Transforming Delaware's Health:
A Model for State Health Care System Innovation

State Innovation Models (SIM) Workstream Meetings

June 11th, 2013

PRELIMINARY PREDECISIONAL WORKING DOCUMENT: SUBJECT TO CHANGE
PROPRIETARY AND CONFIDENTIAL

WELCOME

Agenda

▪ **Introduction and review of case for change**	***10:00***
▪ Delivery system	*10:45*
▪ Data and analytics	*11:45*
▪ Break	*12:30*
▪ Population health	*1:15*
▪ Payment model	*2:00*
▪ Break	*2:45*
▪ Patient engagement	*3:00*
▪ Version 1.0 answer	*4:00*

Objectives for today

1. Review context for health transformation in DE
2. Discuss emerging themes for each workstream
3. Consider early perspectives on v1.0 answer across workstreams

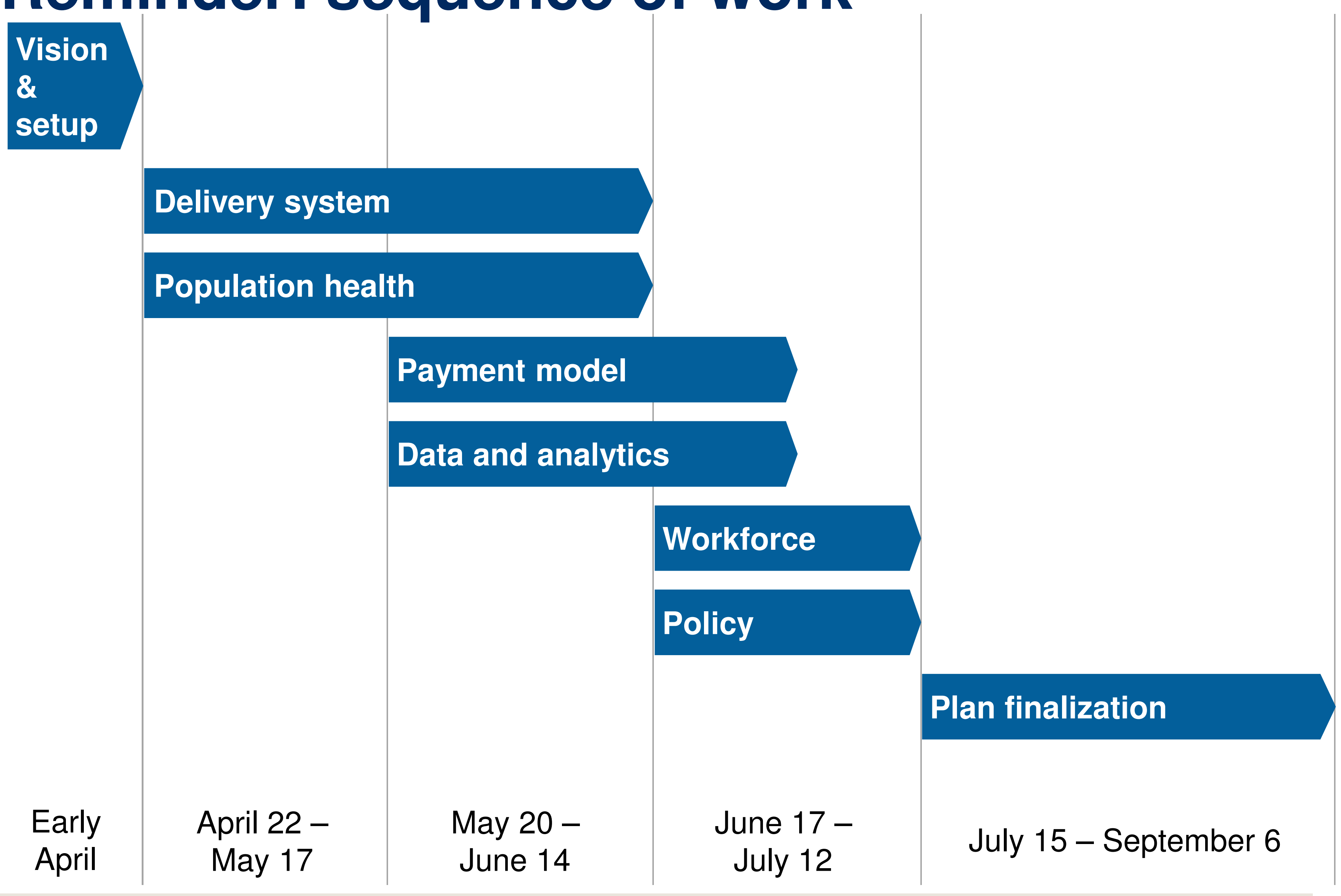
Our goal: achieving the "Triple Aim"

1. **Improving patient experience of care (including quality and satisfaction)**
2. **Improving the health of Delawareans**
3. **Reducing health care costs**

Reminder: our approach follows key areas of transformation

	Chair	Sponsor
Delivery System	▪ Bettina Riveros	▪ Rita Landgraf
Population Health	▪ Lolita Lopez	▪ Karyl Rattay
Payment Model	▪ Matt Swanson	▪ Bettina Riveros ▪ Steve Groff
Data / analytics	▪ Jan Lee	▪ Gary Heckert
Workforce	▪ Kathy Matt	▪ Jill Rogers
Policy	▪ Ed Freel	▪ Brenda Lakeman

Reminder: sequence of work



Reminder: guiding principles

Impact

- Develop a health care transformation strategy that is **multi-payer and multi-stakeholder** and focuses on **achieving the "Triple Aim"**
- **Be one of the leading states** in innovation and impact
- Achieve measurable results in **three years** through practical implementable goals
- Meet the near term objective of developing the State Innovation Plan while focusing on the **primary goal of transforming Delaware's health care**

Approach

- Focus on the **best interests of all Delawareans** and respect the voice of consumers (not just traditional stakeholders)
- Have no **"sacred cows"**
- Make use of **best practice** where possible, applying pragmatic judgment
- Focus on **getting to a practical plan**, rather than a long conceptual debate

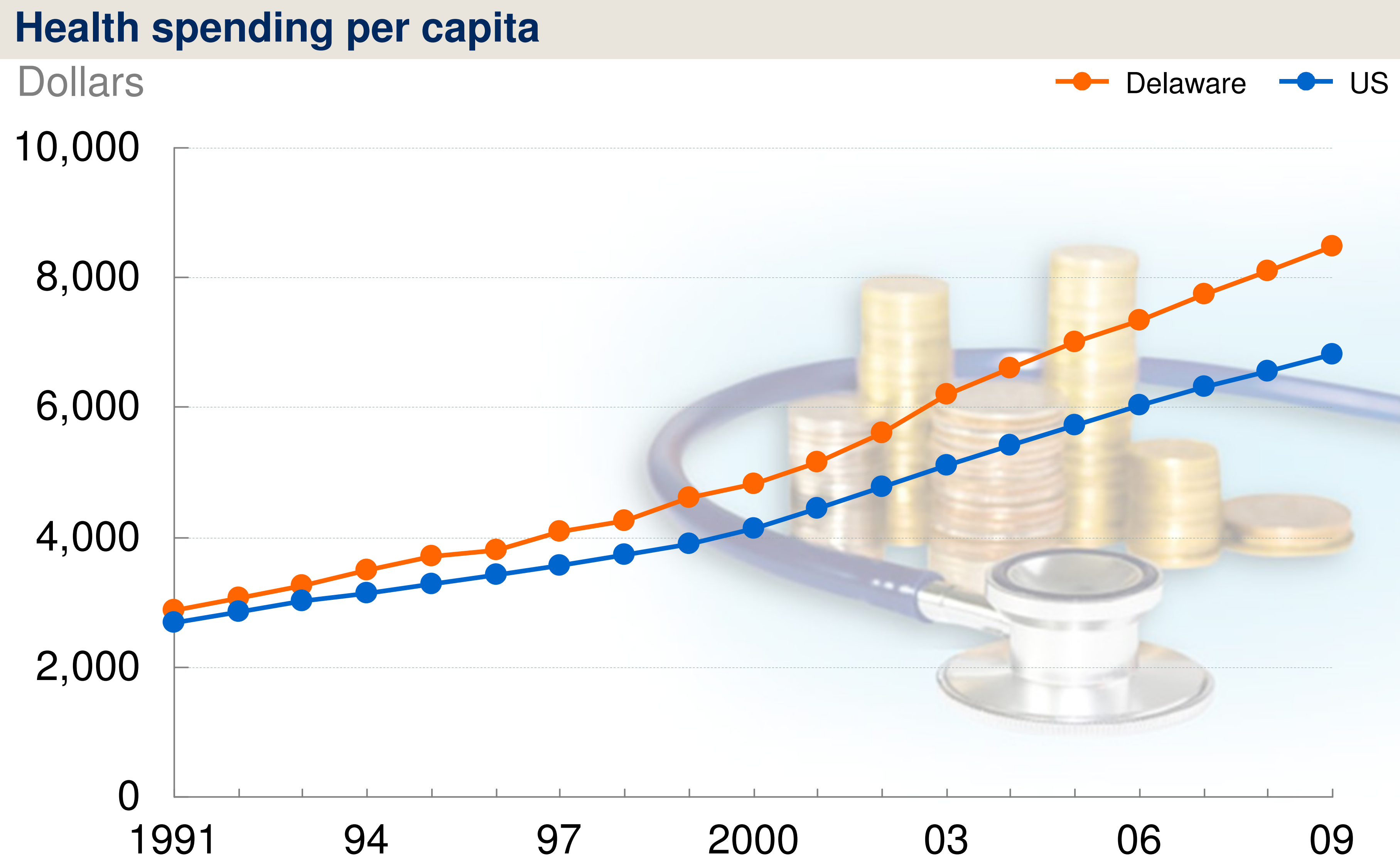
PROPRIETARY AND CONFIDENTIAL

Case for change

Elements of "Triple Aim"	Where we are today
Cost	1 DE's health spending is 25% greater than US average 2 Cost growth is high across segments 3 Health spending creates a significant cost burden, which has eroded real income gains nationally, and may put DE on an unsustainable cost trajectory
Health and health outcomes	4 Although DE has pockets of improvement, DE is near average on health status on many dimensions 5 And in a few areas (e.g., chronic disease), DE lags behind
Experience	6 DE has generally good access to care, but access is more limited in some areas 7 Across geographies, Emergency Room wait times are long 8 Anecdotally, patient experience is below aspirations and there is a need for more care coordination 9 Clinicians feel they work in silos and are unable to deliver best care

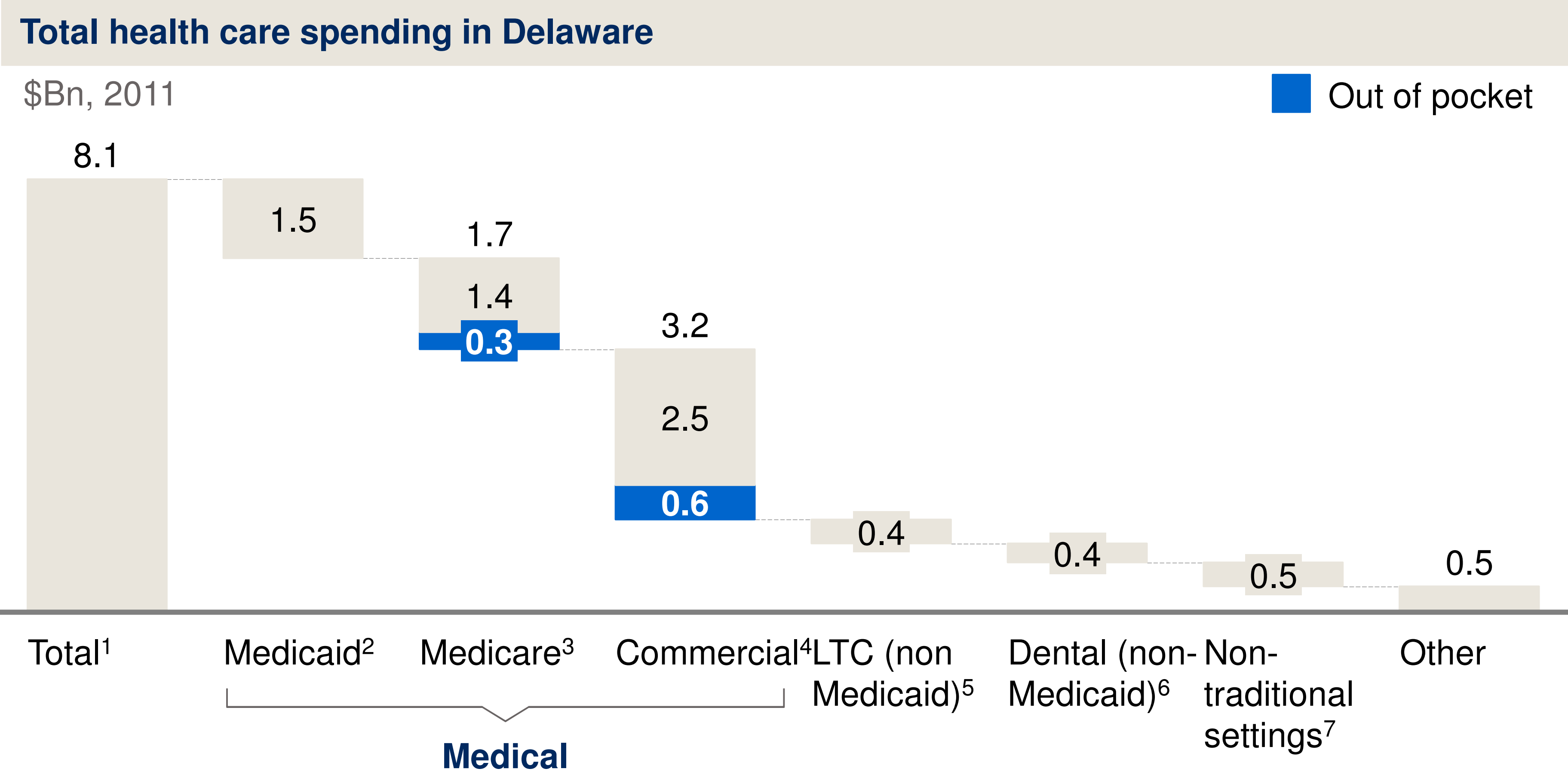
DE spend is 25% higher than US average

Health spending per capita



SOURCE: Kaiser Family Foundation

Health care spending in Delaware – 1st Draft

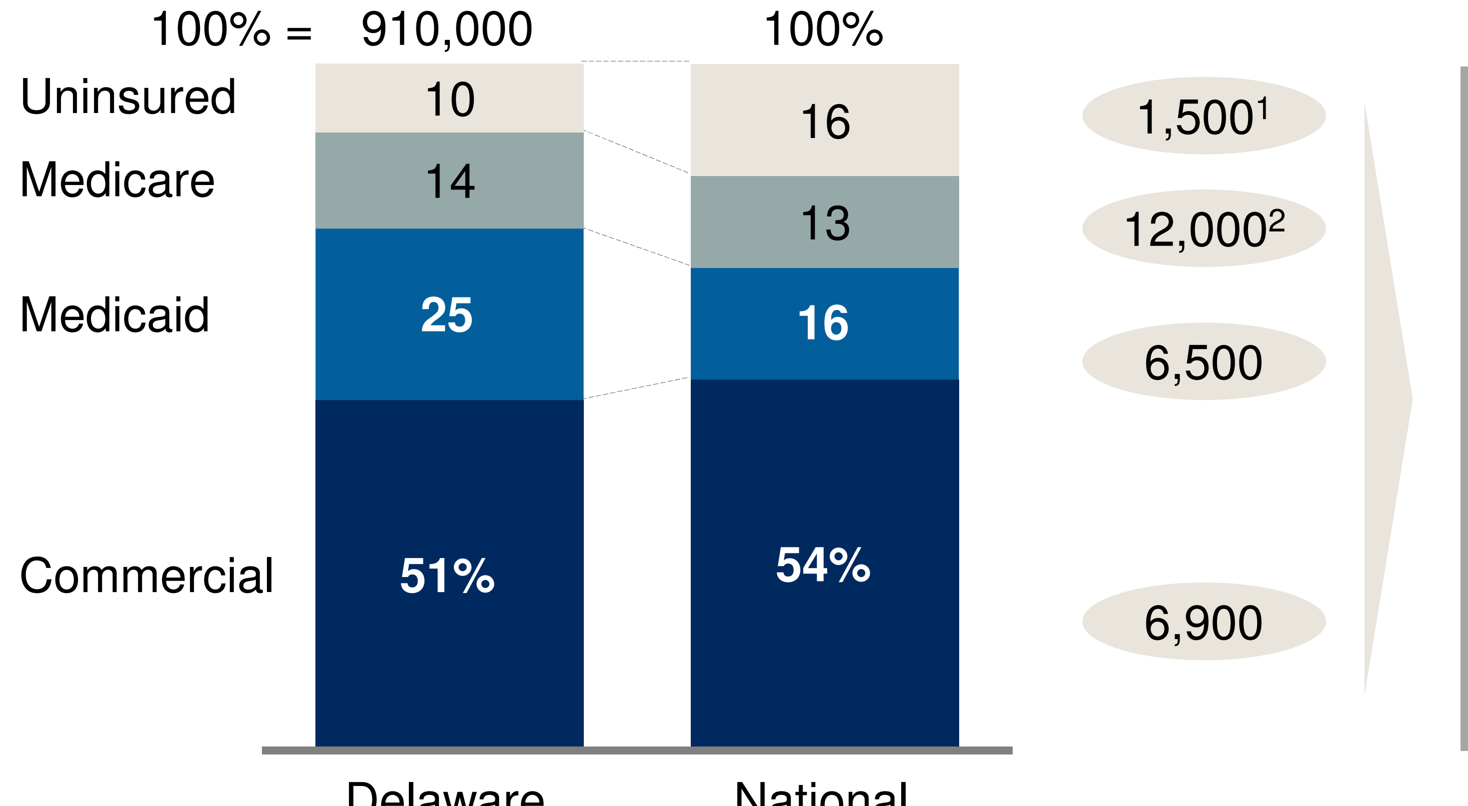


1 Total personal health care expenditure for Delaware (2009 estimate adjusted by national health spending growth rate for 2009)
2 Includes federal and state spending
3 Individual share under Medicare coverage estimated at 20%
4 Assumes 460,000 ESI covered lives at average PMPY of active state employee health plan; individual out of pocket share estimated at 20%
5 LTC includes total nursing home care (adjusted 2009 estimate) less Medicaid nursing facility spending
6 Adjusted 2009 estimate
7 Other Health, Residential, and Personal Care (includes payment for services in non-traditional settings, e.g., community centers, schools)

SOURCE: CMS: Health Expenditures by State of Residence (2009), Medicaid Statistical Information System (MSIS) State Summary Datamart (2011), Medicare Geographic Variation Public Use File (2011); Office of State Employees, Kaiser

PROPRIETARY AND CONFIDENTIAL

Part of higher spend stems from payer mix

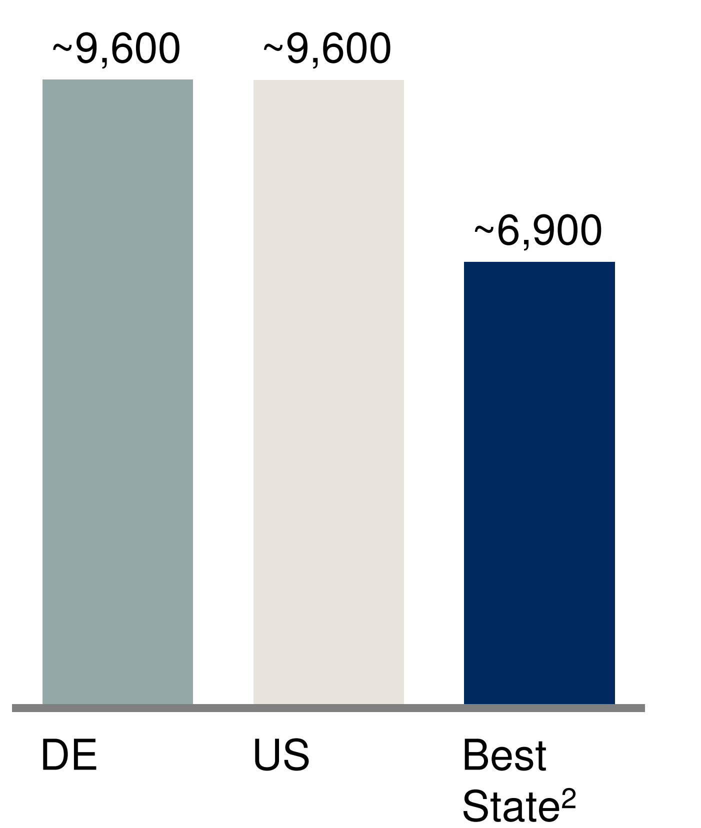


If DE had US average payer mix, keeping PMPYs constant, spend would be ~$340M lower (~5% lower)

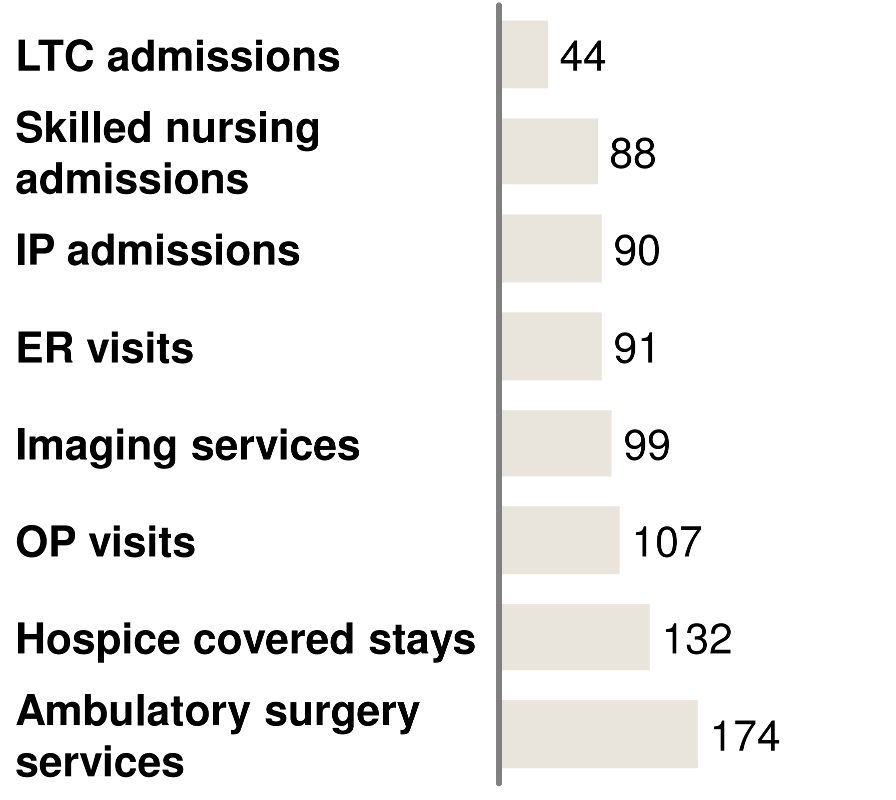
1: Estimate based on Kaiser's "Covering the uninsured"; number of uninsured and out of pocket plus compensated spend: ~$1,500 PMPY national mean
2: Medicare spend, including spend in dual eligibles; PMPY calculation double counts # of dual eligibles in denominator. Also includes out of pocket expenses

SOURCE: Kaiser Foundation, CMS, extrapolations from DE State Employees and Retirees data, US Census

Medicare payments vs. US average - draft



Per capita utilization by setting, 2011, % of US



1: Does not include out of pocket expenses. Includes dual eligibles in the denominator
2: Montana

SOURCE: CMS.gov: National Health expenditure data;
Health Indicators Warehouse, National Center for Health Statistics, CDC

Commercial payments vs. US average - draft

~5,100
~4,500
+15%
~5,300
~4,600
+16%

2010
2011

DE
US

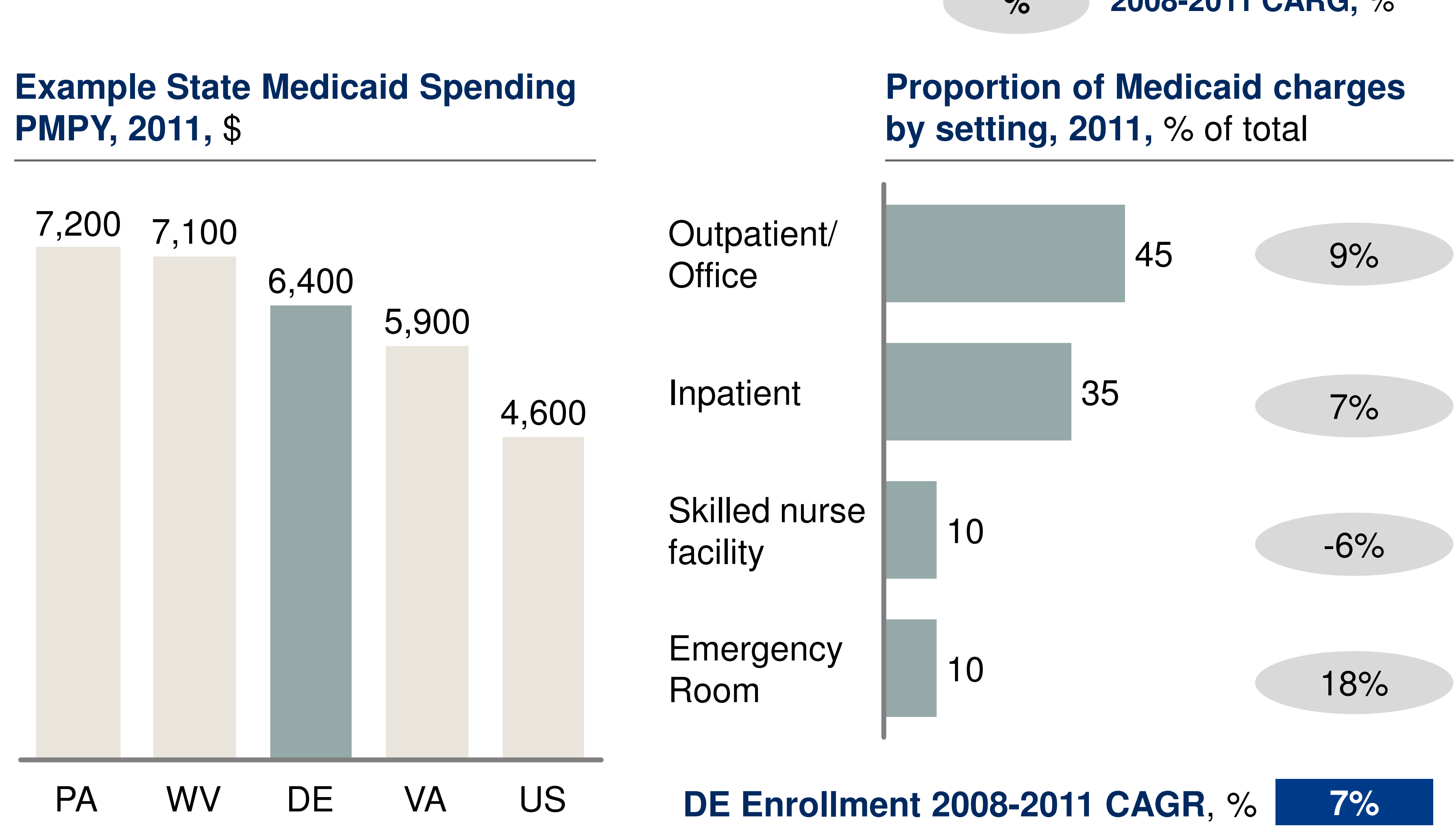
DE CAGR, % 4%

US CAGR, % 3%

1: Does not include out of pocket payments

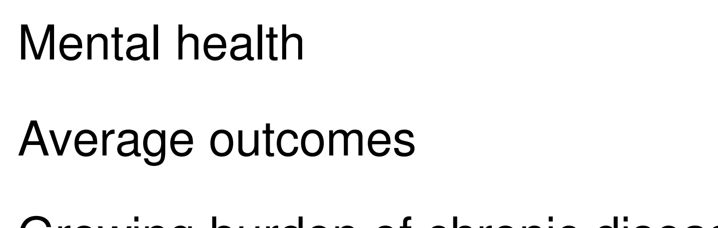
SOURCE: Truven commercial data

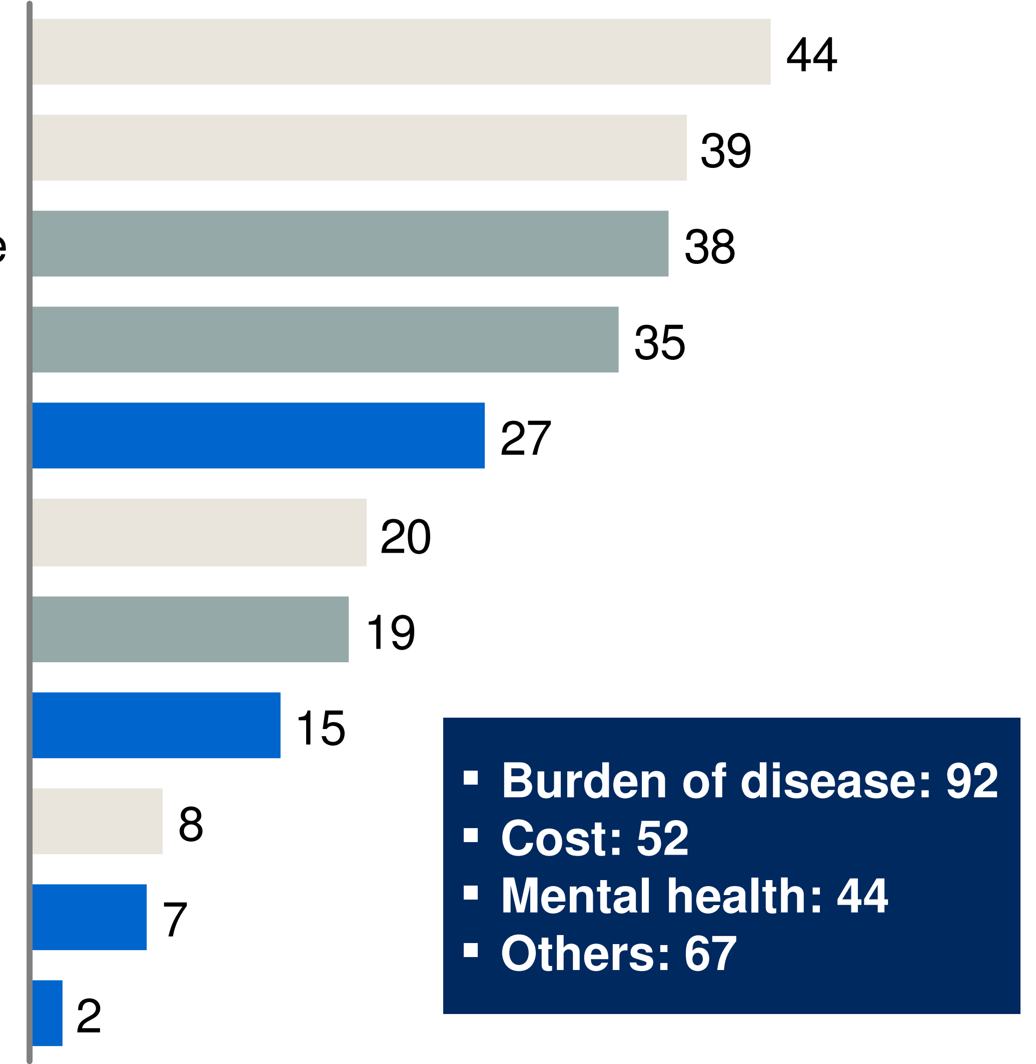
Medicaid payments vs. US average – draft



SOURCE: Medicaid State data; Medicaid (Healthcore presentation)

Issues identified on May 7th





- **Burden of disease: 92**
- **Cost: 52**
- **Mental health: 44**
- **Others: 67**

SOURCE: May 7th Kickoff session – issues identified by audience

Patient stories from May 7th (1/3)[1]

NOT EXHAUSTIVE

● Patient story shared on May 7th

	Healthy		Chronic		Special Needs	
	Healthy	Acute	Single	Multiple	Behavioral[2]	Disability[3]
Elderly						
Adult						
Adolescents						
Children						
Pregnant						
Infants						

"Dave"

"Jon"

"James"

"Mary"

1 All patient names and pictures have been changed

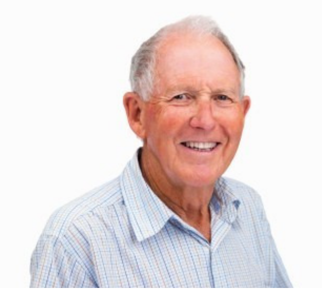
2 Includes mental health, addiction, substance abuse

3 Includes physical, mental and developmental disabilities

SOURCE: May 7th Kickoff session – patient stories submitted by attendees

Patient stories from May 7th (2/3)[1]

Ineffective care coordination



"**Dave**" is a 70 year old, Type II diabetic. He has emphysema and some dementia

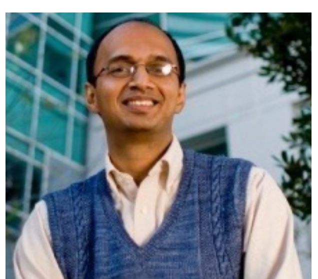
Situation

- Dave's doctors and nurses do not talk to each other
- This leads to multiple medications and treatment plans

Result

- Dave' mismanaged diabetes has led to multiple ER visits
- The lack of a plan frustrates his family
- Medications interacting against each other means one symptom is addressed while another gets worse

Care needs for individuals with disabilities



"**Jon**" is a young adult, who is deaf

Situation

- He is in a car accident and has minor injuries
- No one at the ED could communicate with Jon adequately to understand the emotional trauma he was experiencing.

Result

- While his physical injuries were addressed an important aspect of his care was missed.

1 All patient names and pictures have been changed

SOURCE: May 7th Kickoff session – patient stories submitted by attendees

Patient stories from May 7th (3/3)[1]

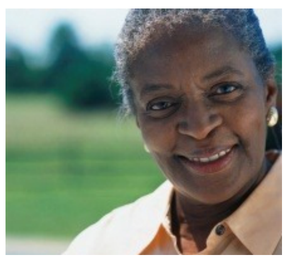
Access to mental health care

"**James**" developed psychotic illness while in college

Situation
- James dropped out of school
- He had no insight into his illness, and no access to appropriate mental health services

Result
- He became homeless and began using substances, leading to legal difficulties
- The system of care did not meet James's needs, resulting in more problems including social problems

Inappropriate care setting



"**Mary**" is a cancer survivor with continued medical complications

Situation
- She needs a medical procedure every 6 weeks
- On private insurance, she had the procedure in outpatient setting
- After transitioning to Medicare/ Medicaid, she had to have the same procedure as an inpatient

Result
- The cost of the procedure doubled – not the procedure itself or her medical needs
- There was no reasons to require the higher level of care facility

1 All patient names and pictures have been changed

SOURCE: May 7th Kickoff session – patient stories submitted by attendees

Agenda

▪ Introduction and review of case for change	*10:00*
▪ **Delivery system**	***10:45***
▪ Data and analytics	*11:45*
▪ Break	*12:30*
▪ Population health	*1:15*
▪ Payment model	*2:00*
▪ Break	*2:45*
▪ Patient engagement	*3:00*
▪ Version 1.0 answer	*4:00*

PROPRIETARY AND CONFIDENTIAL

Delivery system

Goals

- Describe how better care should be delivered, including targeted analysis of utilization and case studies about different models and input from consumers

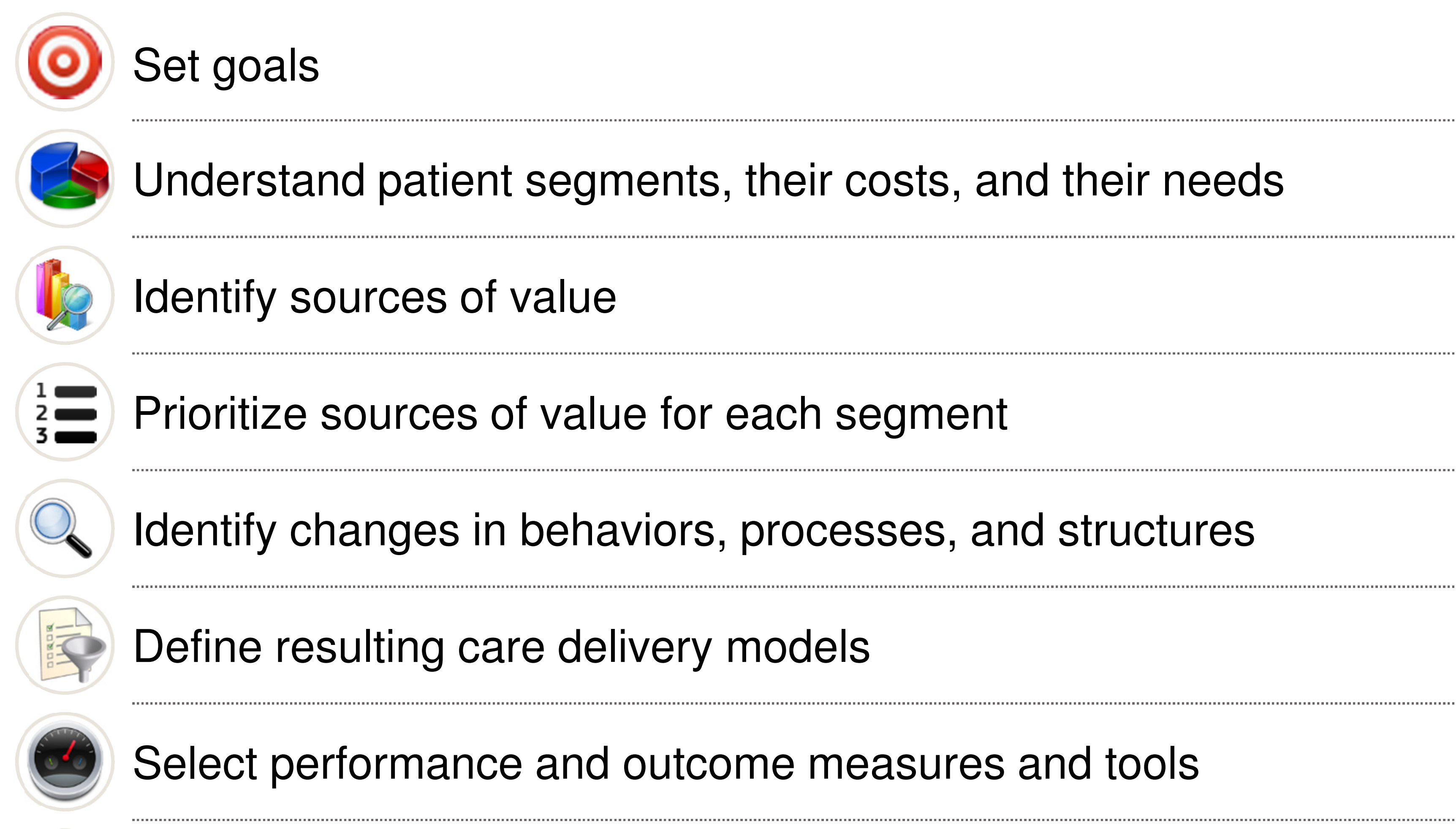
Areas of focus

- Assess different health care delivery models
- Analyze health system structure, including current health care delivery model, and evaluate potential changes and innovations
- Analyze delivery model options
- Assess and identify future quality measures
- Develop a strategy and plan to implement the new quality measurements
- Develop a plan to create and implement the new delivery model

Chair: Bettina Riveros

Sponsor: Rita Landgraf

Delivery System transformation approach



- Set goals
- Understand patient segments, their costs, and their needs
- Identify sources of value
- Prioritize sources of value for each segment
- Identify changes in behaviors, processes, and structures
- Define resulting care delivery models
- Select performance and outcome measures and tools
- Identify implications for other workstreams

Understanding our population

PRELIMINARY

	Examples of segment needs
Elderly	▪ Continuous, comprehensive care, and support and monitoring ▪ Rapid response system with triaging
Adults	▪ Coordinated disease management, access channels for self-management ▪ Appropriate and effective care for acute needs (especially elective procedures) ▪ Convenient, cost effective access to ambulatory/primary care
Adoles-cents	▪ Community services close to patient settings (home, schools) ▪ Access to primary care services, and ancillary services outside of acute setting
Children	▪ Age-appropriate immunization coverage ▪ Access to primary care services, and ancillary services outside of acute setting
Pregnant	▪ Access to OB/GYNs, and prenatal care ▪ Primary and secondary prevention (e.g., prenatal care)
Infants	▪ Age-appropriate immunization coverage ▪ Access to high quality NICU facilities

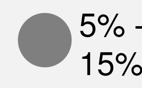
Significant variation in needs within segments (e.g., chronic conditions, behavioral health, special needs)

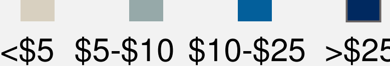
Potential sources of value

	Description	Examples
Primary prevention	▪ Prevention of disease by removing root causes	▪ Smoking cessation
Secondary prevention/ early detection	▪ Early detection of disease while asymptomatic to prevent disease progression	▪ Breast cancer screening ▪ Identification and mgmt of patients at risk of heart disease
Selection of provider type and care setting	▪ Utilizing highest value care settings and downstream providers	▪ Phone consultation vs. in-person visit ▪ Optimized specialist referrals
Effective diagnosis and treatment	▪ Evidence-informed choice of treatment method/intensity	▪ Reduction in inappropriate utilization of c-sections
Care coordination/ chronic disease management	▪ Ensuring patients effectively navigate health system and adhere to treatment protocols	▪ Care coordination, across specialties and channels for chronic conditions (e.g., CHF)
Provider productivity	▪ Reducing waste at provider center	▪ Improve flow in OR to increase number of surgeries performed

HIGHLY PRELIMINARY

Spend by payer and age segment

Total spend (% of total medical spend) <5%  5% - 15% >15%

PMPY ($ '000) 

Total medical spending and PMPYs by age segment and payer, 2011, $Millions / ($ PMPY)

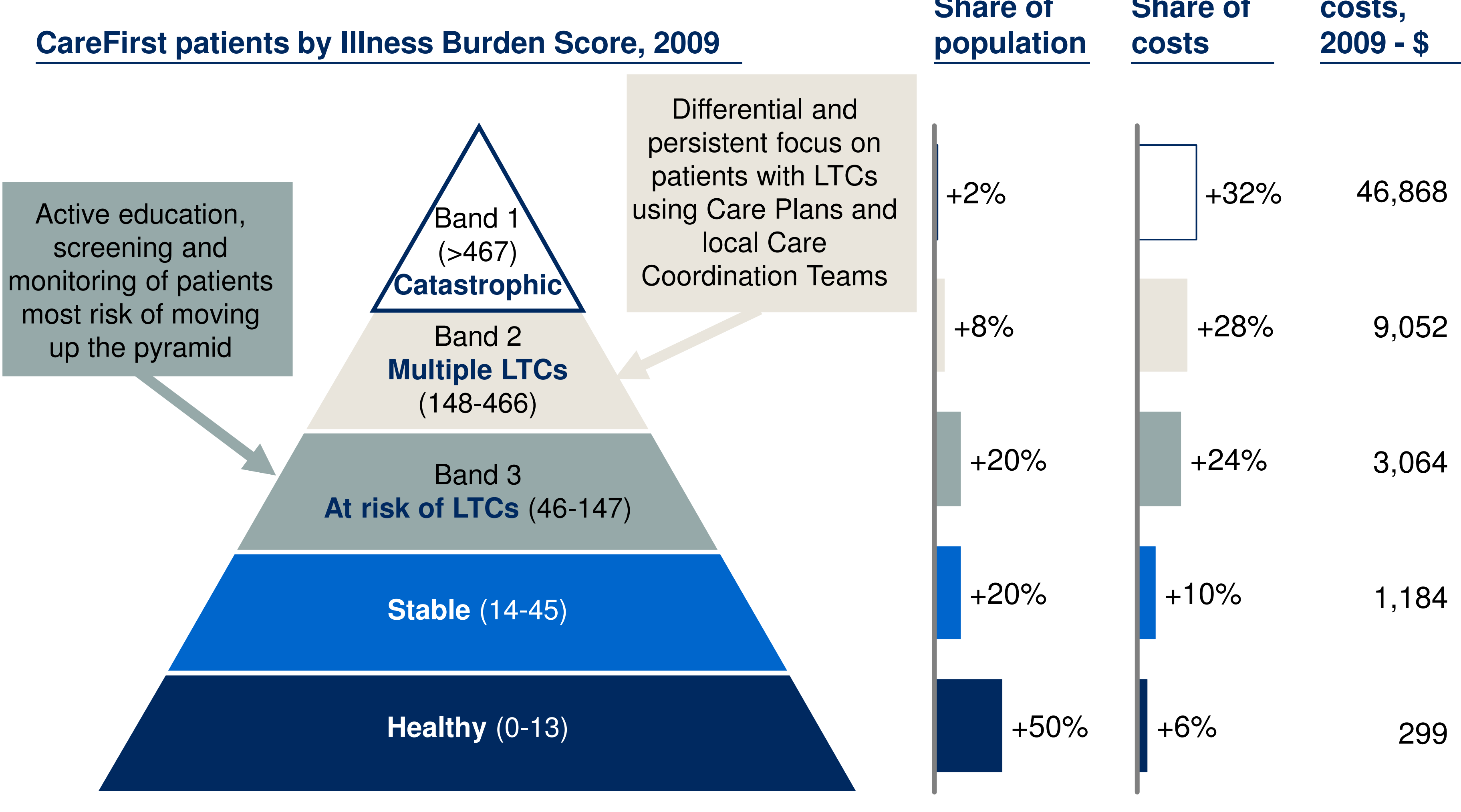
	Medicare[2]	Medicaid[3]	Commercial	Total[1,6]
Elderly	23% (12,800)	3% (19,700)	[4] 1% (12,800)	1,650 (13,400) 6.400 (7,750)
Adults[1]	5% (23,000)	14% (7,500)	43% (7,700)	3,850 (8,100)
Adolescents/ peds	- 0% (N/A)	6% (3,800)	5% (3,000)	750 (3,400)
Infants	- 0% (N/A)	1% (6,300)	2% (19,600)	150 (12,400)
Total	1,700 (13,900)	1,500 (6,500)	3,200 (6,900)	6.400 (7,750)

1 Estimated pmpy excludes 76,000 Adults and 12,000 Adolescents/ Peds who are not insured
2 Adds Medicare spend on dual eligibles, but excluded dual eligibles in denominator of PMPY calculation; 3 Includes all special needs populations
4 Estimate based on Medicare Advantage penetration (~5%), shown here for information purposes; spend and population added in Medicare column
5 Subtracts pregnancies to avoid double counting with adults; 6: total excludes the double counted dual eligibles in Medicare/Medicaid

SOURCE: Kaiser Foundation, CMS, extrapolations from DE State Employees and Retirees data, US Census

PROPRIETARY AND CONFIDENTIAL

Example approach to risk segmentation



LTC = long term condition

SOURCE: CareFirst

Spend by risk level (1/2)

Total spend (% of total medical spend): <5% | 5% - 15% | >15%

PMPY ($ '000): <$5 | $5-$10 | $10-$25 | >$25

Total medical spending and PMPYs by age segment and risk strata, 2011, $Millions / ($ PMPY)

	Healthy	Stable	At risk chronic	Mult. Chronic	Catas-trophic	Total
Elderly	2% (1,700)	3% (7,000)	6% (16,800)	7% (49,100)	8% (224,000)	1,650 *(13,400)*
Adults[1]	4% (970)	6% (4,000)	15% (9,700)	17% (28,300)	19% (129,000)	3,850 *(8,100)*
Adolescents/ peds	1% (410)	1% (1,700)	3% (4,100)	3% (11,900)	4% (54,400)	750 *(3,400)*
Infants	<1% (1,500)	<1% (6,200)	1% (14,900)	1% (43,500)	1% (199,000)	150 *(12,400)*
Total	390 *(950)*	645 *(3,900)*	1,500 *(9,400)*	1,800 *(27,000)*	2,100 *(125,000)*	6,400 *(7,750)*

1 Includes pregnant women

Note: Based on spend multipliers by risk strata from outside DE (CareFirst distribution and risk stratification)

HIGHLY PRELIMINARY

Spend by risk level (2/2)

Total spend (% of total medical spend) <5% 5% - 15% >15% PMPY ($ '000)

<$5 $5-$10 $10-$25 >$25

Total medical spending and PMPYs by age segment and risk strata, 2011,
$Millions / ($ PMPY)

	No Chronic conditions (CCs)	1 CC	2+ CCs	Mild MH[2]	Severe MH[2]	Total
Elderly	2% (4,300)	3% (9,100)	12% (15,000)	5% (22,100)	4% (75,500)	1,650 *(13,400)*
Adults[1]	32% (5,700)	6% (11,900)	7% (20,400)	12% (16,200)	2% (123,000)	3,850 *(8,100)*
Adolescents/ peds	11% (3,300)	1% (6,700)	<1% (8,800)	<1% (3,600)	<1% (39,000)	750 *(3,400)*
Infants	2% (12,400)	<1% (23,100)	<1% (31,400)	<7% (17,900)	<1% (203,000)	150 *(12,400)*
Total	3,100 *(5,000)*	600 *(10,600)*	1,200 *(16,600)*	1,100 *(17,600)*	400 *(86,600)*	6,400 *(7,750)*

1 Includes pregnant women
2 Mild mental health and severe mental health patients include patients that have chronic conditions (single or multiple)
Note: Based on spend multipliers by risk strata from outside DE, extrapolated to DE population and cost total

Potential areas of focus

	Healthy		Chronic		Special Needs	
	Healthy	Acute	Single	Multiple	Behavioral[1]	Disability[2]
Elderly						
Adult	A			D	F	
Adolescents	B	C		E	G	H
Children						
Pregnant						
Infants						

Example areas of focus

- **A** Prevention – adults
- **B** Prevention – youth
- **C** Effective diagnosis and treatment
- **D** Care coordination – adults/elderly
- **E** Care coordination - youth
- **F** Care coordination / health homes – adults/elderly
- **G** Care coordination / health homes – youth
- **H** Care coordination / health homes – special needs

1 Includes mental health, addiction, substance abuse
2 Includes physical, mental and developmental disabilities

Case examples: diagnosis and treatment

	Examples	Example impact
Protocols & guidelines		▪ Significant reduction in Inductions <39 weeks ▪ ~90% reduction in central line infections ▪ >80% stroke brain scan <24hrs
Patient and provider education	CareMore	▪ ~75% drop in neurosurgery site infection ▪ ~25% fewer hospitalizations
IT and decision tools	National Diabetes program	▪ ~13% reduction in cost of care for diabetics ▪ ~7% saving in total medical costs

SOURCE: Institute for Healthcare Improvement, CareMore site, Paulus RA, et al. Health Affairs 2008, Nagel et al., *Managed Care*, 2006, NHS sites

Emerging perspectives – effective diagnosis and treatment

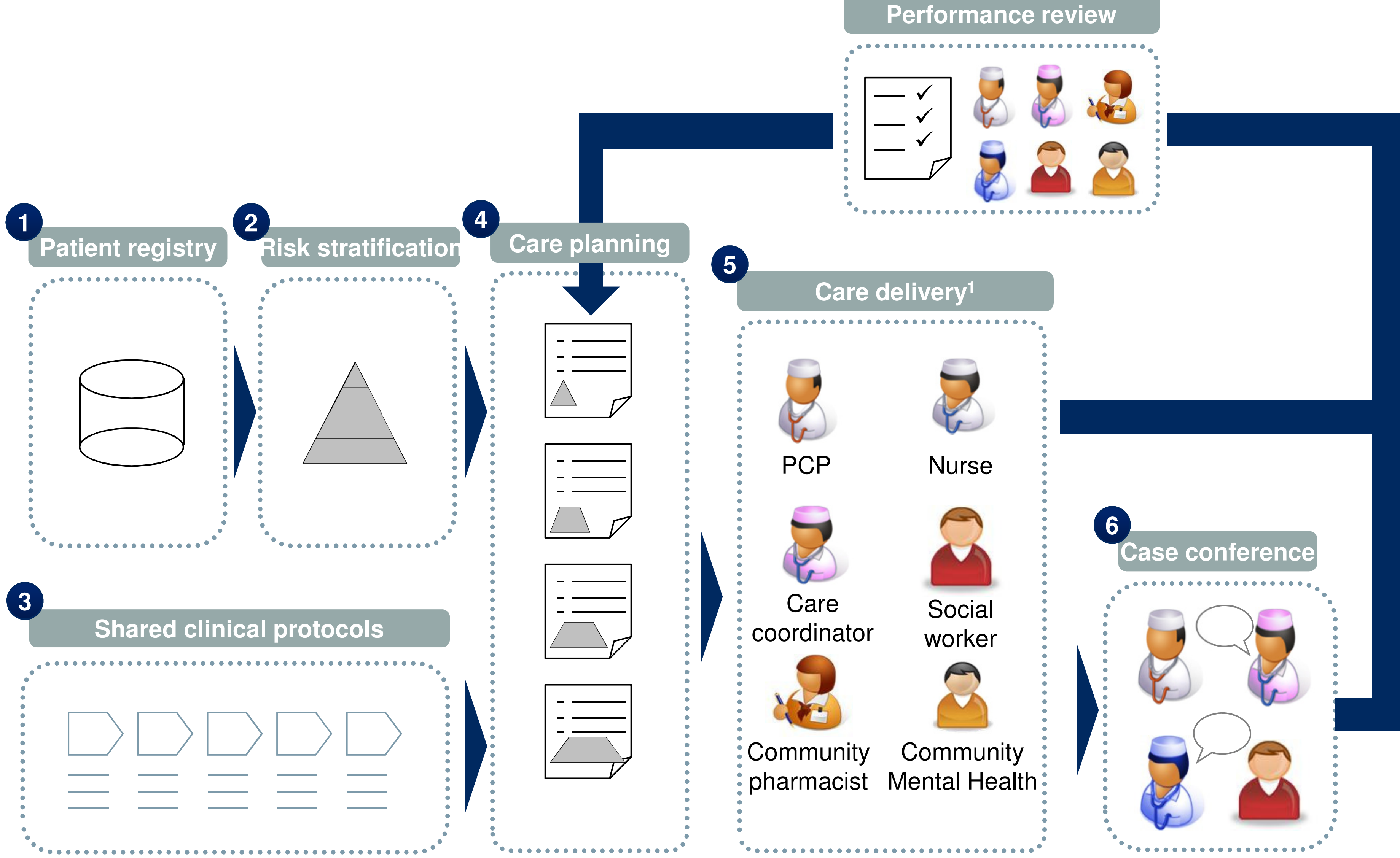
Challenges

- Reducing unwarranted variation
- Creating opportunities for earlier intervention
- Providing care at more cost effective settings
- Inconvenient access for consumers
- Bureaucratic process for providers
- Lack of patient accountability

Potential interventions

- Transparency around cost and quality
- Agreement on best practice protocols and mechanism to rapidly share
- Aligned incentives with evidence-based treatment of episodes
- Location of care closer to patient, and earlier interventions
- Expanded access of both hours and services outside acute setting
- Enhanced capabilities, especially at primary care level
- Patient ownership and accountability, including enhanced education and literacy

What does care coordination do?



1 Icons are illustrative only: any number of other professionals may be involved in a patient's care, a case conference or performance review

Emerging perspectives on care coordination

Information

- Access to information is a prerequisite for care coordination

Risk strata

- Shared utility for predictive risk stratification
- Focus on top 0.5% and next 5%; discussion on next segment

Care packages/ protocols

- Consensus-driven, standard care packages and protocols
- Intervention, resource intensity vary by risk, segments, and cost
- Clarify/create governance structure to facilitate and measure implementation of care plans, and rapid sharing of best practices

Care delivery

- Need multidisciplinary teams
- Care coordinator defined by task and skill requirements
- First coordination encounter in person

PROPRIETARY AND CONFIDENTIAL

Case examples: care coordination

Setting of Care Delivery Focus

Community
- Home care
- Community organizations

Ambulatory
- PCP
- Specialist
- Alternate settings (retail, tele, urgent)

Facility
- Acute hospital
- Specialty clinics (e.g., behavioral health)
- Long-term care centers

Agenda

▪ Introduction and review of case for change	*10:00*
▪ Delivery system	*10:45*
▪ **Data and analytics**	***11:45***
▪ Break	*12:30*
▪ Population health	*1:15*
▪ Payment model	*2:00*
▪ Break	*2:45*
▪ Patient engagement	*3:00*
▪ Version 1.0 answer	*4:00*

PROPRIETARY AND CONFIDENTIAL

Data & analytics

Goals

- Define the requirements relative to the delivery and payment models, assess how well current systems meet these needs and then evaluate options for how to proceed

Areas of focus

- Build an inventory of health data sources and systems
- Assess health data capacity and infrastructure
- Assess health data flow and reporting needs for State Innovation Plan
- Identify linkages among data systems
- Analyze options to close analytic gaps and build future-state analytic capabilities
- Develop plan for building data analytic capacity for State Innovation Plan

Chair: Jan Lee

Sponsor: Gary Heckert

Topics for the data and analytics session

Topic	Time
▪ Context of data and analytics in DE's State Innovation Model (SIM)	*5 min*
▪ Review of data and analytics capabilities for innovation in care delivery and payment	*10 min*
▪ Overview of the DHIN's capabilities	*10 min*
▪ Discussion: additional capability enhancements	*20 min*

Key design questions

- A What **capabilities** do key stakeholders **require** to implement the care delivery and payment innovation?
- B What **current** capabilities does Delaware have?
- C What is the optimal level of **infrastructure standardization**?
- D What is the best **strategy for development**?
- E What will be the **pace of roll-out**?
- F What is the required **budget**?
- G What is the best **funding** model?

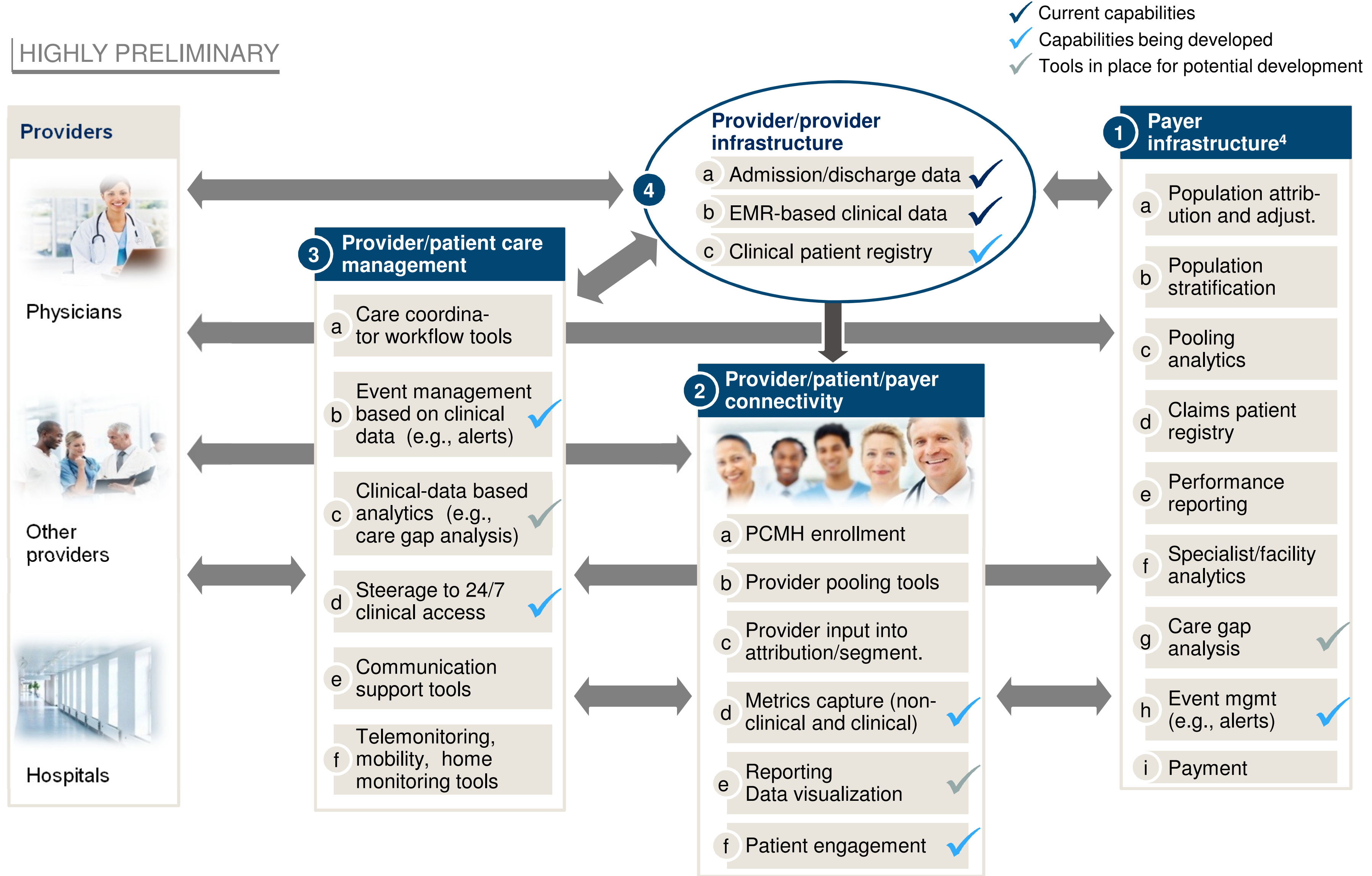
Core care delivery and payment innovation technology beliefs

- **Technology is an enabler** to any care delivery and payment innovation program and should **not be the rate limiter**
- Successful programs **are iterative, focusing first on quick-wins** then set priorities on additional capabilities
- Program and technology design should be **provider-centric and patient-centric** to maximize adoption
- Delaware can significantly leverage **existing capabilities** (e.g., health information exchange) to accelerate impact

Capabilities required to enable new models

Category	Description
1 Payer infrastructure	▪ Payer tools that **analyze claims and other data** to determine cost, quality and payment
2 Provider /patient /payer connectivity	▪ Channels (e.g., provider/patient portal) for **information exchange** between stakeholders to improve care delivery and transparency
3 Provider/ patient care management	▪ Provider tools to **coordinate care** for high risk patients
4 Provider/ provider infrastructure	▪ **Clinical data exchange** among stakeholders, including longitudinal patient registry

Typical technology solution architecture



DE has unique assets

Details to follow

Category	Assets/uniqueness
Existing systems/ infrastructure[1]	▪ DHIN ▪ PMP ▪ MMIS ▪ Health registries ▪ DPH databases
Enabling IT trends	▪ Increasing EMR adoption rates ▪ 98% eRx pharmacy adoption
Ongoing initiatives (not exhaustive)	▪ DC-PCMH (Delaware Collaborative-PCMH) ▪ Highmark PCMH ▪ Hospital PCMH (e.g. Christiana's Dep. of Family Medicine) ▪ Other initiatives
Manageable size	▪ Fewer hospitals, but with significant IT capabilities ▪ Fewer patients/providers

1 Payer capabilities to be evaluated and included

If You're a Geek…
… this is what DHIN looks like:

Papastavros
Nemours
Tri State
CCHS
BB
BH
St F
LC
Quest
DPS
Nanticoke
MDI
OMI
DIA
VPN or other transport method
DHIN Immunization Web Service
Med Labs Diag 2013
DHIN SFTP
Immunization from Nem, PCC, CVS
Nanticoke ADT / ELR for MU2
Nexus Interface Manager
Accu Reference Lab 2013
Atlantic General ADT / Lab 2013
Via Affinity GW
DE Health Net 2013
DPH
Syndromic Surveillance
Electronic Reportable Lab
Immunizations
Query / Retrieve
DHIN
Grid
eOrders 2013
AP at Dr's Office Retiring 2013
Inbox at Dr's Office
Dr's Office EMR System iNexx iNbox

What DHIN does

Data Senders	DHIN	Data Receivers

Aggregates all known data about each patient
- Lab results
- Radiology reports
- Pathology reports
- Hospital ADTs
- Transcribed reports
- +/- Medication history

Auto-print

or

Populate EMR

or

View data via web portal

Current membership in DHIN (as of May 2013)

Blue = new in FY13
Gray = likely prospect
✓ = in PROD
➢ = in CERT

★ Hospitals (100% + out of state)
- ✓ Bayhealth
- ✓ Beebe
- ✓ Christiana Care
- ✓ St Francis
- ✓ AI duPont
- ✓ Nanticoke
- ➢ Atlantic General (MD)
- Penninsula Regional (MD)
- Union Hospital (MD)

Labs (~99% of results)
- ✓ Lab Corp
- ✓ Quest
- ✓ Drs Pathology Svcs
- Med Labs Diagnostics (NJ)
- ➢ Accu Reference Labs
- Mercy Diagnostic Labs (NJ)
- Ameritox (B'more)

Radiology Groups (~97% of studies)
- ✓ Tri-State Open MRI
- ✓ Papastavros
- ✓ Ocean Medical Imaging
- ✓ Mid-Del Imaging
- ✓ DE Diagnostic Gp
- ✓ Diag Imaging Assoc
- CNMRI

Health Plans (covering ~43% of DE residents)
- ✓ Medicaid
- ✓ State Employees
- ✓ Highmark BCBS DE

Providers (~98%)
- Over 7,000 users in 659 practices

★ FQHCs (100%)

★ Skilled Nursing (100%)

Assisted Living (80%)

Home Health (4)

Hospice (3)

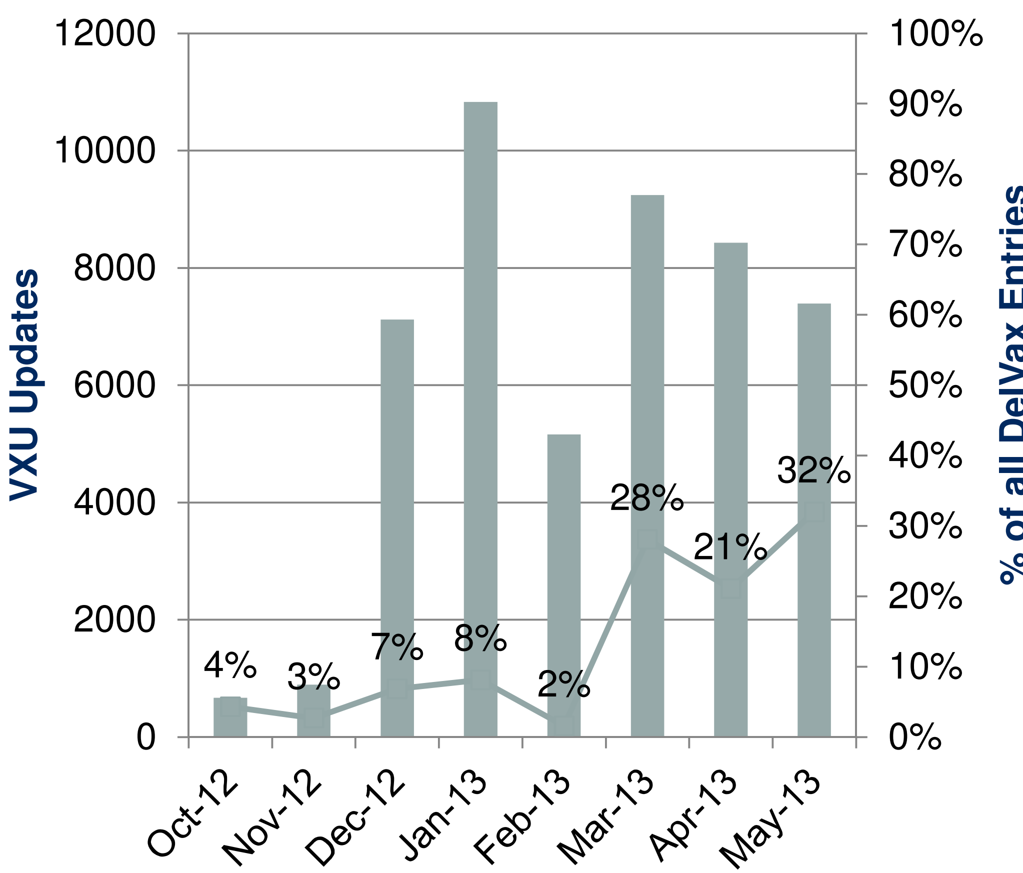
Pharmacies (5)

Division of Public Health

CRISP (Maryland State HIE)

DHIN's current services (as of June 2013)

- Results Delivery
- Query (The Community Health Record)
- Public Health Reporting
  - Syndromic Surveillance (hospitals)
  - Reportable labs (hospitals)
  - Immunizations (hospitals and practices)
- Certified EHR interfaces (68% of EHR practices)



Near term development activities

Currently in Development

- Event Notification Service (Aug 2013)
- Image viewing (? Jul 2013)
- Care Summary Exchange
- Bi-directional Immunization Exchange (Dr. DPH)
- Continue to on-board new data senders
- Consumer engagement tools (Oct 2013)

Planned within Next Year

- Add Public Health lab as a data sender
- Incorporate newborn screening
- Connect DHIN and CRISP
- Connect with the Federal network (eHealth Exchange)
- Clinical quality measure reporting
- Reports/views based on natural language processing
- Work driven by SIM grant

Agenda

▪ Introduction and review of case for change	*10:00*
▪ Delivery system	*10:45*
▪ Data and analytics	*11:45*
▪ Break	*12:30*
▪ **Population health**	***1:15***
▪ Payment model	*2:00*
▪ Break	*2:45*
▪ Patient engagement	*3:00*
▪ Version 1.0 answer	*4:00*

Population Health: overview

Goals

- Identify and prioritize set of programs that:
  - Ensure seamless integration and coordination of the Delivery System model with the broader community, and with non-healthcare providers and organizations
  - Ensure that all Delawareans understand the importance of primary and preventive care and how to access and navigate the health care, community and public health systems

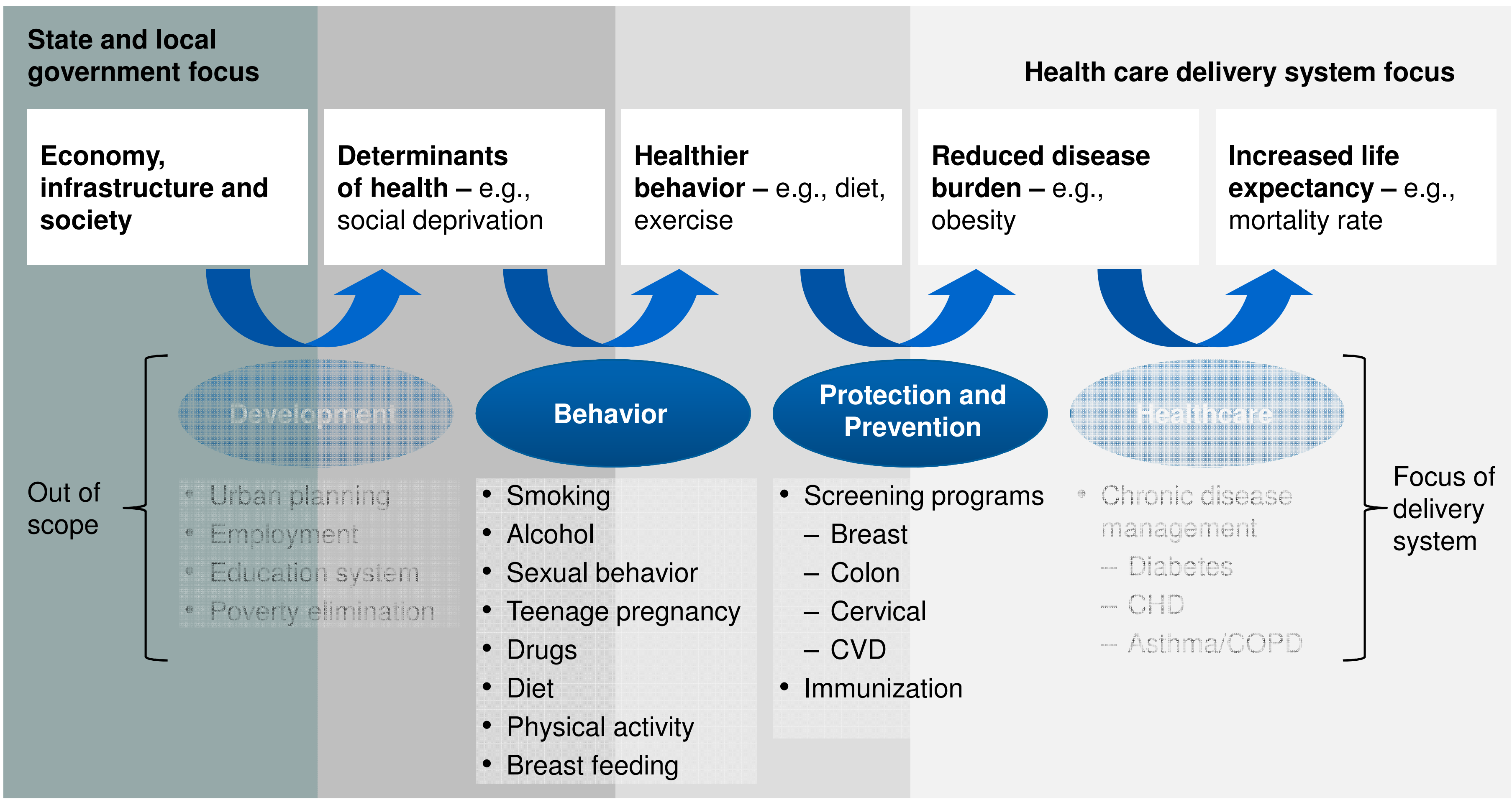
Areas of focus

- Assess population health requirements
- Analyze options for population health improvements
- Map together options of population health and health care delivery model
- Develop a plan for improving population health

Chair: Lolita Lopez

Sponsor: Karyl Rattay

Population health focus



Delaware's population health needs

NOT EXHAUSTIVE

	Example needs	Example recommendations
Governor's Council and DE Burden of Disease reports	▪ High tobacco use and excessive alcohol ▪ Lack of exercise, poor diet and high obesity ▪ High prevalence of diabetes and CVD	▪ Create more responsive healthcare system (e.g., training to serve at-risk populations) ▪ Create healthy and supportive environment (e.g., joint-use agreements with schools' physical activity resources) ▪ Build capacity for individual health (e.g., obesity prevention campaign in workplace)
State Health Assessment	▪ Low coordination of care with public health ▪ Low level of behavioral health treatment and mental health well-being	▪ Create "healthline" that provides education for improving health behaviors ▪ Establish school district health champions, providing role modeling and guidance ▪ Increase breadth of mental health screening and treatment

SOURCE: DE public health reports, Governor's council recommendations, DE burden of disease reports

Ongoing efforts in population health

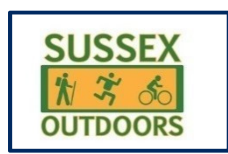
NOT EXHAUSTIVE

Population health challenges

Contributing factors

- **Lifestyle factors (e.g., smoking, obesity)**
- **Access to care (e.g., insurance status, provider availability)**
- **Inadequate screening / treatment of risk factors**
- **Suboptimal treat-ment of disease[1]**

Existing DE interventions

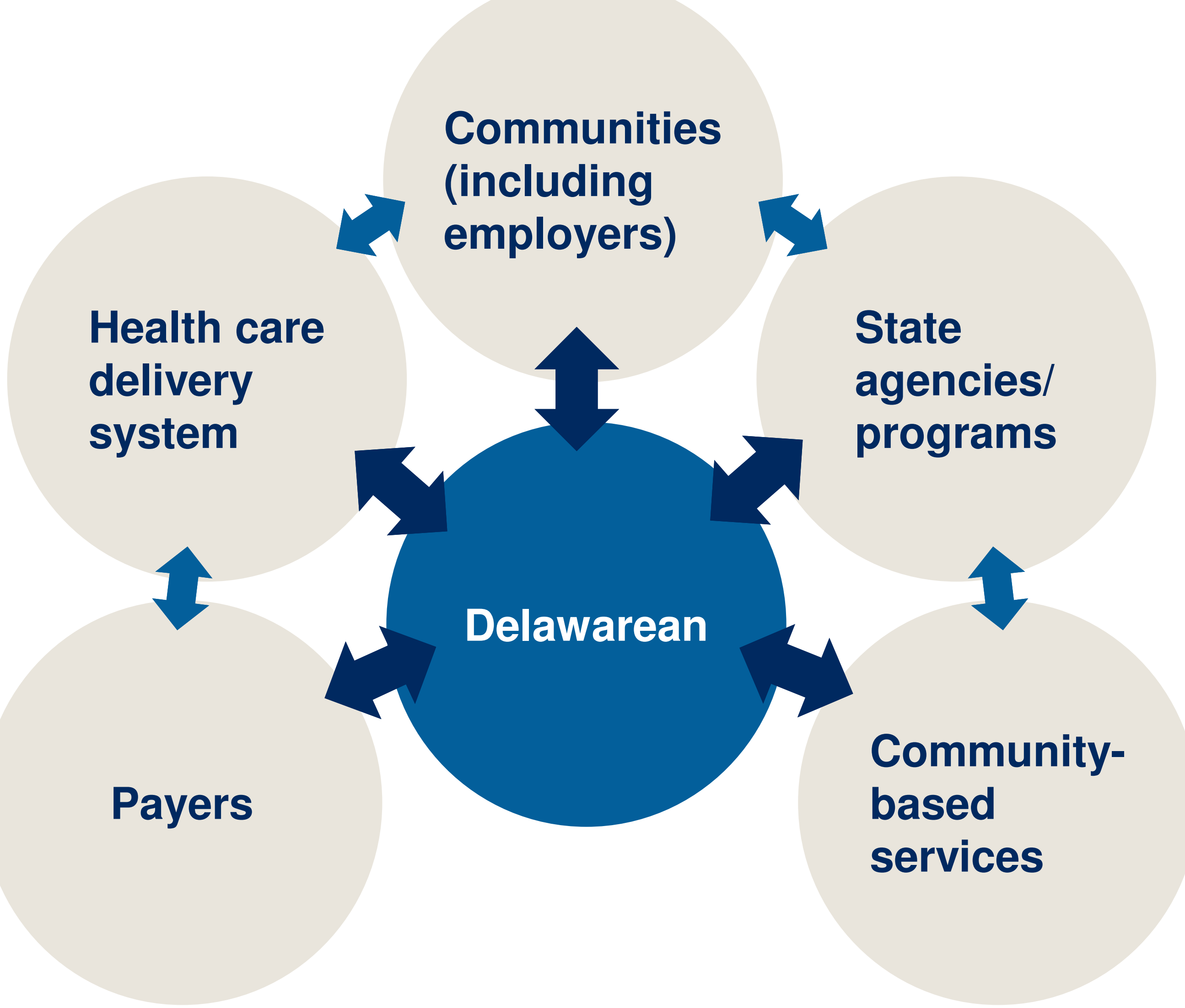


1 Focus of delivery system

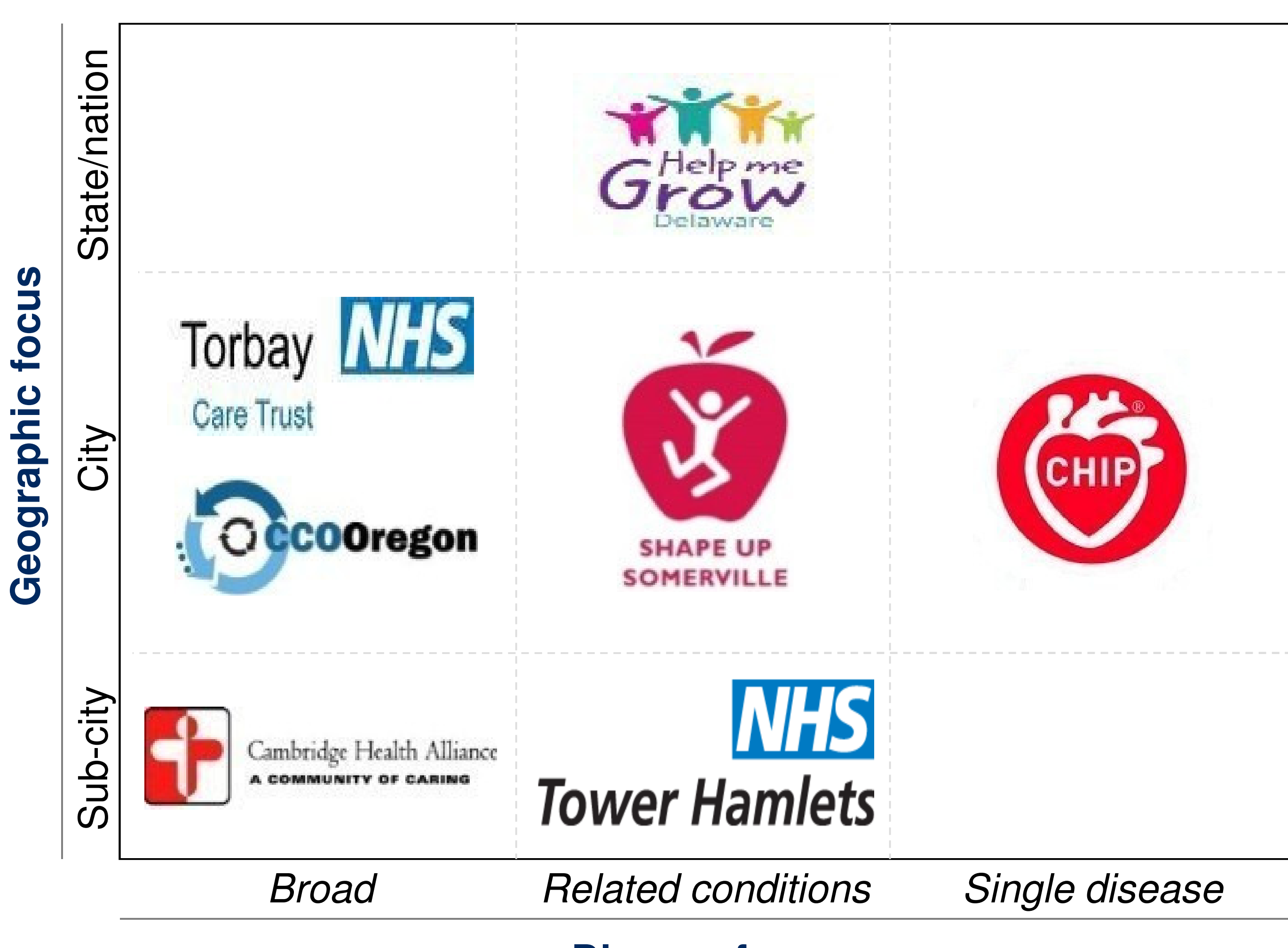
SOURCE: Report to the Governor's Council on Model Initiatives (2013)

ILLUSTRATIVE

Integration as a priority



Case examples



SOURCE: Interviews with program representatives; Program websites; New York Academy of Medicine: *A Compendium of Community-based Prevention Programs* (2008)

Case example: Tower Hamlets (1/2)

United Kingdom

Population health and delivery system aligned into 8 care networks, each with population of 20-40K

Hospital
Provider practice

SOURCE: Interviews with program representatives; Program website

Case example: Tower Hamlets (2/2)

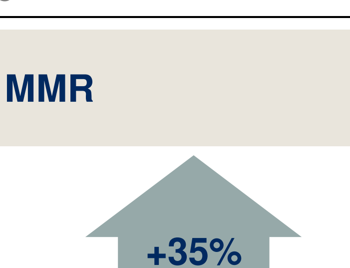
Performance improvements

Percentage point increase

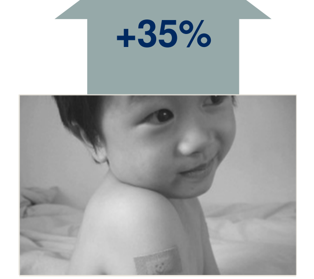
Patients satisfied with access

+20%

MMR



+35%



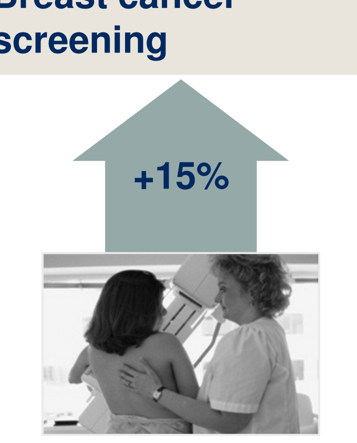
Patients with care plans

+80%

HbA1c <7.5

+8%

Breast cancer screening



+15%

District nurse productivity

+20%

What it takes

- Facilitate clinical leaders to articulate common vision
- Develop simple visual tools to support operations management
- Design and implement incentives to shift behaviours
- Ensure individual and collective accountability to performance goals
- Provide capability building applied in real life

SOURCE: Interviews with program representatives; Program website

Case example: CCO Oregon

Coordinated Care Organization Service Area Density

* Indicates CCO service area varies by zip code

CCO Count 1 2 3 County Boundaries

Created by Office of Forecasting, Research and Analysis, OHA/DHS, March 1, 2013

- **Community health workers foster conn-ectivity with local programs/services**
- **Private electronic health information exchange facilitates data sharing**
- **New Oregon Trans-formation Center provides technical assistance to CCOs**
- **Oregon Health Authority articulates guiding principles (e.g., Triple Aim)**
- **CCO partnerships unite local stake-holder groups (e.g., payers, providers)**
- **CCOs implement community-based strategies to address health challenges**

SOURCE: OR Health Policy Board website; OR Health Care Innovation Plan (2012); CCO Oregon website

Case example: Cambridge Health Alliance

Cambridge Health Alliance
A COMMUNITY OF CARING

Regional service areas created to tailor interventions to community needs

Programs / services developed to fill gaps in community-based resources

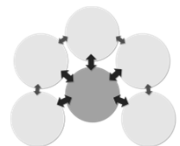
Volunteer Health Advisors provide culturally-sensitive community outreach

Delivery system and public health formally linked through health department

Outcomes measured rigorously through collaboration with academic institutions

SOURCE: Cambridge Health Alliance website

Potential integration in DE – early ideas



Community stakeholders organize regional "neighborhoods" and develop local population health strategy

Non-traditional health care workers (e.g., health ambassadors) link community members with local programs and services

Delivery system integrates with community organizations (e.g., through shared incentives, common governance)

IT resources educate patients about local resources

Common scorecard used by all stakeholders to measure success

Design questions for integration

For discussion today

- What is the purpose of the integration?
- **Will there be a geographic focus (e.g., aligned with ACO, ZIP)?**
- **Will there be a disease focus?**
- **Will there be a segment focus (e.g., newly insured, disparities)?**
- How to foster coordination through people, processes, and systems?
- Who are the integration partners?
  - Who leads the integration?
  - What is the degree of linkage amongst partners?
- How prescriptive is the integration plan?

SOURCE: Institute of Medicine. "Primary Care and Public Health - Exploring Integration to Improve Population Health." (2012)

Agenda

▪ Introduction and review of case for change	*10:00*
▪ Delivery system	*10:45*
▪ Data and analytics	*11:45*
▪ Break	*12:30*
▪ Population health	*1:15*
▪ **Payment model**	***2:00***
▪ Break	*2:45*
▪ Patient engagement	*3:00*
▪ Version 1.0 answer	*4:00*

PROPRIETARY AND CONFIDENTIAL

Payment model workstream charter

Goals

- Identify the right payment model (e.g., pay for value, episodes and capitation) to incentivize providers to optimize quality and better manage costs

Areas of focus

- Analyze peer state programs
- Analyze data to inform evaluation of payment models
- Synthesize analyses and implications for payment model
- Analyze options for change, including potential impact and trade-offs
- Develop preferred payment option and impact
- Develop financial forecast of impact of new payment models
- Develop plan to implement payment model

Chair: Matt Swanson

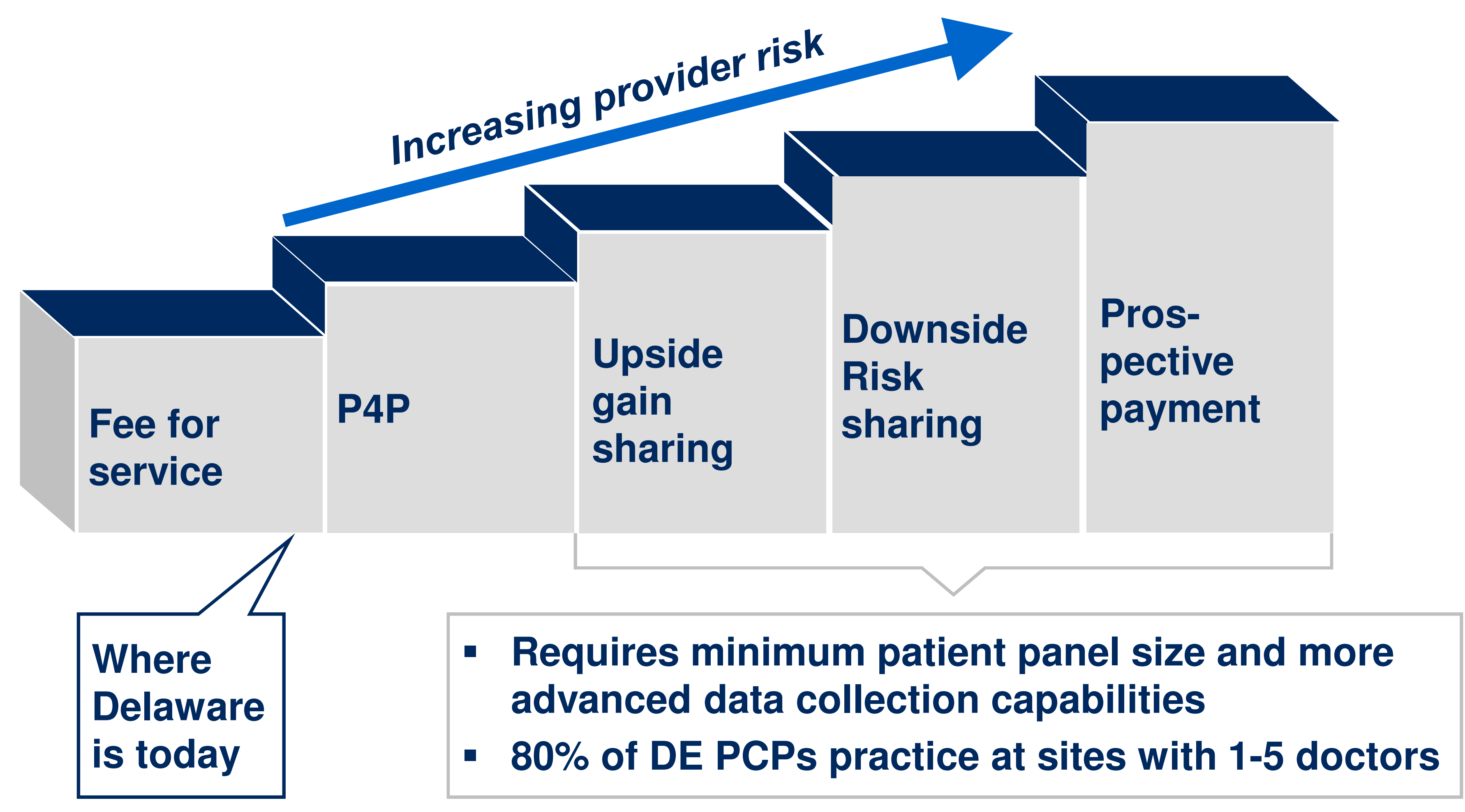
Sponsor: Bettina Riveros, Steve Groff

Key design considerations

- ❑ Scope of provider accountability
- ❑ Reward structure
- ❑ Performance aggregation
- ❑ Pace of roll-out
- ❑ Defining level of performance rewarded
- ❑ Pace to end-state payment model

There are also important **technical** decisions, e.g., metrics, attribution, risk adjustment

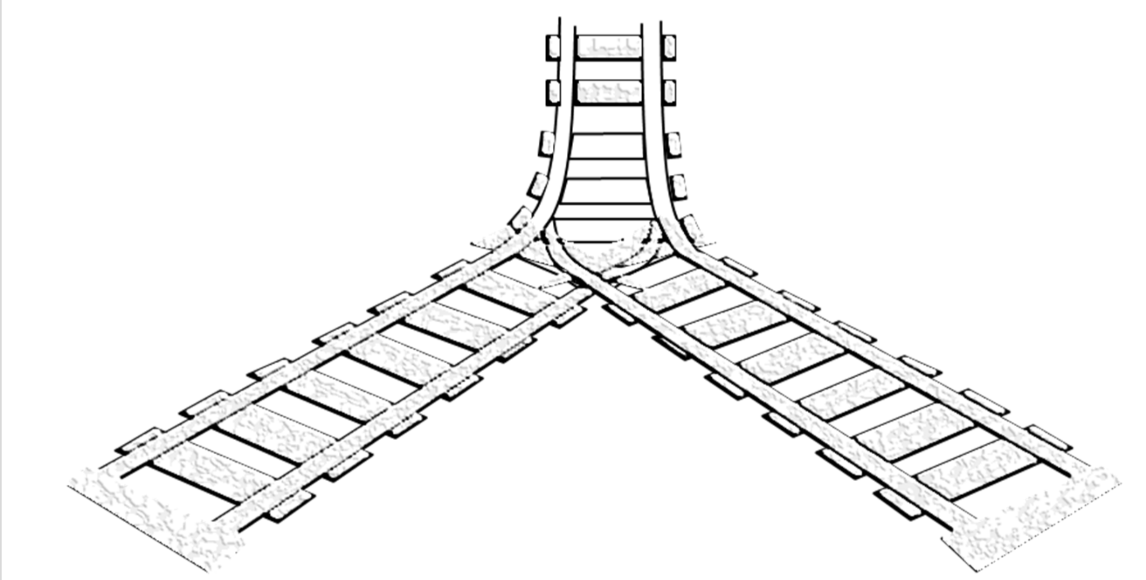
What is the right reward structure?



SOURCE: Delaware Department of Health and Social Services, DE Health Care Commission Health Care Workforce Report 2012, SK&A physician database, May 2013, Interviews

Potential implications for DE

ILLUSTRATIVE



Track 1

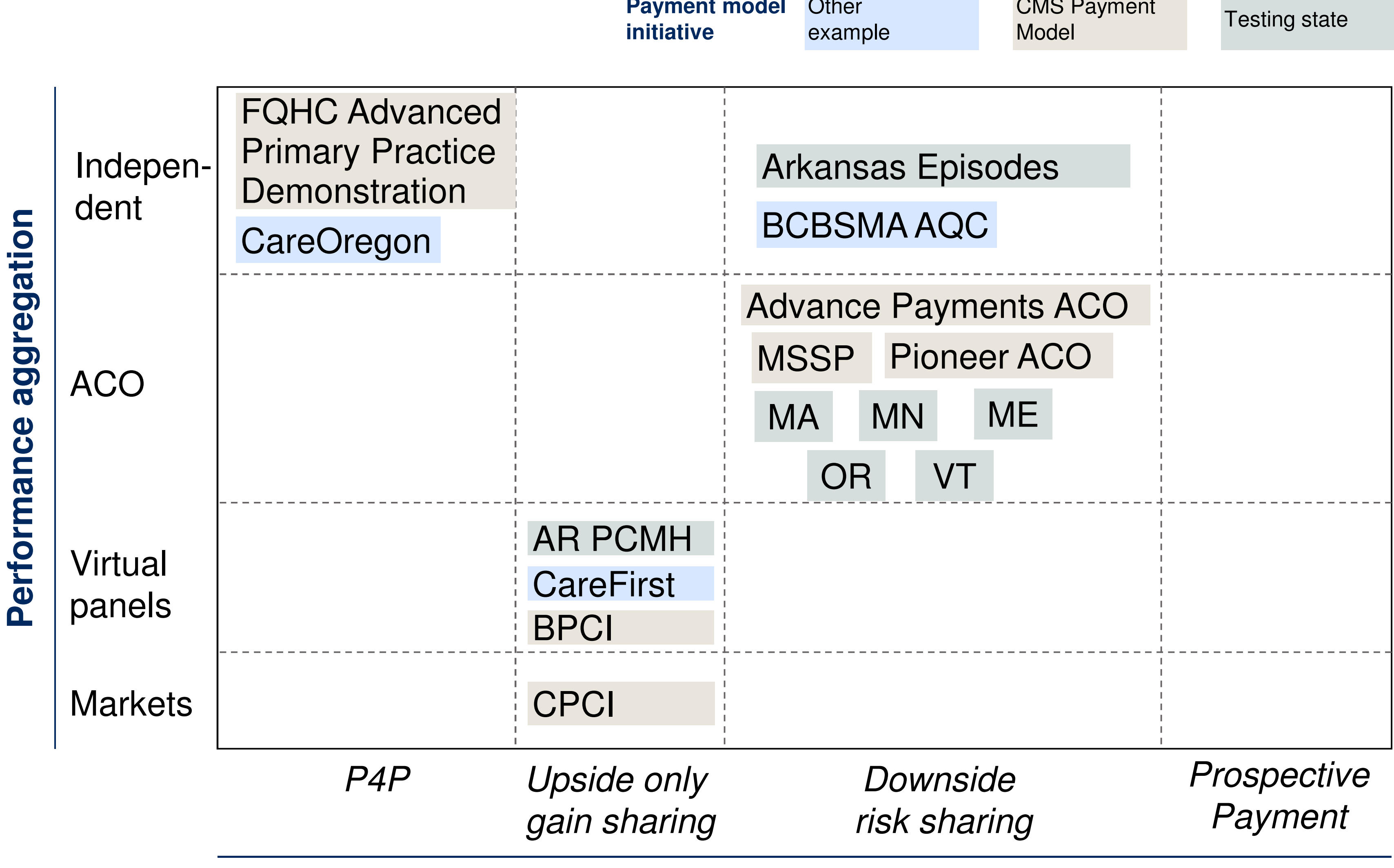
- Accessible to broad range of providers
- Phased transition to gain sharing

Track 2

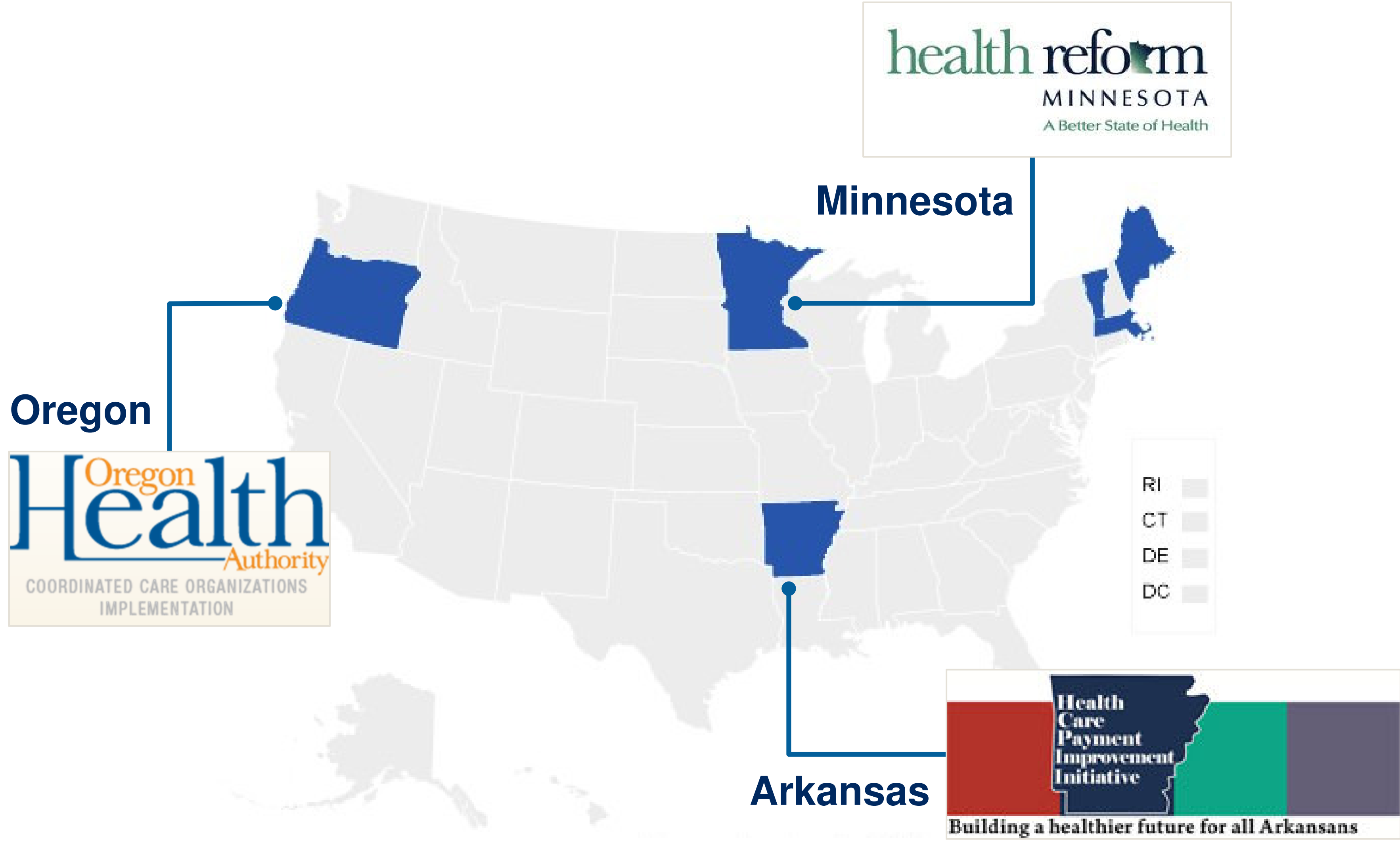
- For providers willing to take on greater risk
- Phased transition to risk sharing

- DE providers have varying abilities to take on risk
- Two track model would provide flexibility and allow majority to participate

Payment innovation in other states



Examples from SIM testing states



Case example: CareFirst

- Large health insurer operating in MD, DC, and VA
- Per capita health costs near top of national rankings
- Majority of PCPs in small practices

Approach

- Introduced a PCMH model at scale
- PCPs form "virtual" panels of 5-15
- PCPs paid to develop care plans
- Nurses contracted by CareFirst for support
- Patients assigned based on claims history or choice
- Patients receive incentives for engaging
- PCPs share in total cost of care savings
- Goal: cut cost growth by 2 percentage points

SOURCE: Patient-Centered Medical Home Program: Program description and guidelines, CareFirst, 2011; Health Affairs

For discussion

1. Are you supportive of moving towards a value-based payment model built on total cost of care?
2. To what extent should balance of incentives be primary care vs. acute care (or both)?
3. Is there support among providers to ensure parallel incentives for employed and independent physicians?

Agenda

Item	Time
Introduction and review of case for change	*10:00*
Delivery system	*10:45*
Data and analytics	*11:45*
Break	*12:30*
Population health	*1:15*
Payment model	*2:00*
Break	*2:45*
Patient engagement	***3:00***
Version 1.0 answer	*4:00*

PROPRIETARY AND CONFIDENTIAL

Context

Broad shared recognition of **need for increased patient ownership, accountability, and engagement**

Patients will have soon have access to a **wealth of new information** (e.g., DHIN portal, navigators for Exchanges)

However, **DE lacks a comprehensive approach** to engage patients in their own care

Additional funding opportunity could be used to catalyze statewide patient engagement effort

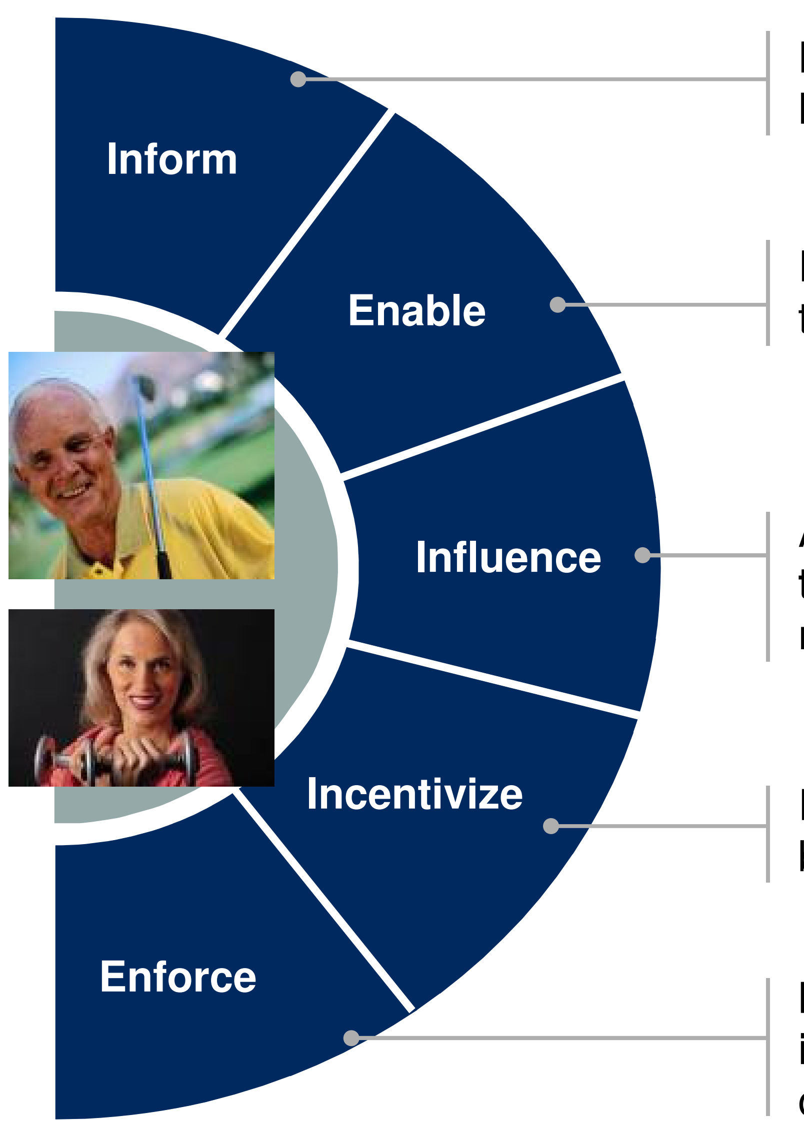
For discussion: how can DE develop an integrated approach to patient engagement?

Health Care Innovation Awards – Round 2

Overview	Up to **$1B** in awards: ▪ **30 awards** in the amount of **$1M - $30M** each ▪ **3-year** performance period
Priority categories	**Four priority categories**: ▪ Outpatient and post-acute settings ▪ Specialized needs populations ▪ Specific provider types ▪ Geographic, clinical, or socioeconomic sub-populations

SOURCE: FOA and http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html

Patient engagement



Educate and inform individuals around healthy behaviors

Provide **support for individuals** in changing their behaviors (e.g., support tools)

Actively **engage and persuade individuals to change behavior** (right timing, right message, using a broad array of influencers)

Provide **incentives and rewards** for behavior change

Mandate healthy behaviors/banning inappropriate ones (e.g., benefit design changes, policy changes)

PROPRIETARY AND CONFIDENTIAL

Behavior Health Status Incentive

5-2-1-Almost None-0

> 5 Fruits and Vegetables
> 2 Hours or less screen time
> 1 Hour or more of activity
> Almost None: Sugar sweetened beverages
> Absolutely None: Tobacco Use

Know Your Numbers

> Waist Circumference
> Blood Pressure
> Tobacco use
> Hemoglobin A1C (adults)
> BMI (children/adults)

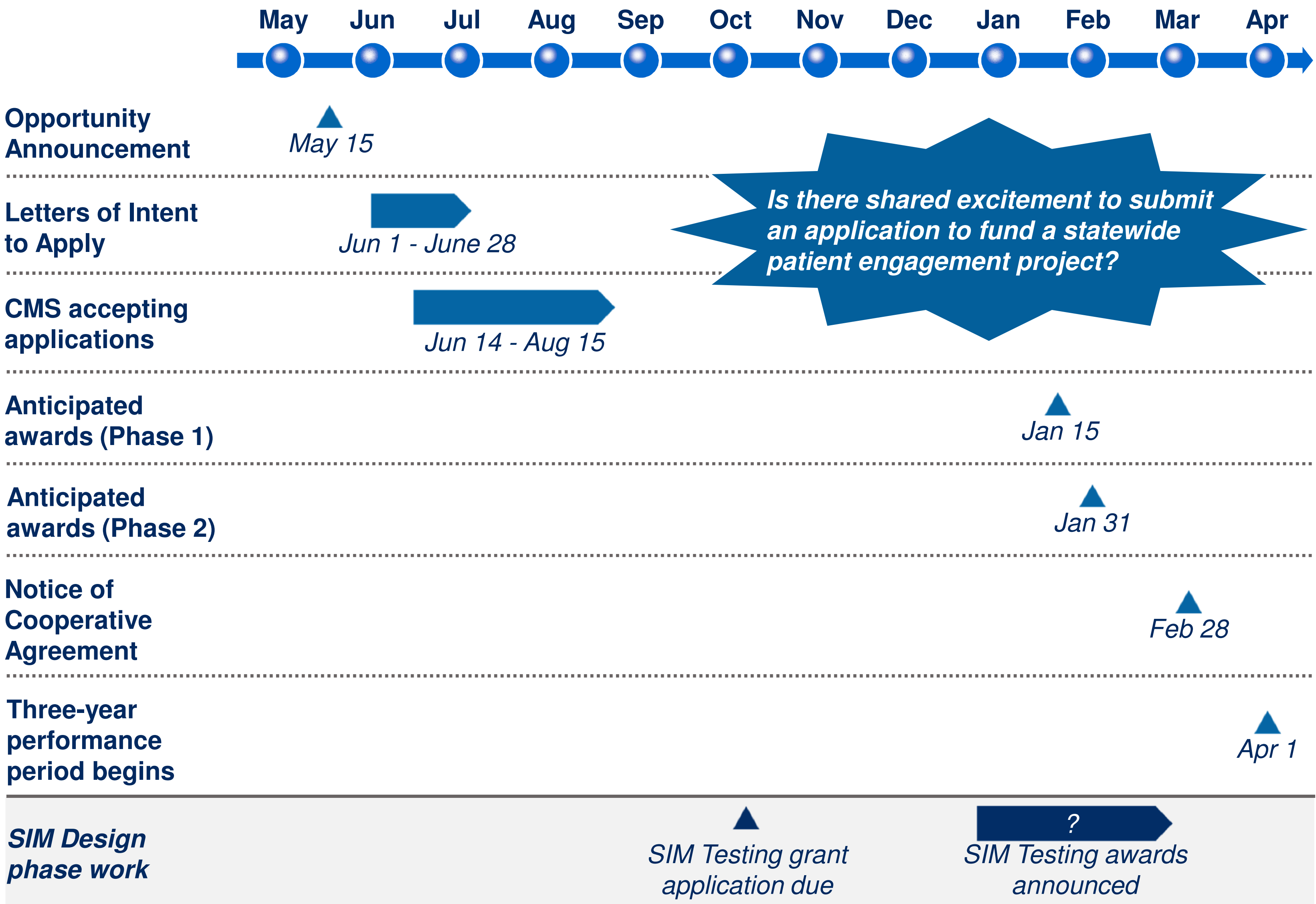
Plus3Network

> A health-focused social network that motivates people to be active and adopt other health behaviors.
> A tool that enables private/public partnerships to make a difference.
> It supports the idea that every time I do something active and healthy for me, it also benefits a cause I care about.
> It motivates people to achieve healthier behavior and outcomes and leverage a philanthropic purpose.

Some ideas we have heard recently

- Make use of iTriage platform and partner with PCPs/care coordinators to support consumers and their caregivers/family to understand their numbers, set goals, and monitor…
- Make use of natural aggregators for consumers (e.g., employers, schools, nursing homes) to influence behavior through peers and education…
- Use behavioral economics to support employee programs (e.g., exercise, diet)…
- Drive value consciousness through linking individual health behavior and coverage costs…
- Develop group education and social media networking to support behavioral change…
- Develop a “health challenge” to incentivize improvement against individual health goals…
- Connect Exchange facilitators to encourage adoption of iTriage and achievement of meaningful use…
- Develop information tools to help explain care choices to consumers (e.g., comparison of cost and quality)
- Other…

Timeline for Health Care Innovation Awards



SOURCE: FOA and http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html

Agenda

▪ Introduction and review of case for change	*10:00*
▪ Delivery system	*10:45*
▪ Data and analytics	*11:45*
▪ Break	*12:30*
▪ Population health	*1:15*
▪ Payment model	*2:00*
▪ Break	*2:45*
▪ Patient engagement	*3:00*
▪ **Version 1.0 answer**	***4:00***

Emerging answer – 1st draft

- Patient engagement strategy based on activating patients and supporting behavior change
- Develop health neighborhoods bringing together delivery system and community in local neighborhoods to set goals for health, review performance, align engagement efforts
- Focus on high risk, high cost patient segments with care coordination. Support with
  - Support additional care coordination activity with additional reimbursement (based on common standards) and ability to use this reimburse to provide coordination directly or contract with pre-qualified vendors
  - Use DHIN to support common risk stratification “currency” as a core utility and support patient access to information, and transparency of performance
- Develop effective diagnosis and treatment across the board supported with guidelines across payers and providers and transparency in reporting.
  - Develop clear governance model, focused on supporting effective diagnosis and treatment for care coordination and for high cost/high variance
  - Use DHIN to support identification of potential care gaps and share this with providers
- Reimbursement mechanism aligned with total cost incentive model
  - Multipayer align on measures and total cost model
  - Providers align incentives for employed physicians to match independents
  - [At present, the focus on total cost and small scale of DE suggest not developing episode reimbursement model, though individual providers may wish to pursue as part of total cost].
- Commitment to transparency of performance across providers shared with consumers
- Legislative/regulatory package to enable these changes….

Reminder: timing of key meetings