td>
<td>Family Practice</td>
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<td>235-539</td>
<td>Wright State University Clinical Teaching</td>
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<td>Northeast Ohio Medical University Clinical Teaching</td>
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<td>235-540</td>
<td>Ohio University Clinical Teaching</td>
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<td>235-515</td>
<td>Case Western Reserve School of Medicine</td>
<td>$2,146,253</td>
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<td>235-526</td>
<td>Primary Care Residencies</td>
<td>$1,500,000</td>
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<tr>
<td>235-608</td>
<td>Human Services Project</td>
<td>$1,000,000</td>
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<td>235-606</td>
<td>Nursing Loan Program</td>
<td>$891,320</td>
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<tr>
<td>235-525</td>
<td>Geriatric Medicine</td>
<td>$522,151</td>
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<td><strong>Total</strong></td>
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### Goal

80-90 percent of Ohio’s population in some value-based payment model (combination of episodes- and population-based payment) within five years

### State’s Role

- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
- Require Medicaid MCO partners to participate and implement
- Incorporate into contracts of MCOs for state employee benefit program

<table>
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<th>Year</th>
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<th>Episode-based payments</th>
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<td>▪ In 2014 focus on Comprehensive Primary Care Initiative (CPCi) &lt;br&gt;▪ Payers agree to participate in design for elements where standardization and/or alignment is critical &lt;br&gt;▪ Multi-payer group begins enrollment strategy for one additional market</td>
<td>▪ State leads design of five episodes: asthma acute exacerbation, perinatal, COPD exacerbation, PCI, and joint replacement &lt;br&gt;▪ Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year</td>
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<td><strong>Year 3</strong></td>
<td>▪ Model rolled out to all major markets &lt;br&gt;▪ 50% of patients are enrolled</td>
<td>▪ 20 episodes defined and launched across payers</td>
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<td><strong>Year 5</strong></td>
<td>▪ Scale achieved state-wide &lt;br&gt;▪ 80% of patients are enrolled</td>
<td>▪ 50+ episodes defined and launched across payers</td>
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## 5-Year Goal for Payment Innovation

### Goal
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### State’s Role
- Shift rapidly to PCMH and episode model in Medicaid fee-for-service
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### Patient-centered medical homes

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### Episode-based payments

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| Year 1 | State leads design of five episodes: asthma acute exacerbation, perinatal, COPD exacerbation, PCI, and joint replacement  
Payers agree to participate in design process, launch reporting on at least 3 of 5 episodes in 2014 and tie to payment within year |
| Year 3 | 20 episodes defined and launched across payers |
| Year 5 | 50+ episodes defined and launched across payers |
Ohio’s Health Care Payment Innovation Partners:
High-Value Targets for State-University MEDTAPP Collaboration

Broaden the State’s involvement across institutions – and through collaboration among institutions – to advance:

- Payment Innovation
- Medicaid-focused clinical quality improvement projects
- Medicaid-focused data analytics
- Use of mobile health technology
- Interdisciplinary care team models
- Consumer engagement and empowerment

Source: Ohio Department of Medicaid (September 2014).
Ohio’s Innovation Model
Test Grant Application

- Population Health Plan
- Delivery System Plan
- Payment Models
- Regulatory Plan
- HIT Plan
- Stakeholder Engagement
- Quality Measurement

Current Initiatives

Modernize Medicaid
- Extend Medicaid coverage to more low-income Ohioans
- Reform nursing facility reimbursement
- Integrate Medicare and Medicaid benefits
- Prioritize home and community based services
- Create health homes for people with mental illness
- Rebuild community behavioral health system capacity
- Enhance community developmental disabilities services
- Improve Medicaid managed care plan performance

Streamline Health and Human Services
- Implement a new Medicaid claims payment system
- Create a cabinet-level Medicaid department
- Consolidate mental health and addiction services
- Simplify and integrate eligibility determination
- Coordinate programs for children
- Share services across local jurisdictions

Pay for Value
- Engage partners to align payment innovation
- Provide access to patient-centered medical homes
- Implement episode-based payments
- Coordinate health information technology infrastructure
- Coordinate health sector workforce programs
- Support regional payment reform initiatives
- Federal Health Insurance Exchange
Plenary: State Agency Policy Priorities & Academic Medicine Collaboration

Keynote and Facilitator: Greg Moody, MPA, Director, Governor’s Office of Health Transformation
- John McCarthy, MA, Director, Ohio Department of Medicaid
- Tracy Plouck, MPA, Director, Ohio Department of Mental Health & Addiction Services
- Jeffrey Susman, MD, Chair of Medical School Deans, and Dean, Northeast Ohio Medical University College of Medicine (NEOMED)
- Audience and Panel Dialogue
Break
Topic 1: Quality Improvement to Advance Care Delivery:
How is Ohio Moving the Needle?

Panel 1: Behavioral Health Quality Improvement to Advance Care Delivery

- **Facilitator**: Linda Post, MD, Senior Medical Director, United Healthcare Community Plan of Ohio

- **Panel**:
  - John Campo, MD, The Ohio State University Wexner Medical Center (Ohio Minds Matter)
  - John Duby, MD, FAAP, Director, Developmental-Behavioral Pediatrics, Akron Children’s Hospital (Building Mental Wellness)
  - David McKenna, MD, RDMS, Wright State University Boonshoft School of Medicine and Miami Valley Hospital (Maternal Opiate Medical Supports)
  - Beverley Laubert, MA, Long-term Care Ombudsman of Ohio (Nursing Facility Quality Improvement Project)
  - Mary Applegate, MD, Medical Director, Ohio Department of Medicaid
  - Mark Hurst, MD, Medical Director, Ohio Department of Mental Health and Addiction Services

- **Audience and Panel Dialogue—Future Directions**
Topic 1: Quality Improvement to Advance Care Delivery: How is Ohio Moving the Needle?

Panel 2: Maternal and Infant Health Quality Improvement to Advance Care Delivery

• **Facilitator:** Steven Gabbe, MD, Chief Executive Officer, The Ohio State University Wexner Medical Center

• **Panel:**
  - Jay Iams, MD, The Ohio State University Wexner Medical Center (39 Weeks, Progesterone)
  - Michelle Walsh, MD, Chief of Neonatology, University Hospitals Rainbow Babies and Children’s Hospital (Neonatal Abstinence Syndrome and Reducing Rehospitalizations)
  - Carole Lannon, MD, MPH (OPQC)
  - Brandi Johnson, Operations Manager, Holzer Medical Clinic (Strong Start Ohio)
  - Jessica Foster, MD, Medical Director, Bureau for Children with Developmental and Special Health Needs, Ohio Department of Health
  - Brad Lucas, MD, Chief Medical Officer, Buckeye Health Plan
  - Mary Applegate, MD, Medical Director, Ohio Department of Medicaid

• **Audience and Panel Dialogue—Future Directions**
Luncheon: MEDTAPP Healthcare Access (HCA) Initiative Project

- MEDTAPP Healthcare Access (HCA) Initiative Project Recognition, Video, and Networking
MEDTAPP Healthcare Access (HCA) Initiative Projects

The University of Akron
Nursing
Kathleen R. Tusaie, PhD, APRN, BC

Case Western Reserve University
Dentistry
Catherine A. Demko, PhD

Pediatrics
Nancy Roizen, MD
Claudia Hoyen, MD

Psychiatry
Robert J Ronis, MD, MPH

MetroHealth/Interdisciplinary
Christina Antenucci, MD
Clint Snyder, PhD

Cleveland State University
Nursing/Social Work/Community Health Worker
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Healthcare Access (HCA) Initiative

Project Video Highlight Reel
The Health System is Transforming: Now What?

Katie Gaul, MA and Erin Fraher, PhD MPP
Program on Health Workforce Research & Policy
Cecil G. Sheps Center for Health Services Research, UNC-CH;
and the Health Workforce Technical Assistance Center

September 23, 2014

Ohio MEDTAPP Summit: “Transforming Healthcare Through State-University Partnerships”
Here’s our agenda

- Context: The health system is rapidly changing: What are the workforce implications?
- Interprofessional education and practice
- Shortage, or no shortage? How do you know?
- The Medicaid workforce
- Social accountability
- Are we all rowing in the same direction? The need for effective relationships
The Context: Health system transformation is underway

- Emphasis is on primary and preventative care
- Health care is integrated across:
  - medical sub-specialties, home health agencies and nursing homes
  - community- and home-based services
- Technology used to monitor health outcomes
- Payment incentives promote accountability for population health
- Designed to lower cost, increase quality, improve patient experience
The Context: Workforce planning for a rapidly changing health system

- **Lots of people asking:** “How can we align payment incentives and new models of care to achieve the triple aim of better care for individuals, better health for populations and lower costs?”

- **Not enough people asking:** “How can we transform our health workforce to achieve the triple aim?”

- Rapid health system change requires *retooling*:
  - the skills and competencies of the health workforce
  - the questions health workforce researchers ask and answer
  - the types of programs we develop and implement to create a flexible, adaptable, and continuously learning workforce
Flexible workforce, with new competencies, needed in transformed system

A more flexible use of workers will be needed to improve care delivery and efficiency that includes:

1. Existing workers taking on new roles in new models of care
2. Existing workers shifting employment settings
3. Existing workers moving between needed specialties and changing services they offer
4. New types of health professionals performing new functions
5. Broader implementation of true team-based models of care and education
Re: #4. It’s not just about numbers needed in future, it’s about new health professional roles

- Patient navigators
- Nurse case managers
- Care coordinators
- Community health workers
- Care transition specialists
- Living skills specialists
- Patient family activator
- Grand-aides
- Paramedics
- Home health aids
- Peer and family mentors

- All of these professions play role in managing patient transitions between home, community, ambulatory and acute care health settings
- Evidence shows improved care transitions reduce unnecessary hospital admissions, lower costs and improve patient satisfaction
Re: #5. Need to develop true team-based models of care and education

- How do new roles “fit” with existing health professionals in team-based models of care?
- Chicken or egg: what comes first, team-based practice or team-based education?
- Significant professional resistance exists
- Need to identify new competencies, standardize and credential (?) new skills

Real and lasting change cannot happen without simultaneously addressing payment, regulatory and education policy
Want to learn more on IPE/IPP?

- LEAP = Learning from Effective Ambulatory Practices
  - Neighborhood Family Practice, Cleveland

- National Center for Interprofessional Education and Practice
  [https://nexusipe.org/](https://nexusipe.org/)

- UCSF Center for Health Professions, Innovative Workforce Models
  [http://futurehealth.ucsf.edu/Public/Center-Research/Home.aspx?pid=539](http://futurehealth.ucsf.edu/Public/Center-Research/Home.aspx?pid=539)

- IOM Global Forum on Innovation in Health Professional Education

- And also... Health Careers Pathways (H2P) Consortium
Part 2: Switching Gears
News of physician shortages grabs headlines

The New York Times

Doctor shortage, increased demand could crash health care system

By Jen Christensen, CNN
updated 5:37 PM EDT, Wed October 2, 2013

Success of health reform hinges on hiring 30,000 primary care doctors by 2015

The Washington Post

In the U.S., Put More On Exhausted Physicians
These estimates of shortfalls tend to overlook (mal)distribution

- Most shortage estimates are at the national level.
- But there is wide variation in the distribution of physicians (and other health professionals) by both specialty and geography
- What if supply is adequate – but providers are just in the “wrong” place or not serving the populations most in need
These estimates of shortfalls by specialty also overlook reality of practice

- Physicians flexibly adjust scope of services they provide according to training, practice context and personal preferences
- Counting heads overlooks real world practice where there is:
  - **Between-specialty plasticity** – physicians in different specialties provide overlapping scopes of services
  - **Within-specialty plasticity** – physicians within the same specialty have different practice patterns
Using plasticity turns workforce modeling upside down

- We developed a model that does not produce estimate of *noses needed* by specialty
- Instead, it asks: what are patients’ needs for care and how can those needs be met by different specialty configurations in different geographies?
Selected modeling efforts

- Sheps Center, FutureDocs Forecasting Tool
  www2.shepscenter.unc.edu/workforce

- HRSA non-primary care specialties

- HRSA nursing model... coming soon...?

- AAMC... in development (using OH as pilot location)
Who’s in the Medicaid Workforce?

- How do you know??
- Big issue for behavioral health
- Big issue for oral health
- What are innovative models of that integrate behavioral and mental health?
- GME and Medicaid – accountability is coming, and soon
Accountability

- Many resources are put into health professional education
- Is the “right” workforce going to the “right” places to serve the “right” populations at the “right” time?
- What’s the return on investment for state funds used to train and deploy the workforce?
- Who’s evaluating these efforts?
In NC, most med grads leave state and don’t practice in needed specialties and geographies

NC Medical Students: Retention in Primary Care in NC’s Rural Areas

Total Number of 2005 NC med school graduates in training or practice as of 2010: 408

- Initial residency in primary care: 261 (64%)
- In training/practice in primary care in 2010: 155 (38%)
- In primary care in NC in 2010: 86 (21%)
- In PC in rural NC: 10 (2%)

Source: North Carolina Health Professions Data System with data derived from the Duke Office of Medical Education, UNC-CH Office of Student Affairs, ECU Office of Medical Education, Wake Forest University SOM Office of Student Affairs, Association of American Medical Colleges, and the NC Medical Board, 2011.
What do workforce stakeholders need to do to help transform workforce

1. Harvest and disseminate learning from workforce innovations
2. Reach outside for new ideas and new partners
3. Focus on the practice, hospital and health system, not just the clinician
4. Identify and codify emerging health professional roles and then train for them
5. Plan for the spread and sustainability of innovations at the time they are initiated
6. Build Evidence Required to Support Changes in Licensure, Credentialing and Accreditation

How do you get stakeholders to work together and speak the same language?

1. Build strong, effective partnerships
2. Communicate and trust
3. Have a strong, neutral facilitator

- **North Carolina:** NC Institute of Medicine ([http://www.nciom.org](http://www.nciom.org))
- **Colorado:** Colorado Health Institute ([http://www.coloradohealthinstitute.org/](http://www.coloradohealthinstitute.org/))
Questions?

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Program on Health Workforce Research and Policy  
http://www.healthworkforce.unc.edu

North Carolina Health Professions Data System  
http://www.shepscenter.unc.edu/hp

Health Workforce Technical Assistance Center  
http://www.HealthWorkforceTA.org
Topic 2: Interdisciplinary Patient Centered Team Models

- **Topic Speaker:** Katie Gaul, Deputy Director, Health Workforce Technical Assistance Center – National Perspective
- **Facilitator:** Mina Chang, PhD, Chief of Health Research and Program Development, Ohio Department of Medicaid
  - MEDTAPP Healthcare Access (HCA) Initiative Overview and Introduction
- **Panel:**
  - Mark Munetz, M.D., Margaret Clark Morgan Foundation Endowed Chair in Psychiatry at Northeastern Ohio Universities Colleges of Medicine and Pharmacy (NEOMED) and the Chief Clinical Officer for the County of Summit Alcohol, Drug Addiction and Mental Health Services Board (HCA Principal Investigator)
  - Christina Antenucci, MD, Assistant Professor, Case Western Reserve University, School of Medicine (HCA Principal Investigator)
  - Deborah Larsen, PT, PhD, Director, School of Health and Rehabilitation Sciences, Associate Dean, College of Medicine, Associate Vice President for Health Sciences, and Associate Professor, The Ohio State University College of Medicine (HCA Principal Investigator)
  - Beth Ferguson, MHA, Mental Health Administrator, Ohio Department of Mental Health and Addiction Services
  - Jennifer Higgins, Director of Workforce Development, Ohio Association of Community Health Centers
  - Briana Hervet, PhD, Director, Choose Ohio First, Ohio Board of Regents
- **Audience and Panel Dialogue—Future Direction**
Break
Topic 3: Using Data to Identify and Improve Care for Ohio Medicaid’s Vulnerable Populations

• **Facilitator:** Patrick Stephan, Deputy Director, Medicaid Development and Administration, Ohio Department of Developmental Disabilities

• **Panel:**
  - Kelly Kelleher, MD, Director, Center for Innovation in Pediatric Practice and Vice President of Health Services Research at The Research Institute at Nationwide Children’s Hospital (Center for Medicare and Medicaid Innovation Projects)
  - Shahla Mehdizadeh, PhD, Adjunct Associate Professor, Miami University, Department of Sociology and Gerontology (Needs of the Long-Term Care Population)
  - Hope McGonigle, PhD, Health Administrator, Ohio Department of Developmental Disabilities (National Core Indicators, Waiting List Survey)
  - Orman Hall, MA, Director, Governor Kasich’s Cabinet Opiate Action Team (Opiate Dependence)
  - Timothy Sahr, MPH, MA, ThM, Director of Research and Analysis, Ohio Colleges of Medicine Government Resource Center (Use of Data Dashboards)

• **Audience and Panel Dialogue—Future Directions**
Distribution Rates of Prescription Opioids in Grams per 100,000 population, Ohio, 1997-2011

Opioid analgesic grams distributed

Unintentional Drug Overdoses & Distribution Rates of Prescription Opioids in Grams per 100,000 population, Ohio, 1997-2011

Opioid analgesic grams distributed

Unintentional drug overdose death rate

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- **Audience and Panel Dialogue—Future Directions**
Closing Conversation

Shannon Ginther, JD
Assistant Director
Ohio Colleges of Medicine
Government Resource Center
Thank you for attending!