
**CURB
Meeting Minutes
January 15, 2014**

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PRESENT:

Board: Michel Benoit, MD, Patricia Berry, MPH, Delores Burroughs-Biron, MD, David Butsch, MD, Ann Goering, MD, William Minsinger, MD, Paul Penar, MD, Norman Ward, MD, Richard Wasserman, MD

DVHA Staff: Bill Clark, Daljit Clark, Jennifer Herwood, Susan Mason, Thomas Simpatico, MD (moderator), Scott Strenio, MD

Guests: Mark Gorman, MD, Anna Noonan

Absent: John Mathew, MD

HANDOUTS

- Agenda
- Draft minutes from 11/20/2013

CONVENE: Dr. Thomas Simpatico convened the meeting at 6:30 pm.

1.0 Introductions

2.0 Review and Approval of Minutes

The minutes were reviewed and approved with a minor change.

3.0 Updates:

- **Medical Director** – The new DVHA medical director, Scott Strenio was introduced to the group. Dr. Strenio began at DVHA in December, 2013.
- **Gold Card** – The Radiology Gold Card program began on January 1, 2013 with 6 providers who were deemed eligible. After review of the data, we added an additional 4 providers on January 1, 2014. Imaging utilization data will be reviewed annually to identify additional providers eligible for Gold card.
- **CURB Context** – Dr. Simpatico provided a brief synopsis and context for the meeting. He reviewed the triple AIM. These are the guideposts that inform the work we do. Systems integration and social service programs and the impact it has on health care delivery. The processes for:
 - Items already on board that periodically come up for renew.
 - Requests for developing technologies
 - Best practice opportunities work with UVM
 - Managed by Managed Care Med Committee
 - Offshoots are DURB, QC, Compliance Committee and CURB.

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- The above percolates up to Senior Management team and then to the Commissioner.

4.0 Old Business:

- **Partial Hospitalization Program Update** – We will provide an update at the next meeting. We are hoping it will be implemented in the next 4-6 months.

5.0 New Business:

TIA Treatment Protocol and Outcome – Dr. Mark Gorman, Director of the Stroke Program and Neurologist at FAHC presented to the group. TIA and stroke are basically the same, the difference is that TIA is a stroke that does not leave any neurological signs, but does present an enormous inherent risk of subsequent stroke. He presented data from a few studies that show that patients who present with TIA are at an increased risk of stroke, death and disability.

- 10% of TIA patients returned within 3 months with a stroke
- 5% returned within 48 hours with a stroke.
- Out of the 5 %, 85% of the strokes are disabling or fatal.
 - These patients have serious cardiovascular events

The data is very consistent; two different models show similar data.

Currently, many individuals are scheduled for follow up echocardiograms 25-38 days post TIA. Many tests are not completed because they are cancelled, missed, not scheduled.

The Algorithm for evaluation and treatment is simply aspirin and aggressive medical management, unless you have high grade carotid stenosis or have a condition treated with an anticoagulant.

Medical research shows we should provide more aggressive medical management of patients with TIA. Rapid evaluation and management is feasible and may reduce deaths and disability.

The proposal is for rapid evaluation and management of TIA. Within 8 hours of presenting with TIA the patient needs neuro and vascular imaging, echocardiogram, telemetry, and labs. Then the patient is quickly risk-stratified and it is determined which method of treatment is best. Individuals with carotid stenosis can be directed toward an endarterectomy; those with atrial fibrillation can be directed toward proper medical treatment, and individuals at high risk for stroke can be admitted for treatment with antiplatelet medications and statins.

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Studies show that early treatment reduces the risk significantly. Aggressive, rapid treatment shows 80% reduction of stroke. This will cut down in hospital admissions and hospital bed days.

Dr. Gorman presented some data specific to FAHC.

Conclusions – TIA is the same as stroke, rapid evaluation is feasible and will reduce stroke, disability and death. The suggestion is not to add testing, we do this anyway. The proposal is to do it more quickly, within 8 hours of TIA.

This is a cost neutral proposal and would alleviate anxiety for the patient and the physician.

Discussion:

- Is this 8 hour plan feasible in small hospitals?
- Contingency plan should be in place for the smaller hospitals.
- Should we operationalize for our patients?
- How does this affect Medicaid or is it mostly Medicare?
- If Medicare, would CMS pay for a short stay at a hospital?
- Medicare patients cost Medicaid in their nursing home costs.
- We need to understand reimbursement.
- A single stroke can cost a lot of money; by reducing the cost risk of stroke we could save money and prevent morbidity and mortality.
- Revenue neutral to hospital, but could save the system a lot, as the stroke costs the system through loss of work, nursing care, rehabilitation, etc.
- Is the proposal to treat these patients in the ER?
- Dr. Gorman would like to be able to go to VT hospitals and provide this data to demonstrate the benefits of rapid evaluation and treatment. Testing and proper decisions regarding treatment could be done in the ER, via a short inpatient stay, or as an outpatient on the following day.
- Academic Detailing – this is important to raise the status of TIA.

Action Items:

For the next meeting DVHA will present:

- Capacity of Vermont hospitals to do the protocol
- Financial model for supporting this proposal
- Medicaid TIA and Stroke data

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Transportation Update – Bill Clark, Managed Care Compliance Director provided an update regarding Medicaid’s transportation program. Transportation is provided to Medicaid recipients by regional brokers for medically necessary transportation. Medicaid uses public transit, volunteer drivers, cabs and special needs vehicles. This does not include ambulance services.

There are 7 regional brokers who we pay a capitated per member per month (PMPM) payment. The PMPM is based on cost allocation and benchmarking. The broker assumes some of the risk if their performance slips.

100% of the appointments are verified by the broker.

This contract change resulted in the following:

- \$1 million in annual transportation savings
- Fewer grievances and appeals
- Customer satisfaction has been high
- Improved relationship with brokers
- Increase in appointment verification
- Financial incentive for brokers to be efficient
- Model is based on mutual respect and cooperation
- Increase in ride coordination and use of volunteers

Next Steps for Transportation

- Address CMS compliance concerns
- Pay based on shorter “look-back” period
- Build in more quality/performance expectations
- New software = better coordination

6.0 Technology Requests:

- **Modification of Process: Assimilation of new Technology Requests** – We tabled this topic until the next meeting due to time constraints.

Adjournment – CURB meeting adjourned at 8:25 PM

Next Meeting

March 19, 2014

Time: 6:30 PM – 8:30 PM

Location: Department of Vermont Health Access, Williston, VT