
**Clinical Utilization Review Board (CURB)
September 21, 2016**

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PRESENT:

Board: Michel Benoit, MD, Ann Goering, MD, John Matthew, MD, David Butsch, MD, Paul Penar, MD, Michael Rapaport, MD, Norman Ward, MD

DVHA Staff: Kristy Allard, Daljit Clark, Evan Welsh, Thomas Simpatico, MD (moderator), Scott Strenio, MD

Guests: Melissa Moore, Jane Ripley, Oleg Neaga, Philip Ades, Stephen Higgins, Sanchit Maruti, William Kiethcart, Stephanie Kilaga,

Absent: Jessica MacLeod, NP, Nels Kloster, MD

HANDOUTS

- Agenda
- Draft minutes from 7/20/2016 Meeting

CONVENE: Dr. Thomas Simpatico convened the meeting at 6:35 pm.

1.0 Introductions

2.0 Review and Approval of Minutes

The minutes from 07/20/2016 meeting were reviewed and approved as written.

3.0 Updates

CURB Membership

Dr. Matthew and Dr. Goering have decided to stay on as CURB members and are currently going through the reapplication process.

Acupuncture Pilot

Vermont Legislature has approved \$200,000 for the Department of Vermont Health Access (DVHA) to conduct an acupuncture pilot for use with pain management. The pilot is designed to rigorously test the effectiveness of this treatment on pain management. There is a desire depending on results to move the acupuncture pilot into opiate addiction treatment.

DayOne Suboxone Transition (DOST) Update

Sanchit Maruti & William Keithcart

DayOne has been ongoing for 8 months now. It mostly consists of patients from within the University of Vermont Medical Center (UVMC) network with patients from the Chittenden county Hub with UVMC primary care practices(PCP). The program is also looking at UVMC inpatient admission for potential patients. So far there have been

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over 100 people go through the DOST program. The majority have been transferred to a PCP after care is complete at DOST. Others have been referred back to the Hub or to residential treatment. Many patients are very pleased with the services, some even wanting to stay in the program after completion. Two areas where DOST is becoming a cost savings is in relapsing patients and valve replacements. They have found there to be a cost saving by having relapsed patients go back into the DOST program rather than residential care. They have also been finding that this program has cut down on the number of valve replacements and repeat valve replacement patients.

Discussion:

What is the waiting list at the Chittenden county Hub like? There currently is no firm answer to this but, the best idea is that it is larger than comfortable. There is a new Hub opening in Franklin county. It should be opening in January 2017 and hope to have around 200 people. There is hope that this will help alleviate some of the waiting list form Chittenden county. PCPs are becoming more comfortable with HUBs because of medical assisted treatment (MAT) team visits to the practices.

Vivitrol Update

The Vivitrol Pilot is still ongoing. Marble Valley Correctional is doing injections. There is a preplanned admission system for getting patients into the program. Patients go through an oral trial period before receiving the injection of Vivitrol. There are also 5 and 7-day detox periods for buprenorphine and 10-day opioid wash out programs. After receiving the injections patients are monitored for effectiveness and results. Unfortunately, the pilot has been slower than initially expected.

Palliative Care Update

DVHA has had a phone conference with Blue Cross Blue Shield (BCBS) discussing what guidelines they have for their palliative care benefits. This conference call helped DVHA gain more details on how to set up a palliative care program for adults. DVHA plans to mimic the BCBS benefit setup. Some things DVHA and BCBS are working on together are to identify what data can trigger a palliative care referral. Another discussion is what benefits should DVHA add into the palliative care benefit. This will allow for a similar bundle to what BCBS offers. BCBS data has shown a cost saving even though only a small population has utilized the services. The metrics surrounding palliative care is an additional area that is being worked out. Some questions are: how to track savings and cost, when is the best time to refer patients to palliative care. Along with BCBS, DVHA is looking to align its service with Vermont correctional services for palliative care.

Discussion:

Home health agencies have been saying we are sending palliative care referrals too late into prognosis. Home health agencies dealing with the patients can greatly help a palliative care program succeed. One thing to consider is the marketing behind the name palliative care. Palliative care is almost too closely tied to hospice care that it may need

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to be marketed under another name. For example, BCBS calls their program “supportive care.”

4.0 New Business/Updates

Reward Strategies

Stephen Higgins

There has been a center at UVM for reward strategies since 2013. The Vermont Center on Behavior and Health (VCBH) has a National Institute for Health (NIH) Centers of Biomedical Research Excellence (COBRE) grant. The Center focuses on relationships between behavior and chronic disease risks. Some background to why this is the focus is the fact the U.S. is behind in healthcare compared to other industrialized nations. The U.S. is spending more on healthcare. The NIH agrees that the attitude towards healthcare is poor. The poor health in the U.S. is disproportionate among the lower income families. The VCBH has been working with financial incentives, such as vouchers, to promote better overall health. Steven Higgins has been working on reward strategies at UVM since the 1980's and 90's with the cocaine epidemic. They used vouchers for goods to help to keep cocaine users in rehab and off the drug. This type of reward strategy can be seen in current times in corporate wellness programs. From 1991-2014 there have been 176 published controlled studies on financial incentive in healthcare. Of these 176, 151 or 86% have shown large positive treatment effects. Recently members of the VCBH have begun touring to speak to providers and insurers of the benefits of reward strategies.

Pregnant Smokers Example

Maternal cigarette smoking is a leading preventable cause of poor pregnancies outcomes. Data shows that maternal cigarette smoking is higher in lower socioeconomic statuses. The lower socioeconomic individuals focus on the immediate decisions over the long term effects. The methods for the study were as follows: 166 pregnant cigarette smokers who came from obstetric and Women, Infants and Children (WIC) programs from the Burlington area. The majority of whom are under 25 years of age, Caucasian, unemployed and without private health insurance and high school or less education level. The controlled trials compared abstinence-contingent and non-contingent vouchers. The contingent group received vouchers based on verified smoking status over the course of the study. This group receives incentives on an escalating scale. While the non-contingent group received vouchers independent of smoking status. The cost of the voucher for both studies was around ~\$450 per women which came out to be ~\$1.50 a day.

This study has yielded results that show the contingent group both raised the abstinent percent and increased the average birth weight of the pregnancies. Another outcome of this study was the delivery costs show a ~\$4,000 difference between the contingent and non-contingent groups. The outcomes derived from this study show the usefulness

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financial incentives to promote health behaviors. It is a large opportunity for Vermont Medicaid to improve care.

Reward Strategies Cont.

Philip Ades

Cardiac Rehab Study

VCBH has an ongoing study for incentives in preventive cardiology. The members of the study are recruited through the hospital and asked if they would like to participate in the cardiac rehabilitation program. There are currently 140 Medicaid patients enrolled in the cardiac rehab study. Any enrollee who completes 1 rehab session is counted. The study is tracking the fitness measures at 4 months and 12 months, how many sessions are completed and the overall costs. The overall costs are evaluated by an economist. The incentives tied to this program are given on completion of exercise visits. The incentives are on an escalating scale for subsequent visits. However, the scale resets if two or more sessions are missed.

The outcomes so far from this study is that there is a ~50% difference in participation between those who received incentives and those who did not. There are trends so far showing that this is resulting in less emergency room visits and hospitalization. Some additional outcomes are that there is a lot of knowledge being learned about the population from these types of studies. Such things as 1 on 1 session are working best with these socioeconomic groups. VCBH has been finding from the results that they pick up more early indicators and info about the population's health. The incentives in the cardiac rehab study results in about ~\$600 per person. The incentives given are very meaningful to the participants and a heavy motivator.

Diabetes Remission Study

VCBH is also conducting a study on "Remission of Recently Diagnosed T2DM (Type 2 Diabetes) with Weight Loss and Exercise". Previous studies have shown that weight loss interventions have decreased Diabetes risk by 58% compared to placebo and traditional medications. The past studies prompted the VCBH to do a more in depth study. In the current study interventions for participations are performed in a cardiac rehabilitations setting. The program focuses on the lifestyle changes. There are two major parts. One being behavioral weight loss. This involves 24 weekly counseling sessions with calorie goals and self-monitoring or dietary behaviors. The second portion is the exercise program. This includes walking as a primary exercise which is a gradually progression to almost daily activity. Participants conduct 1-3 sessions a week on site and are given an accelerometer for off-site exercise. There is also a focus optimizing lifestyle exercise outside of the onsite sessions.

The results thus far show that 8 of 10 are in partial remission. There is an average of 20 pounds of weight loss and peak aerobic capacity increase of 18% on average. The average decrease in Hemoglobin A1c (HBA1c) is 1%. The participants also showed a 38% decrease in heart disease risk factor indicators as a result of the study. The cost for

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this study is ~\$300 per person for 4 months of the program. While this study is being conducted across all insurers it shows promise that it can make an impact in the Medicaid population.

Discussion:

Creating a system of incentives that help precursor treatments can help cut down the amount of high cost services that could otherwise result. One thing to keep in mind that incentives are a good way to spend money but they should not be treated as “mutual funds” or ways to create money. There is no guarantee that there will be a cost savings but it can improve the overall health. Some questions that do arise is whether or not public money can be used for a Medicaid incentive program? Is it possible to use a public program such as the Ben & Jerry’s Foundation? Traditionally there can’t be separate groups receiving different incentive levels. We do not want to create a system of unbalanced care. There is however, language in the affordable care act for incentive plans. This has prompted the Centers for Medicare & Medicaid Services (CMS) has recently allocated \$80 million dollars to do further research on incentive studies in the Medicaid and Medicare population. If incentives are given they have to meet a reasonableness of the tradeoff between costs. There is also the possibility to use affordable care organizations (ACO) investment funds or ACO Innovation funds to study the results of an incentive program in Medicaid. Other insurers have shown the benefits of reward strategies in healthcare. There are some downsides. One being that people come to expect the rewards and will only perform certain actions if there is an incentive. Even with this downside those who only act for the incentives still show benefits as a result of the care.

5.0 Next Steps

DVHA needs to have discussion with the legal staff regarding the legality of Medicaid sponsored incentive programs. Deciding what can be done and how often it can be done. Another question is, can the Global Commitment investment savings money be used to study the effects of these programs. This may require some further discussions with upper management in DVHA. Once these actions are taken, a strategy can be outlined and language drawn up for the CURB to review and approve.

Is there a way reward strategies can be linked to the waiting lists at the Hubs? One thing that is currently being done that can be used to alleviate the waiting lists at the Hubs is tamper proof suboxone devices. Stacey Sigmon has developed this device and organized a trial in the Burlington area that has shown positive results. These suboxone devices contain a 2-week supply of suboxone doses. This is a bridging therapy that would allow the people on the waiting list to receive some care. There is education through interactive voice response (IVR) systems and random call backs for checkups for the device. However, there is still a bottleneck at the provider level. The question then arises; can we use reward strategies to increase the use of the suboxone device.

Adjournment – CURB meeting adjourned at 8:00 PM

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Next Meeting

Suggested agenda items:

- **Palliative Care Update**
- **Incentive Program Update**

November 16, 2016

Time: 6:30 PM – 8:30 PM

Location: Department of Vermont Health Access, Williston, VT

DRAFT