WISCONSIN LEGISLATIVE COUNCIL

PERFORMANCE-BASED DISEASE MANAGEMENT PROGRAMS FOR LARGE POPULATIONS

Room 412 East, State Capitol
Madison, Wisconsin

July 24, 2008
10:00 a.m. - 4:30 p.m.

[The following is a summary of the July 24, 2008 meeting of the Special Committee on Performance-Based Disease Management Programs for Large Populations. The file copy of this summary has appended to it a copy of each document prepared for or submitted to the committee during the meeting. A digital recording of the meeting is available on our Web site at **http://www.legis.state.wi.us/lc.**]

Call to Order and Roll Call

Chair Wieckert called the meeting to order. The roll was called and it was determined that a quorum was present.

COMMITTEE MEMBERS PRESENT:	Rep. Steve Wieckert, Chair; Sen. Julie Lassa, Vice Chair; Reps. Chuck Benedict and Jake Hines; and Public Members Dr. Alexandra Adams, Mikki Duran, Marilyn Follen, Jo Musser, Susan Nitzke, Dr. Kenneth Schellhase, and Dr. Deborah Wubben.
COMMITTEE MEMBERS EXCUSED:	Public Member Cinthia Christensen.
COUNCIL STAFF PRESENT:	Rachel Letzing and Mary Matthias, Senior Staff Attorneys.
APPEARANCES:	Amy Winterfeld, Program Principal, Health Program, National Conference of State Legislatures (NCSL); Jennifer Kammerud, Legislative Liaison, Department of Public Instruction (DPI); John Hisgen, Health Education and Activity Consultant, DPI; David Dees, Director of Community Nutrition Programs, DPI; Jessica Sharkus, RD, CD, Public Instruction Supervisor in the School Nutrition Program, DPI; Milda Aksamitauskas, MPP, Policy Analyst, Division of Health Care Access and Accountability, DHS; Denise Runde, MSPH, Policy Initiatives Advisor, Division of Access and Accountability, DHS; Mary Pesik, Nutrition and Physical Activity Coordinator, Division of Public Health, DHS; Marilyn Follen, Administrator, Quality Improvement and

APPEARANCES CONTINUED: Care Management, Marshfield Clinic, Marshfield; Dr. David B. Allen, M.D./Professor Pediatrics-Endocrinology, University of Wisconsin American Family Children's Hospital, Madison; and Dr. Brian Fidlin, PsyD, Program Director, NEW Kids Program, Children's Hospital of Wisconsin, Milwaukee.

Opening Remarks

Representative Wieckert, Chair, welcomed the committee and gave a brief summary of the Joint Legislative Council. He discussed rules for voting and described the process of reimbursement of expenses. He noted that the committee's meetings will be recorded and available on the Internet.

Introduction of Committee Members

Chair Wieckert introduced himself and noted that Senator Julie Lassa is the Vice Chair of the committee. Chair Wieckert said that the public is already aware of the problem of childhood obesity and what is needed are ways to fix it. He stated that offering incentives and encouraging best practices are better methods to address childhood obesity than imposing mandates. At Chair Wieckert's request, committee members briefly introduced themselves.

Presentations by Invited Speakers

[Note: PowerPoint presentations and other documents referred to by the speakers are posted on the committee's Internet site.]

Amy Winterfeld, Program Principal, Health Program, NCSL. Ms. Winterfeld provided an overview of the obesity epidemic in the United States and described state legislative approaches to combating childhood obesity. She said that obesity rates have risen dramatically over the past three decades and noted that in 2007, 24.7% of adults and 13.5% of children age 10 to 17 in Wisconsin were obese. She noted that obesity is a major factor that drives up health care costs and the total annual medical obesity costs in Wisconsin are $1.486 billion dollars (in 2003 dollars).

Ms. Winterfeld said that obesity is a hot topic for legislation and explained the various ways in which state legislatures have responded to the childhood obesity problem. A number of states have adopted nutrition standards for school foods by setting or encouraging guidelines for healthier foods and beverage choices at school. At least 10 states currently require some type of nutrition education at school, generally by requiring nutrition education as a component of the school health curriculum or including nutrition education in obesity prevention. Farm-to-school or fresh fruit and vegetable programs have also been adopted in at least 17 states. At least five states have enacted bills to limit or ban the use of trans fat in school foods and the California Legislature recently passed a bill to ban trans fat in restaurants and other food facilities.

State legislatures have also enacted legislation regarding physical education and physical activity in school that sets or encourages requirements for the frequency or duration of physical education and physical activity at school. At least six bills were enacted by states in the 2005-2007 Legislative Session

urging or requiring schools to provide daily recess or physical activity for a specified duration during the school day. Other legislative responses include body mass index (BMI) measurement or fitness testing in schools and diabetes screening and management at school.

Ms. Winterfeld stated that federal law (Section 204 of Public Law 108-265, The Child Nutrition and Women, Infants and Children (WIC) Reauthorization Act of 2004) requires each school district participating in federal school meal programs to establish school wellness policies beginning with the 2006-2007 school year. In response to the federal law, at least nine states have enacted legislation in support of school wellness policies.

In response to questions from committee members, Ms. Winterfeld stated that evidence shows that nutrition education is effective, especially when it is incorporated into the school curriculum and when parents are involved. She said state legislation that has broad support, benefits multiple sectors, and lowers health care and health insurance costs has a better chance of being passed. Often, involvement from the executive branch, such as the Governor's office, is also required.

Jennifer Kammerud, Legislative Liaison, DPI. Ms. Kammerud provided an overview of the state laws, rules, and policies related to nutrition, health, and physical activities in schools that target childhood obesity. She explained that the Community Nutrition Team at DPI focuses on nutrition and physical activities for children in preschool and day care settings and administers two federal U.S. Department of Agriculture (USDA) meal reimbursement programs: the Child and Adult Care Food Program and the Summer Food Service Program. Federal regulations for both programs specify meal pattern requirements for children to ensure that daily energy needs are met for proper nutrition.

Ms. Kammerud stated that the DPI School Nutrition Team oversees federal school lunch, special milk, breakfast, after school snack, and fresh fruit and vegetable programs. All federal child nutrition programs for schools must follow USDA dietary guidelines. DPI public health nutritionists who are registered dieticians conduct a School Meal Initiative Nutrient Analysis (SMI) (a measure of consistency with the USDA dietary guidelines), by analyzing one week of menus from a school in each school district an all private schools every five years. Part of the SMI process includes consultations with the schools to develop improvement plans to meet the nutrition standards. She noted that only one-quarter of school districts employ a registered dietitian as the food service director.

Ms. Kammerud described school health and physical education requirements. State law requires physical education to be provided at least three times per week in grades kindergarten to six and weekly at the middle school level. Access to physical education must be provided to high school students, who must have 1.5 credits to graduate, earned over three separate years. State law specifies that health education be provided and that a half credit is required for grades seven to 12. She noted that the Movin' and Munchin' Schools Program is a newer program that promotes healthy eating and physical activity in school and at home.

Ms. Kammerud noted a number of DPI initiatives that may help reduce childhood obesity rates. These initiatives include recommending that school districts look at implementing virtual fitness centers for students; advising school districts to create a health council of local stakeholder to advise the district on programs and goals; providing nutrition education standards for schools; and providing health teachers and school districts with a document to help design a K-12 written nutrition curriculum. In

addition, she said DPI hopes to expand the school breakfast program, access to fresh fruit and vegetables with USDA funding, and the Movin' and Munchin' Schools Program.

In response to questions, **John Hisgen, Health Education and Activity Consultant, DPI**, stated that the Movin' and Munchin' Schools Program encourages schools to improve food choices, increase physical exercise, and connects everything back to the school curriculum. In addition, the program involves students' families and encourages them to improve nutrition at home and record their results. He said that strong research indicates that virtual fitness centers appeal to children at-risk for obesity who do not want to be physically active. Mr. Hisgen stated that youth health risk appraisals can be effective if there is follow-up, but that schools are not required to do them and only a minimal number currently do them.

In response to a question regarding programs that target low-income minority students, **Jessica Sharkus, RD, CD, Public Instruction Supervisor in the School Nutrition Program, DPI**, said that the summer food service program staff in Milwaukee works with parents and educators on ways teachers can connect with families about better nutrition. She also noted that the USDA fresh fruit and vegetable grant funding must target low-income schools. **David Dees, Director of Community Nutrition Programs, DPI**, explained that summer food service is only available in low income areas.

In response to questions from committee members, Ms. Kammerud said that a donation of a virtual fitness center would not count against a school district's state revenue limits. She stated that it would be better to ban trans fat in schools nationally, instead of state by state, because it is very difficult for the food service industry to meet different state nutrition requirements. Ms. Kammerud noted that many school districts have removed vending machines due to school wellness policy changes.

Denise Runde, MSPH, Policy Initiatives Advisor, Division of Access and Accountability, DHS, described the definition of "disease management" and explained that most health plans and physician's programs use disease management as a way to identify populations with common chronic conditions and intervene to improve the management of an existing disease, rather than as a method of preventive care. She then provided an overview of the disease management process, which includes identifying the population of care, defining the appropriate care, collecting data, assessing if appropriate care was delivered and if a patient's disease is being managed, and then intervening to improve the process of care and outcomes. Improving the process of care and outcomes can be done by providing incentives to provide appropriate care, such as pay for performance, providing incentives to patients to change their behavior, developing disease management programs or carving out the population with the disease and having another entity manage them. She said that the state Medicaid program primarily focuses on pay for performance in defined populations, such as increasing the rate of low-density lipoprotein (LDL) tests for diabetes, decreasing the rate of low birth weight babies, increased reporting of BMI for children, and increasing appropriate medication management for asthma patients. Ms. Runde recommended that the Legislature support the development of a method of collecting non-claims based data and mandate reporting of BMI, LDL, and glucose to the state hygiene lab for purposes of creating a patient registry and to assess if appropriate care is being provided to Medicaid patients.

In response to questions, Ms. Runde noted that there are privacy concerns about mandated reporting of test results, but that there is precedence for mandatory reporting of health care data for public health purposes. She said that the contracts DHS has with health maintenance organizations (HMOs) for Medicaid recipients are the only mechanism DHS has to influence provider behavior. Ms.

Runde stated that evidence-based best practice guidelines for physicians have existed for years, but have not been effective.

Milda Aksamitauskas, MPP, Policy Analyst, Division of Health Care Access and Accountability, DHS, provided an overview of BadgerCare Plus initiatives to reduce childhood obesity. She said that Badger Care Plus is moving to use Healthcare Effectiveness Data and Information Set (HEDIS) to measure performance on certain care and services, such as V85 codes for BMI measurement. Other pay for performance initiatives may include creating a communications plan about childhood obesity by doing outreach to health care providers, updating the Wisconsin Health Check form, data sharing between the WIC program and HMOs, determining a fee for service rate increase for reporting V85 codes, and exploring expansion of covered codes for obesity treatment, such as nutrition counseling by dieticians. She said that BadgerCare Plus is beginning pilot projects regarding individual healthy living incentives to see if such incentives are effective. She also noted that the new DHS budget proposal includes a proposal to reward households that buy fruits and vegetables by increasing their FoodShare benefit.

Dr. Adams clarified for the committee that V-codes are not billable, so therefore physicians do not use them very often, and that Medicaid does not consider obesity to be a billable illness.

Mary Pesik, Nutrition and Physical Activity Coordinator, Division of Public Health, DHS, described the Wisconsin Nutrition and Physical Activity State Plan, the purpose of which is to prevent obesity and reduce chronic disease. Major focus areas of the plan include increasing physical activity, increasing consumption of fruits and vegetables and decreasing consumption of high calorie, low nutrient foods. Ms. Pesik explained the state infrastructure that exists to address obesity, including the Nutrition and Physical Activity program, which is funded by a five-year Centers for Disease Control cooperative agreement. Other state activities include the third grade oral health survey, which includes BMI, the Healthier Wisconsin Worksite Initiative, the Governor's School Health Award, and the Healthier Wisconsin Schools Project. She said that DHS is also working with DPI on the National Governor's Association Healthy Kids grant. She also noted that there are many public health activities and programs in the community to address obesity, including programs to support breastfeeding, access to fruits and vegetables, and active community environments.

Public Member Marilyn Follen, Administrator, Quality Improvement and Care Management, Marshfield Clinic, described the current system of health care management and discussed Marshfield Clinic's participation in the Centers for Medicare and Medicaid Services (CMS) Physician Group Practice (PGP) Demonstration. Marshfield Clinic is one of 10 sites in the nation chosen to participate in the PGP project. Ms. Follen explained that the PGP is Medicare's first pay for performance demonstration for physicians, which tests physician groups' ability to lower costs and improve quality in the Medicare program and provides financial and quality-based payment incentives. Ms. Follen said that Marshfield Clinic's strategies under this project included using electronic medical records, creating an intervention list, and creating a Dashboard (diagnosis, medications, appointments, and PreServ, or preventive services needed by an individual). Marshfield Clinic also developed best practice models for core conditions and care management initiatives such as the nurse line, anticoagulation care management, and dyslipidemia care management. Ms. Follen noted that challenges to the project included the lack of support in the current reimbursement models for practice redesign and individual or population based care management efforts, and convincing payors to share the cost savings for currently non-reimbursed services.

Dr. David B. Allen, M.D./Professor Pediatrics-Endocrinology, University of Wisconsin American Family Children's Hospital, described the facts and trends about childhood obesity. He said that in the past 25 years, there has been a steep and progressive rise in childhood obesity and in common pediatric obesity-related disorders, such as Type 2 diabetes, but that no government policy currently mandates corrective action. He said that childhood obesity is a multi-faceted problem that requires a comprehensive public health approach that involves families, schools, the community, and public policy. Dr. Allen described policies and laws that would combat childhood obesity, including tracking and reporting of BMI and fitness, school nutrition requirements, school daily physical activity requirements, safe walking routes to schools, and requiring parents to obtain treatment for children with chronic obesity.

Dr. Brian Fidlin, PsyD Program Director, NEW Kids Program, Children's Hospital of Wisconsin, provided an overview of the NEW (Nutrition, Exercise and Weight management) Kids Program at Children's Hospital. Dr. Fidlin emphasized that the program provides individualized treatment but involves the entire family. He described the 3-2-1-0 Blast Off to a Healthier Family initiative, which is a toolkit for health care providers to use in a primary care setting to screen for healthy lifestyle behaviors in families, raise awareness of daily lifestyle habits that impact health, and guide families as they establish healthier lifestyle habits. Dr. Fidlin noted that the program tries to get families to make incremental changes so they get a sense of success. He said that current barriers to treating childhood obesity include problematic insurance reimbursement for obesity, which excludes children who are obese but do not have a secondary complication, the lack of mental health insurance coverage and lack of insurance coverage for preventative services for registered dieticians. Dr. Fidlin suggested solutions including medical reimbursement of preventive services for obesity and for treatment for obesity, universal coverage of Health and Behavior Codes, and increased Medicare coverage of dietitians for preventive services.

Other Business

There was no other business brought before the committee.

Plans for Future Meetings

The next meeting of the Special Committee will be ***Friday, September 12, 2008, at 10:00 a.m., in Room 412 East, State Capitol, Madison.*** Speakers scheduled to appear at this meeting include Dr. Ken Thorpe, Executive Director of Partnership to Fight Chronic Disease, and Laura Tobler, NCSL.

Adjournment

The meeting was adjourned at 4:30 p.m.

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