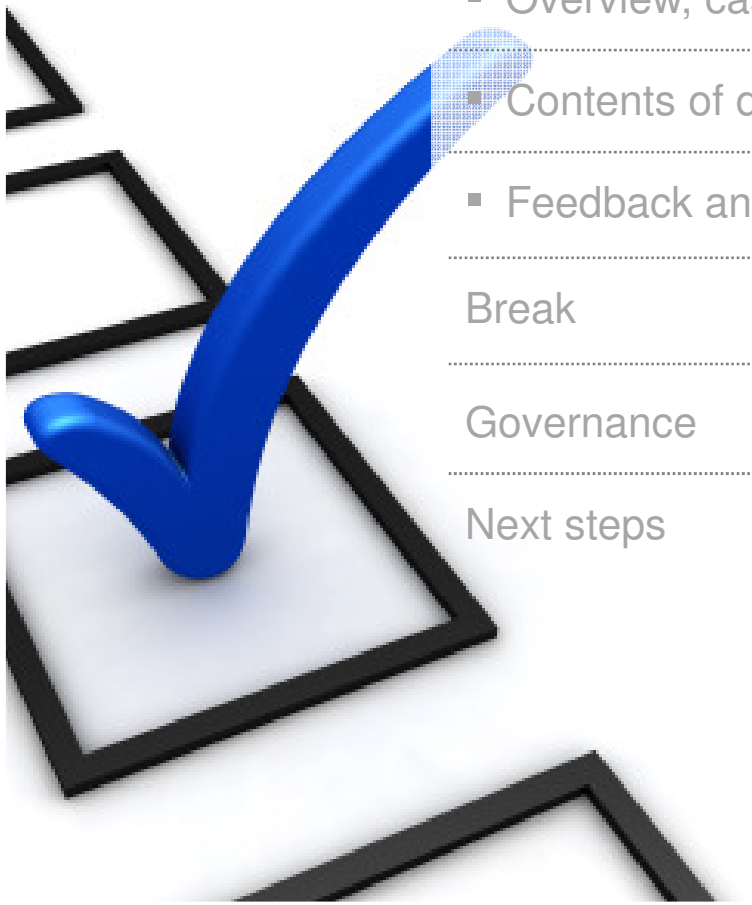
ChooseHealth DELAWARE

All-workstream stakeholder meeting

July 23rd, 2013

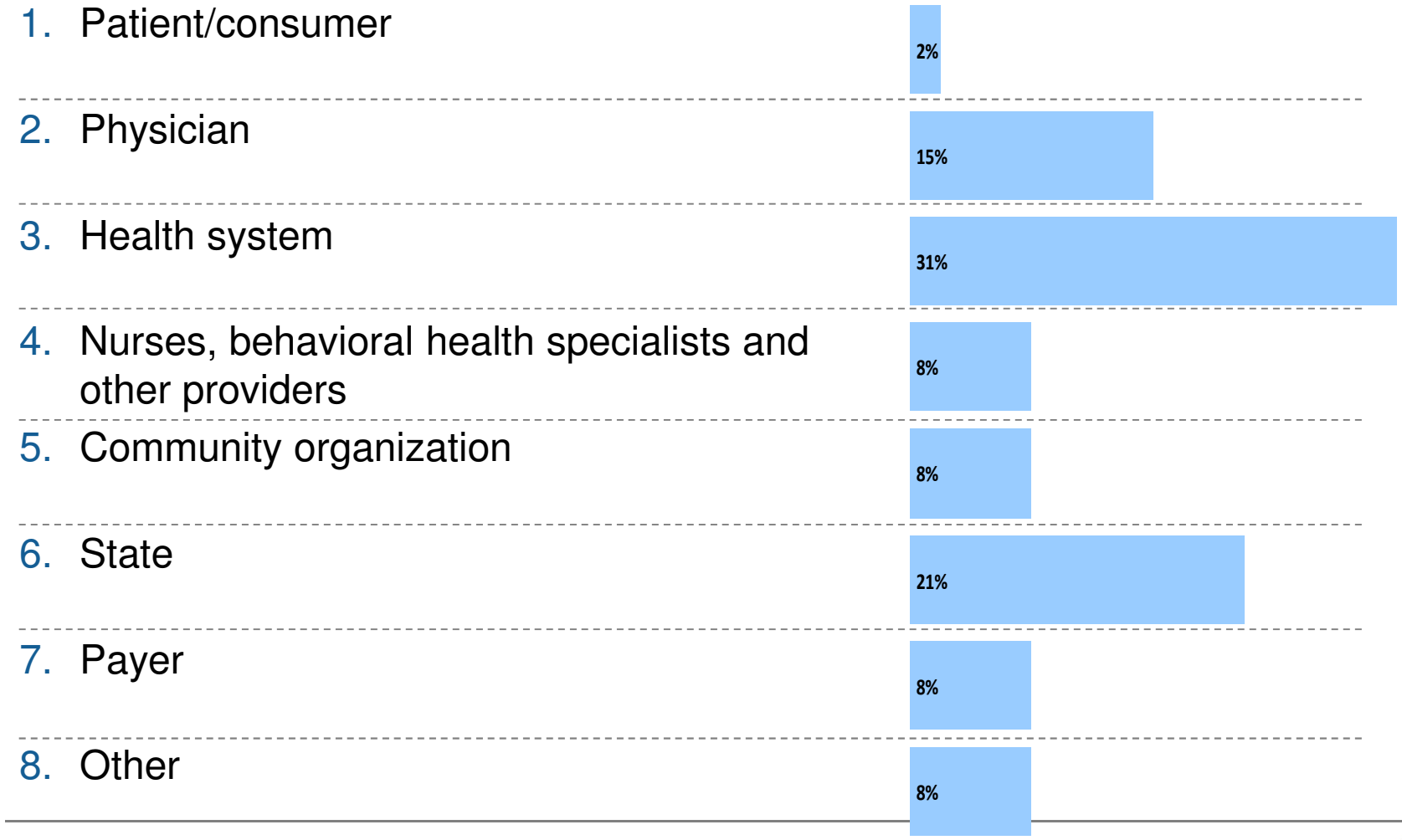
Agenda for today



Introduction and recap	**8:00**
Transformation vision and draft plan	
▪ Overview, case for change and DE context	8:30
▪ Contents of draft plan	8:50
▪ Feedback and discussion	10:45
Break	11:00
Governance	11:15
Next steps	12:00

Who is in the room?

Which stakeholder group do you represent?



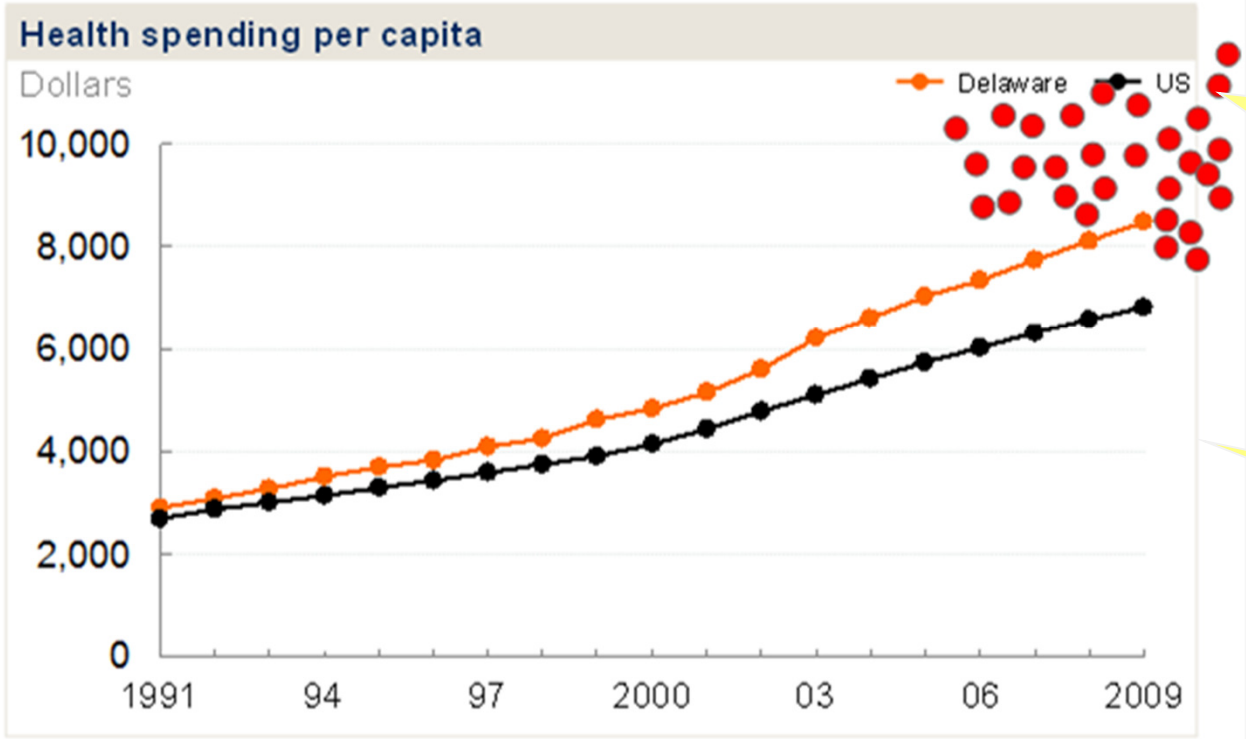
Recap of May 7th

On May 7th, we discussed

- Current state of DE's health care system and need for change
- Potential sources of innovation in DE
- Health care transformation happening elsewhere
- Our approach

Your perspectives on case for change (1/3)

1 Spending is 25% higher than US average



SOURCE: Kaiser Family Foundation

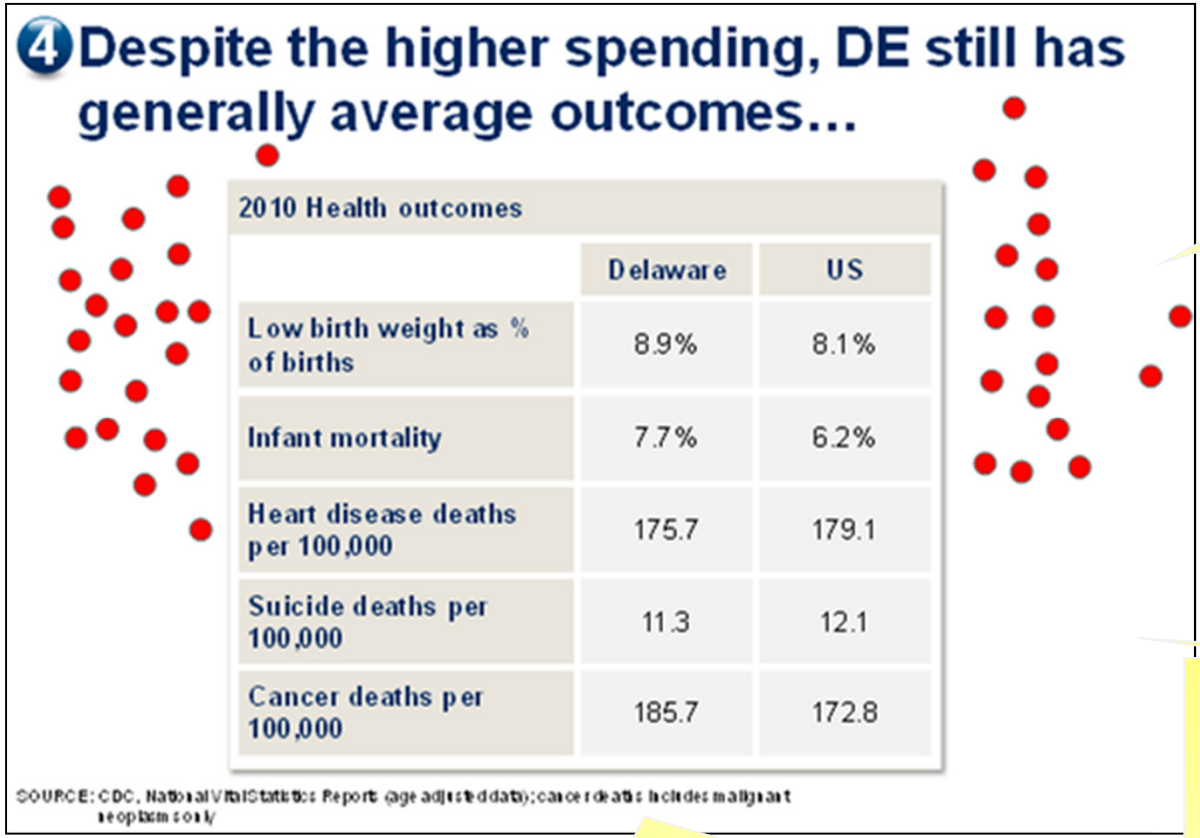
Link spending to evidence supported treatments

Need to emphasize value versus volume; evidence-based practice; reduction in expensive procedures

Why is this? Does chronic disease rate account for this?

SOURCE: May 7th meeting attendee feedback

Your perspectives on case for change (2/3)



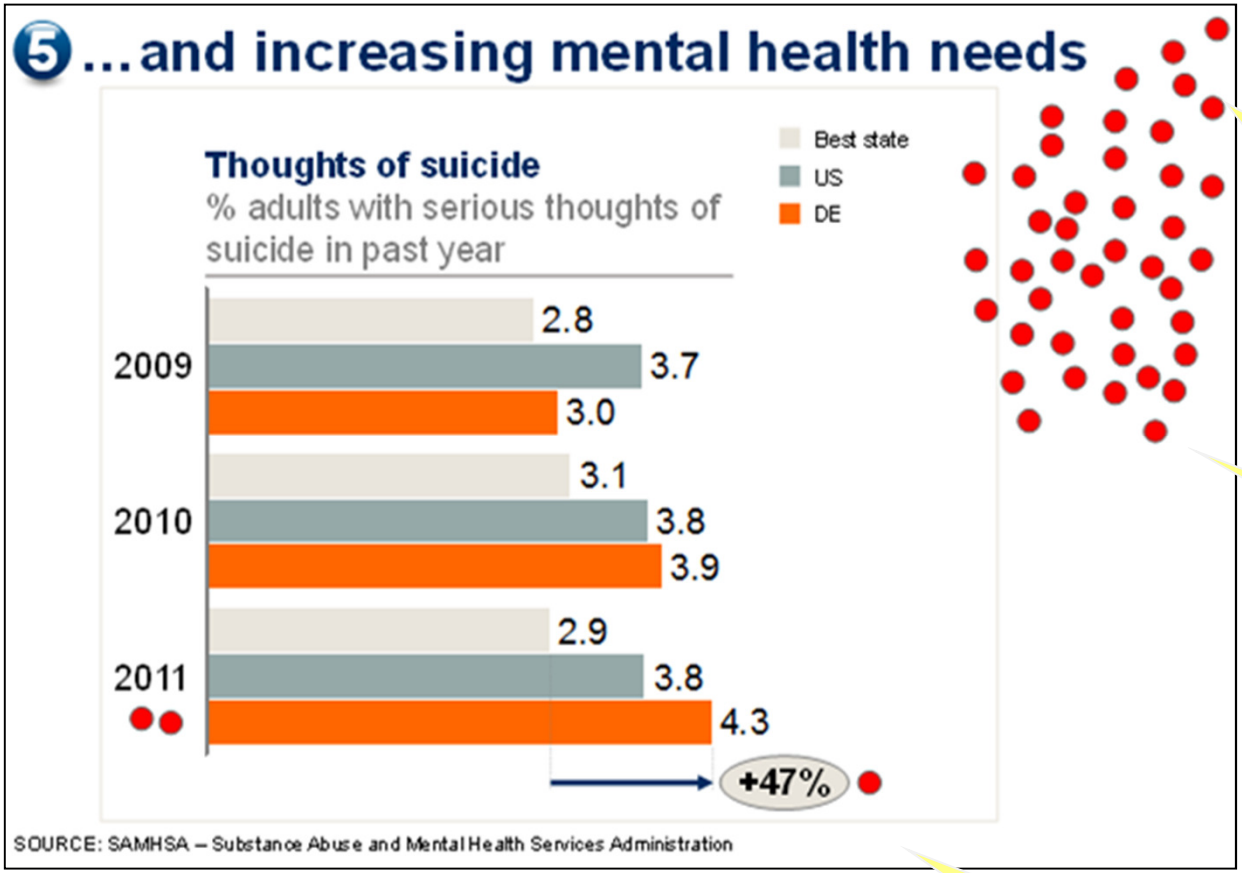
Physicians and patients need to be educated on the relevant outcomes

Increased spending due to duplication and serious omissions due to lack of coordination of care

Cancer outcomes are better than others – maybe some best practices to be learned and applied?

SOURCE: May 7th meeting attendee feedback

Your perspectives on case for change (3/3)



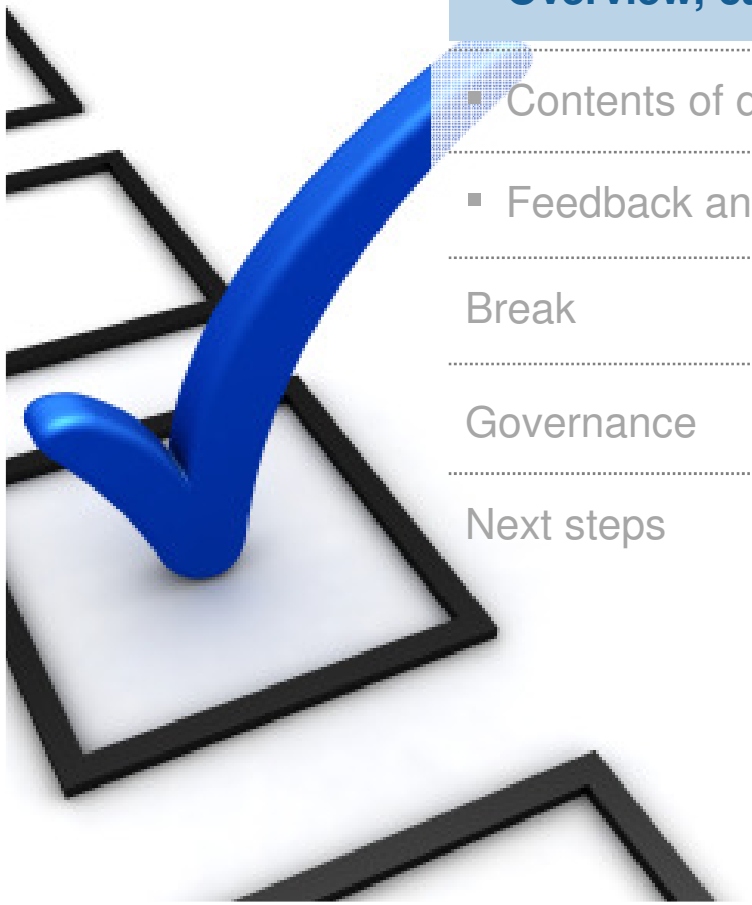
Need increased awareness and participation by primary care arena

Depression is the leading cause of disability for ages 25-44

Kids too!

SOURCE: May 7th meeting attendee feedback

Agenda for today



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Before we get started: working definitions (1/2)

Care coordinator	▪ Worker who enables team-based care by coordinating among providers, the community, and families to support patients in engaging in their own health
CMMI	▪ Center for Medicare and Medicaid Innovation (CMMI) is part of the Center for Medicare and Medicaid Services (CMS), the federal department that oversees Medicare and Medicaid ▪ CMMI is the sponsor of the State Innovation Models initiative
Fee-for-service	▪ Predominant form of payment for health care today – payment is made for each activity that occurs in the health system (e.g., for an office visit or procedure).
Pay-for-value	▪ Form of outcomes-based payment, where providers qualify for incentives based on patient experience and quality of care metrics, with bonuses linked to resource utilization

Before we get started: working definitions (2/2)

Percent of charges	▪ Approach to setting the level of provider reimbursement, where reimbursements are set as a percentage above charges (charges are meant to reflect costs).
SIM	▪ State Innovation Models Initiative (SIM) is the grant program administered by CMMI which aims to promote innovation in health care payment and delivery on multi-stakeholder basis.
Total cost of care	▪ Form of outcomes-based payment where incentives are linked to ability to manage total medical expenditures for the attributed population ▪ Includes shared savings, upside and downside risk, and prospective payment
Triple Aim	▪ Set of goals described by the Institute of Medicine that define an aspiration for improving the health system. Specifically, the Triple Aim refers to improving health, improving the experience of care, and reducing health care costs

Delaware's health care transformation

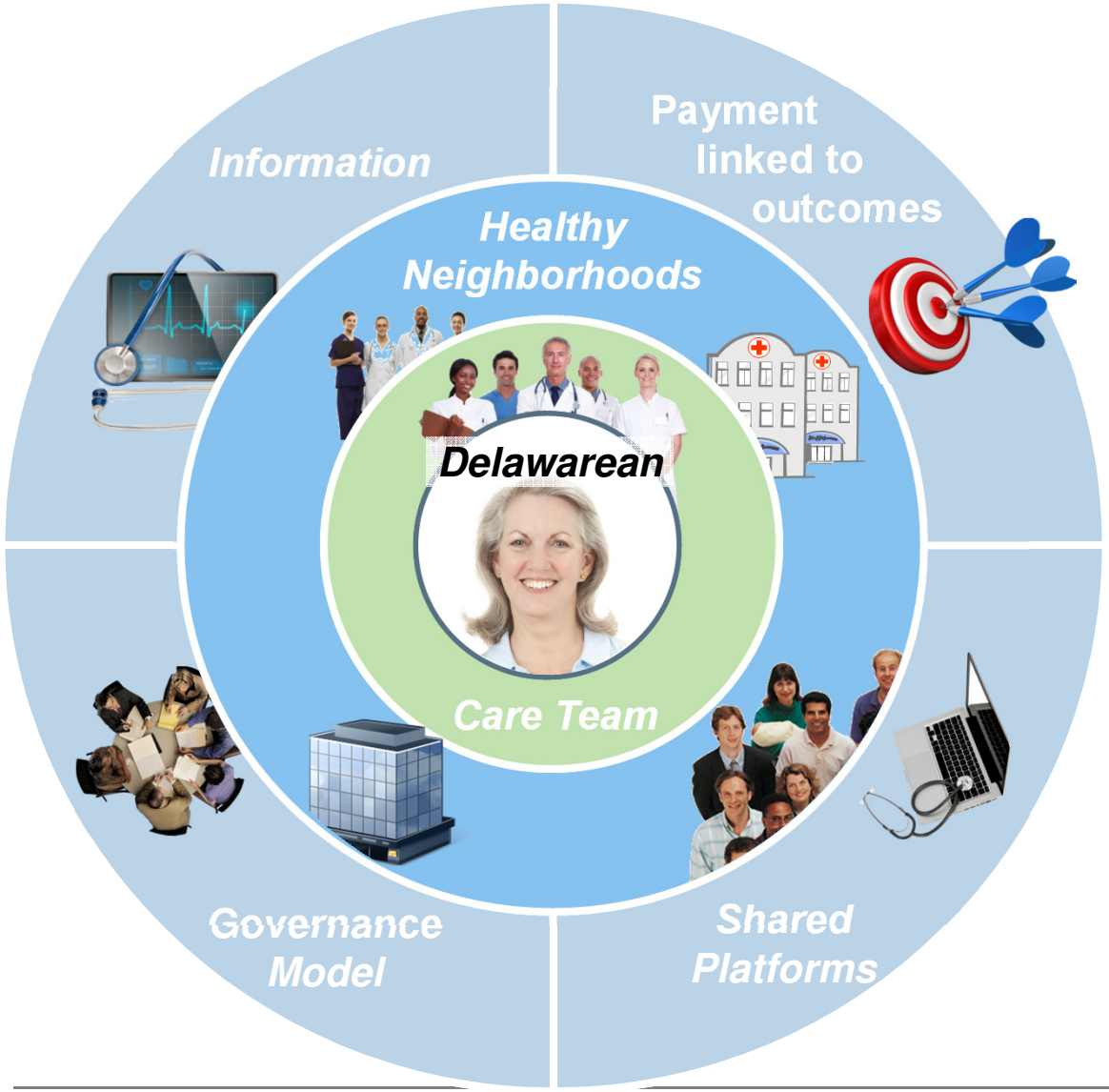
Aspiration

- Delaware aspires to lead the nation in innovation and impact on each dimension of the Triple Aim:
  - improving the **health** of Delawareans
  - improving the **patient experience** of care
  - reducing health care **costs**

Specific goals

- Delaware will be the **healthiest state in the nation**
- Delaware's **health outcomes** will rank among the **top ten percent nationally**
- Delaware will **significantly reduce** health care **expenditures**

Vision for Delaware's health transformation



Vision:

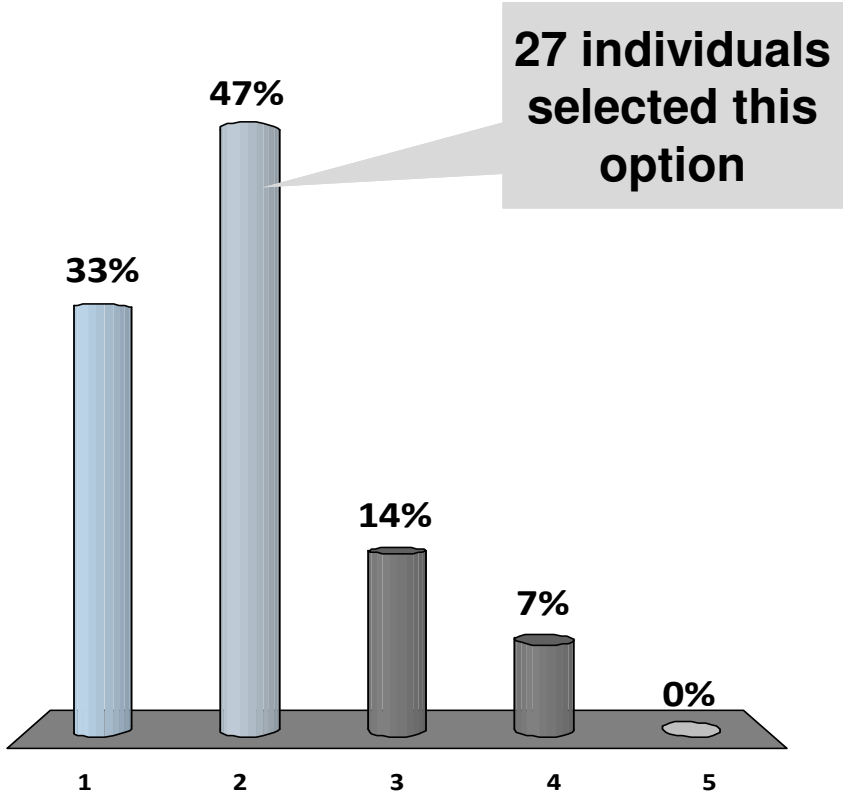
- **person-centered** care with patients empowered and engaged in their own care
- multi-disciplinary **care team**
- **healthy neighborhood** that includes providers, employers, community groups and others
- **information** to enable delivery and payment transformation
- payment that incentivizes **value**
- **shared platform** of resources
- **governance model** to ensure change

Discussion and feedback

TO GENERATE DISCUSSION ONLY – NOT FOR DECISION-MAKING

This vision…

1. Is bold and transformative
2. Is compelling, but needs more to be exceptional
3. It is the minimum aspiration, but puts us on the right path
4. Disagree with part
5. Disagree with all



Overview of draft plan

1. Case for change
2. Delaware context
3. Proposed plan for Delaware
   1. Delivery system
   2. Patient activation and engagement
   3. Payment model
   4. Data and analytics
   5. Population health
   6. Workforce
   7. Policy
4. Implementation

Important notes

- This is is a working document
- Goal is to synthesize current perspectives, to move forward and generate discussion and feedback
- This is one of many opportunities for discussion
- Please also email (sponsors emails on websites) or discuss at follow-on meetings

1.0 Case for change

1.1 Unsustainable healthcare spending:
Delaware spends 25% more per capita on health care than the national average

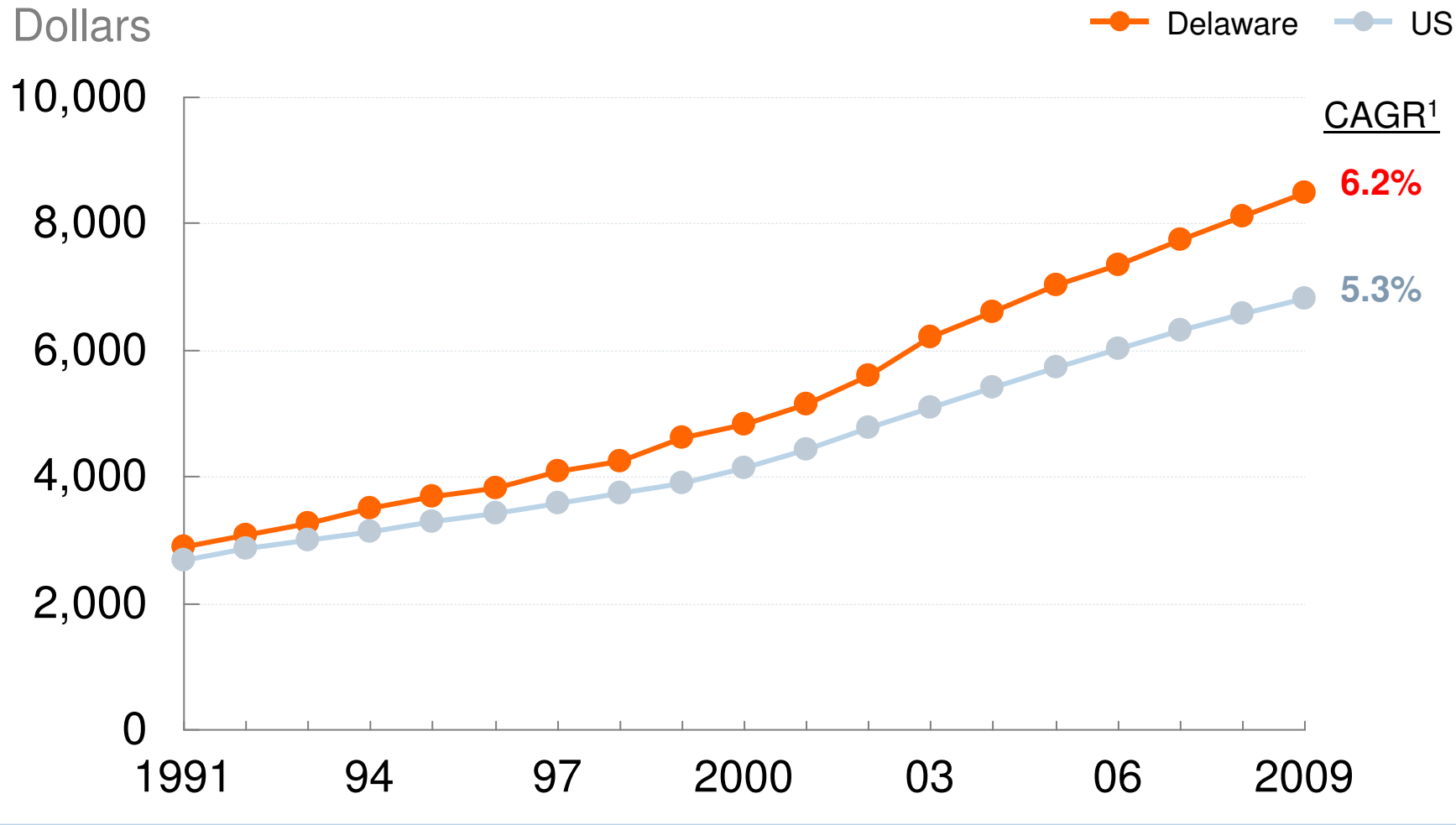
1.2 Outcomes do not measure up:
Delaware's health outcomes are at best about average

1.3 Experience of care falls short of aspirations:
the experience across providers, patients, and their caregivers indicates there's much room for improvement

1.4 Health status:
Delaware remains relatively unhealthy

1.1 Trajectory of health care spending

Health spending per capita

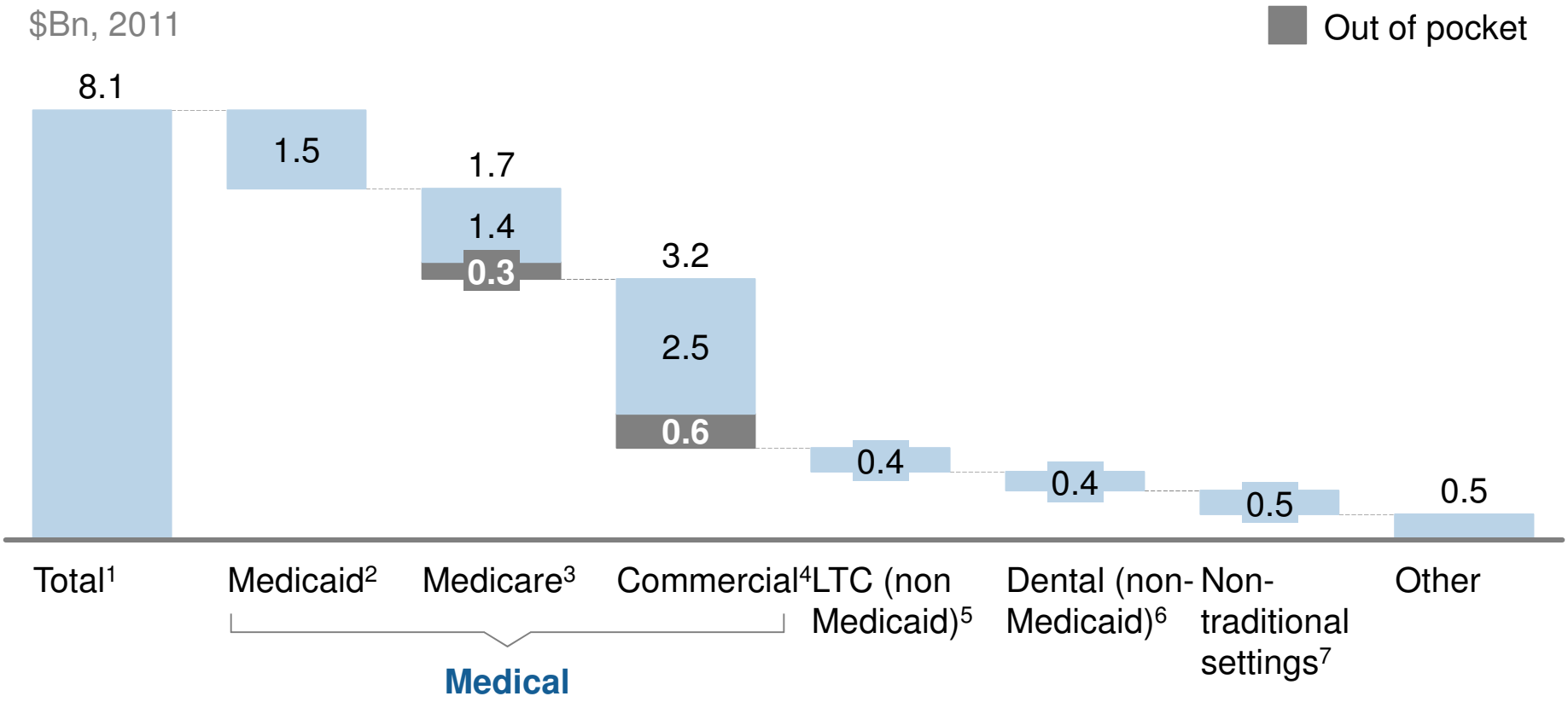


1 Annualized growth rate

SOURCE: Kaiser Family Foundation

1.1 Health care spending in DE (preliminary)

Total health care spending in Delaware



1 Total personal health care expenditure for Delaware (2009 estimate adjusted for two years of growth of 3.8% and 3.9% in 2009 and 2010 respectively, the national health spending growth rate published by CMS)
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

1.2 Example health care outcomes

2010 Health outcomes

	Delaware	US	Best state	Healthy People 2020
Low birth weight as % of births	8.9%	8.1%	5.7%	7.8%
Infant mortality per 1,000 live births	7.7	6.2	3.8	6
Heart disease deaths per 100,000	175.7	179.1	119.4	NA
Suicide deaths per 100,000	11.3	12.1	7.7	10.2
Cancer deaths per 100,000	185.7	172.8	133.7	160.6

SOURCE: CDC, National Vital Statistics Reports (age adjusted data); cancer deaths includes malignant neoplasms only

1.3 Patient stories shared by stakeholders (1/2)[1]

Effective care coordination

"Mrs Doe" – 65 year old woman who needed elective joint replacement surgery

Situation

- Care manager RN assigned to her pre-op
- RN met with patient at surgeon's office and visited home to evaluate needs
- Ensured patient had therapy prep
- Saw patient daily in hospital and facilitated post-op meds and transfer home

Result

- Mrs. Doe able to have her care customized and needs attended to, and to participate in care
- Minimized "handoffs"

Care needs for individuals with disabilities

"Ruth" - Homeless, alcoholic, diabetic woman with mental illness

Situation

- High utilizer of the emergency dept.
  - 6 visits within a 6 week period
- Got connected with a care coordinator/health coach, who provided access to mental health services and pharmacy assistance

Result

- Reduced ED use/cost
- Increased access to appropriate coordinated services

1 All patient names and pictures have been changed

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

1.3 Patient stories shared by stakeholders (2/2)[1]

Lack of access to primary care

"June" - 91 year old woman with CHF who weighs herself daily to monitor fluid retention

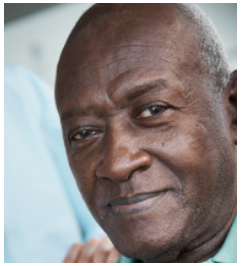
Situation

- Noted that she had gained weight
- Called her doctor, who could not see her for a month
- She agreed to make the appointment (in a month)

Result

- 2 days later, she ended up in the ER
- Primary care may have been able to prevent a trip to the ER
- The subsequent hospitalization caused her significant stress and was much more costly

Inappropriate care setting



"Herb" – Multiple chronic diseases, including hypertension, stroke, diabetes, cancer

Situation

- Discharged from hospital with new medication orders
- Insulin was discontinued after discharge
- Patient experiences diabetic coma, leading to death

Result

- Patient did not know enough to question the change in medication
- Assisted living facility did not question
- Information sharing at hospital could have prevented negative outcome

1 All patient names and pictures have been changed

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

2.0 Delaware context

2.1 State profile and demographics: DE is microcosm of US, but aging faster

2.2 Provider structure and workforce: Six health systems (including a children's hospital), three community health centers, over 2,000 doctors, and 12,000 additional members of care teams

2.3 Payer structure: High levels of coverage; Medicaid covers a higher proportion of adults than average; the structure remains largely fee-for-service

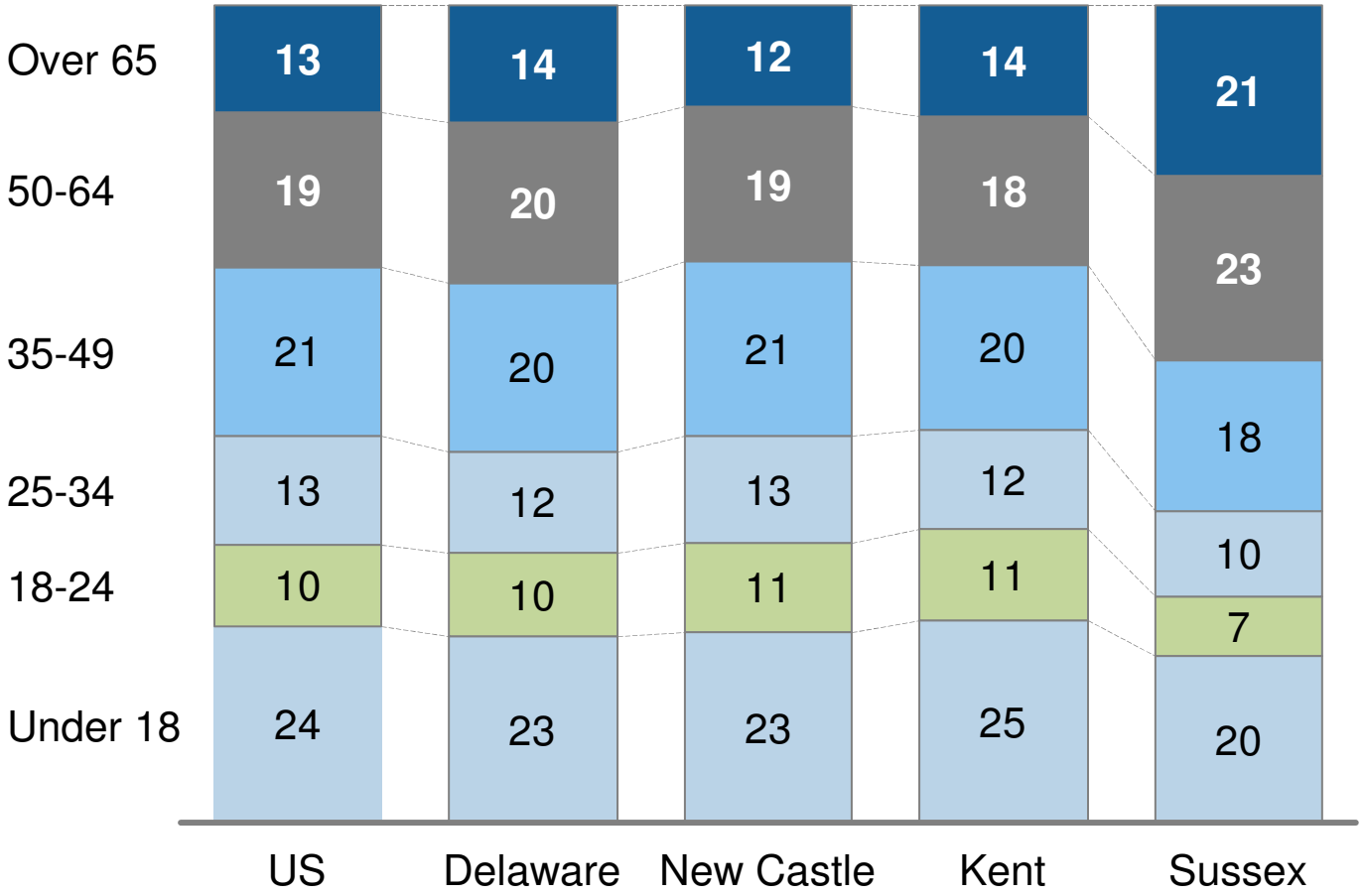
2.4 Existing initiatives: Many programs to leverage: DHIN, Healthcare Commission, Cancer, and CMMI grants

2.5 Role of health care in the State Nearly 10% of jobs are health related; 22.4% of State budget

2.1 State profile and demographics

Population by age group, Delaware counties compared with State and US, 2010

Percent of total population

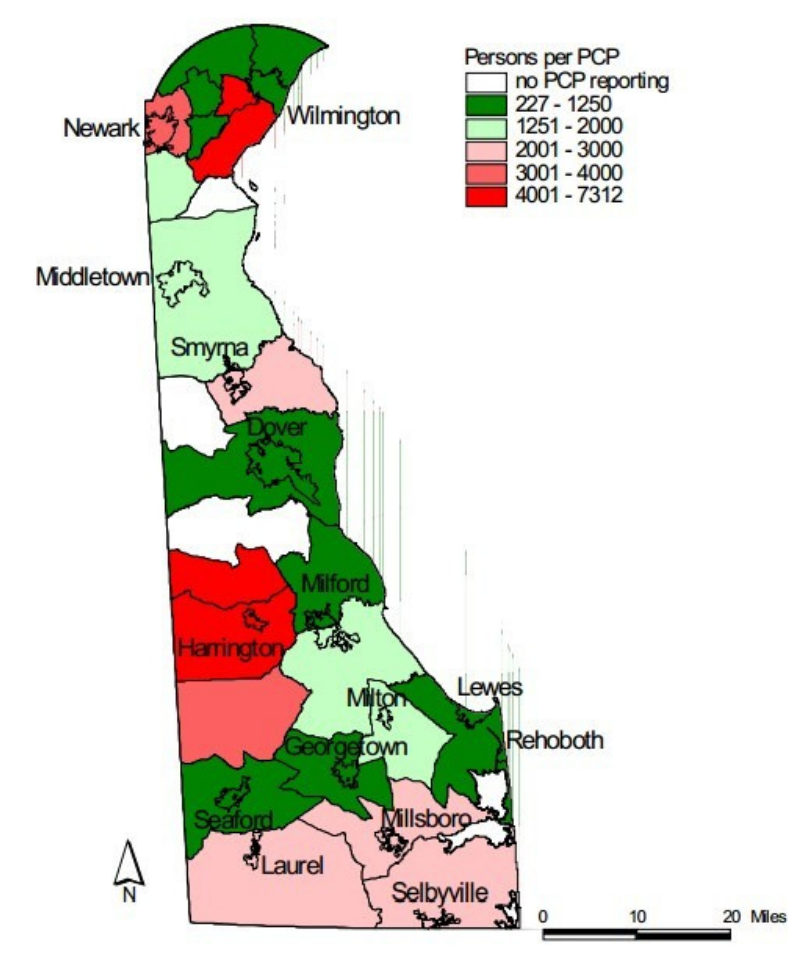


SOURCE: US Census Bureau, 2010 Census

2.2 Primary Care Providers in DE

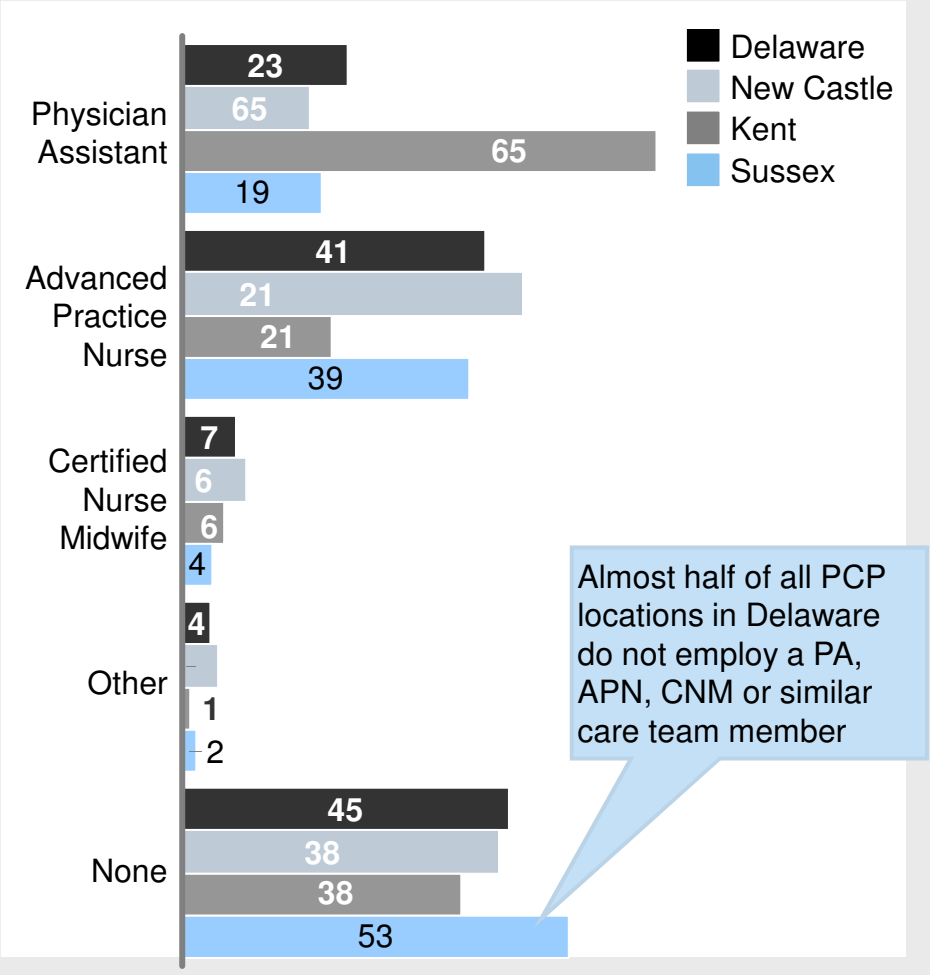
Persons per primary care physician by census county division

Individuals



Use of non-physician care team members

Percent of physicians (primary site of practice)

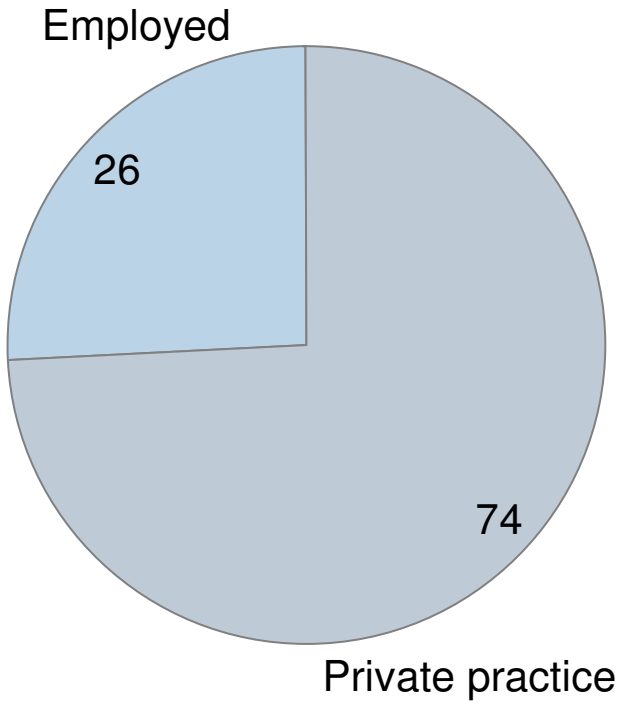


SOURCE: Toth, Primary Care Physicians in Delaware, University of Delaware, 2011

2.2 Most primary care physicians are in private practice

Proportion of DE PCPs employed by a health system or hospital

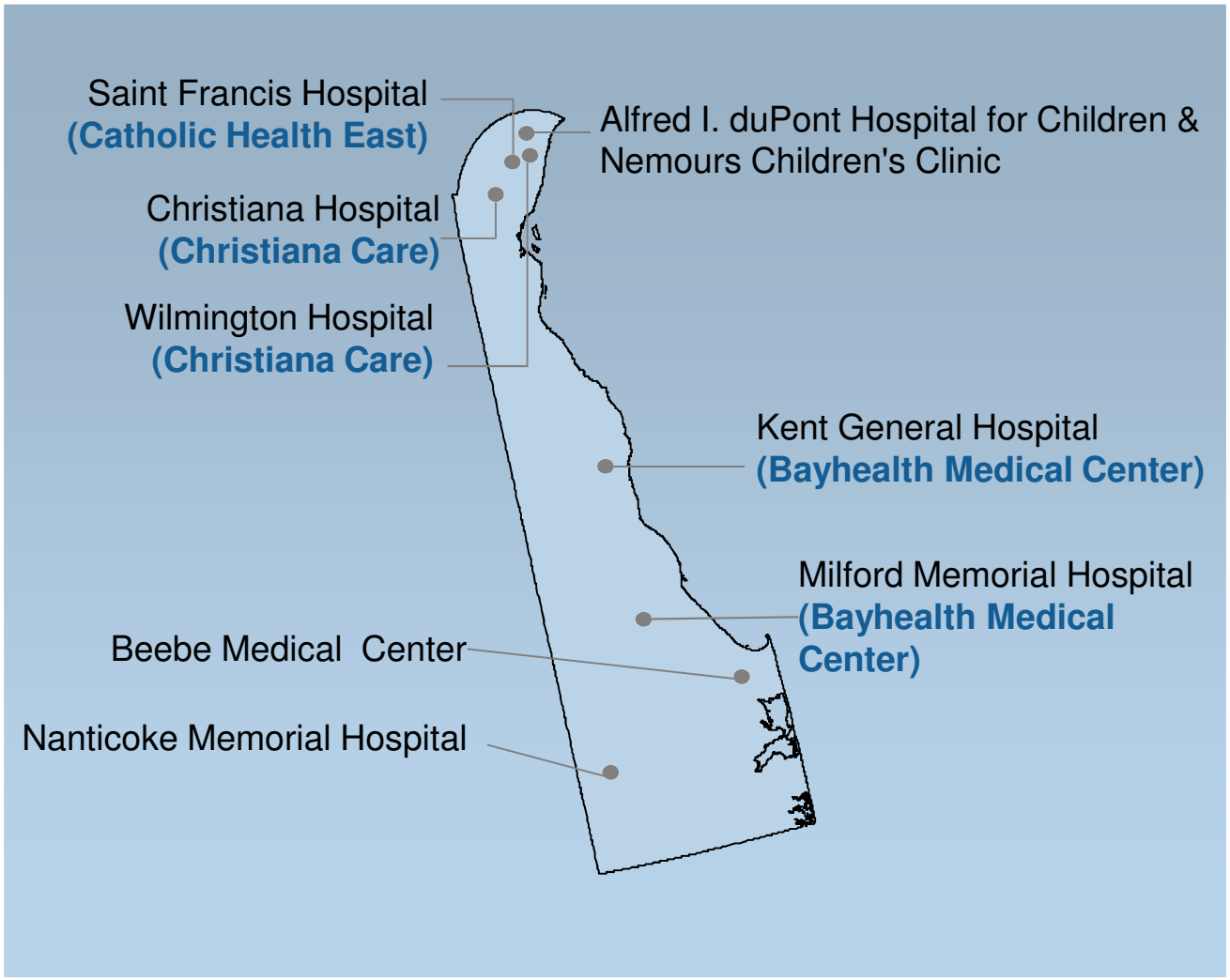
Percent of PCPs



52% of physicians are employed **nationally** (including 49% of primary care physicians)

SOURCE: SK&A physician database, May 2013; Physicians Foundation, Survey of America's Physicians, September 2012

2.2 Acute care in Delaware



Note: Excludes Behavioral, special needs hospitals, long-term hospitals and VA hospitals

SOURCE: American Hospital Directory , December 2011

2.2 DE's health care workforce by county

DE workforce facts

- Above national average for PCPs[1], NPs, PAs and dentists
  - ~715 PCPs (1:1,269 physician-to-person ratio)
  - 79 NPs per 100,000
  - 33 PAs per 100,000
  - 45 Dentists per 100,000
  - 10 Psychiatrists per 100,000[2]
  - 1,103 RNs per 100,000
- 92.2% PCPs say 'will be' or 'may be' practicing in 5 years
- 33% PCPs did residency in DE
- 49 schools, universities and colleges in the area (DE, NJ, PA and MD) offering 100 health care related programs

New Castle County

- 504 PCPs (95 per 100,000)
- 302 dentists (57 per 100,000)
- 73 psychiatrists (14 per 100,000)
- 7,110 RNs (1,345 per 100,000)

Kent County

- 77 PCPs (51 per 100,000[2])
- 50 dentists (33 per 100,000[2])
- 9 psychiatrists (6 per 100,000[2])
- 1,279 RNs (840 per 100,000[2])

Sussex County

- 122 PCPs (66 per 100,000)
- 43 dentists (23 per 100,000[2])
- 7 psychiatrists (4 per 100,000[2])
- 1,481 RNs (804 per 100,000[2])

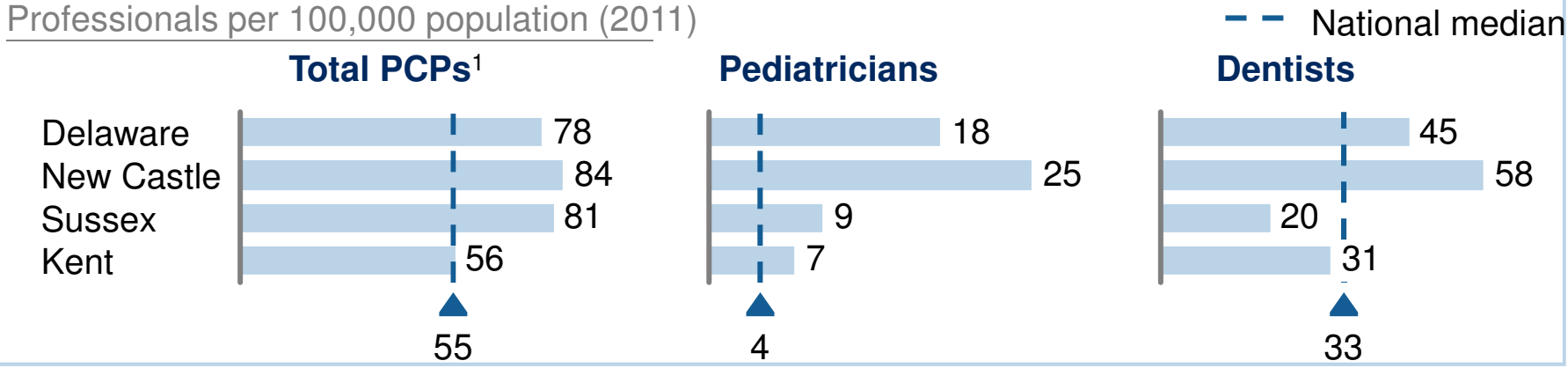
1 Primary Care Physician
2 Below national average

SOURCE: Delaware Health Care Commission Health Care Workforce Report; Health Care Workforce Recommendations, December 2012; Toth: Primary Care Physicians in DE (2011)

2.2 Access and shortage areas (HPSAs)

Providers by county

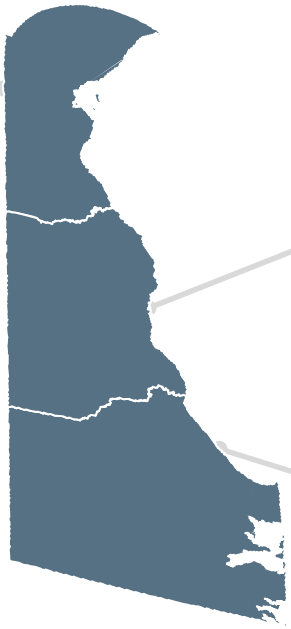
Professionals per 100,000 population (2011)



New Castle County

Short of HPSA minimum FTEs:

- PCPs: 5
- Dentists: 9
- Mental health: 2



Kent County

Short of HPSA minimum FTEs:

- PCPs: 0
- Dentists: 8
- Mental health: 0

Sussex County

Short of HPSA minimum FTEs:

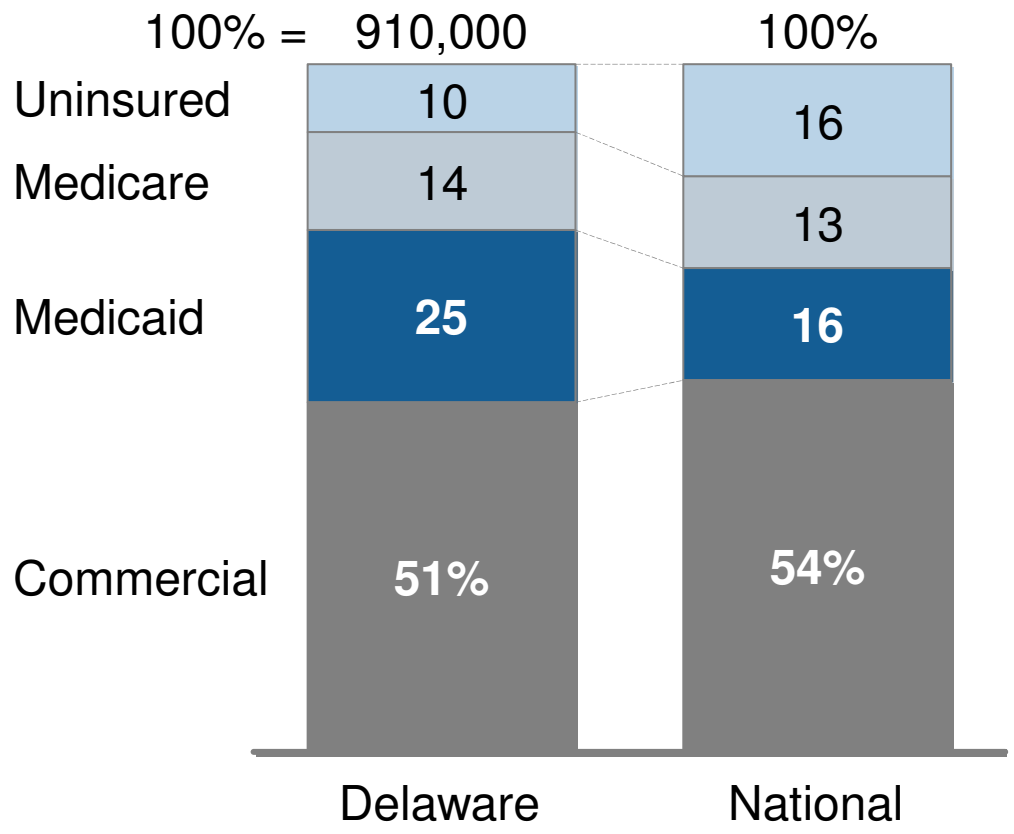
- PCPs: 2
- Dentists: 14
- Mental health: 1

1 Primary Care Physician

SOURCE: Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. DE Health Care Commission Health Care Workforce Report (citing Primary Care Physicians in Delaware, 2011, University of Delaware, Delaware Population Consortium)

2.3 Payer structure

Population distribution by payer, beneficiaries ('000) and %



SOURCE: CMS, US Census Bureau, HealthLeaders-Interstudy

2.6 Implications

- A fundamental need to engage citizens
- A need to respond to obvious gaps in the system
- A need for a framework which accommodates private practice physicians as well as physicians employed by hospitals and health systems
- An opportunity to take advantage of the small number of payers aligning to support a common model – a great advantage relative to other states
- An opportunity to maximize joint efforts and extend them in new ways to support the aspirations of Delawareans

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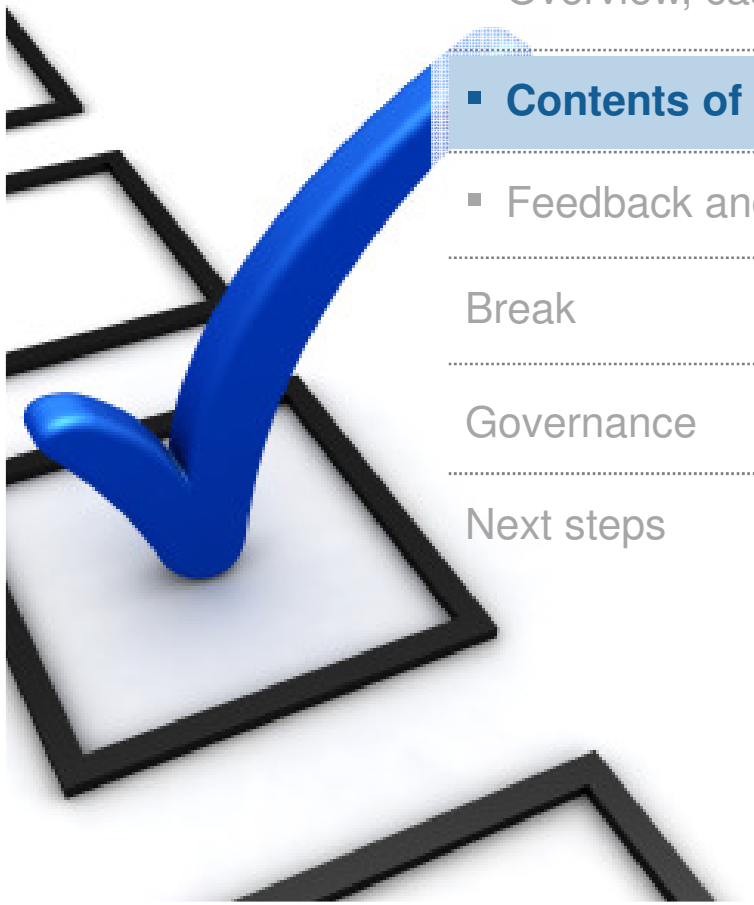

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Vision

- **person-centered** care with patients empowered and engaged in their own care
- multi-disciplinary **care team**
- **healthy neighborhood** that includes providers, employers, community groups and others
- **information** to enable delivery and payment transformation
- payment that incentivizes **value**
- **shared platform** of resources
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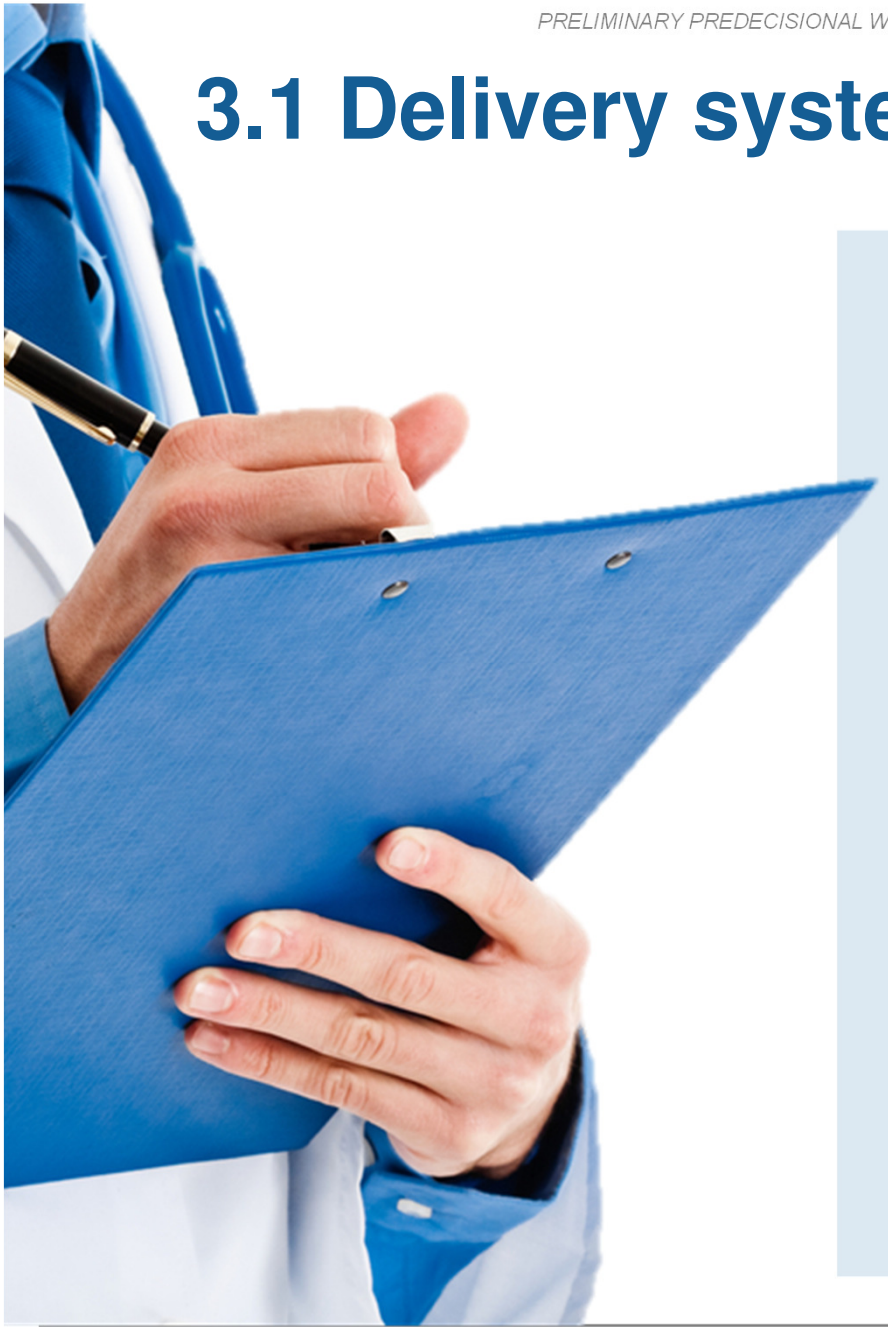
3.1 Delivery system



- **3.1.1** Common principles
- **3.1.2** Focus on areas that drive cost
- **3.1.3** Care coordination
- **3.1.4** Effective diagnosis and treatment
- **3.1.5** Shared platform to support providers
- **3.1.6** Multi-disciplinary teams
- **3.1.7** Quality measures on a common scorecard

3.1.1 Delivery principles

- Patient-centered
- Outcomes-oriented
- Team-based care
- Coordinated care across multiple providers
- Patient choice of provider and convenient access to care
- Technology-enabled

3.1.2 Focus on areas that drive cost

HIGHLY PRELIMINARY

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

Effective diagnosis and treatment for all

Care coordination for high risk adults/elderly and youth

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)*
Adoles-cents/ 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)	<1% (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)

SOURCE: 1 US Census Data; Health Expenditures by State of Residence (2009), Medicaid Statistical Information System (MSIS) State Summary Datamart (2011); Medicare Geographic Variation Public Use File (2011); based on risk strata spend multipliers from other delivery systems, extrapolated to DE population and cost total

3.1.2 Focus on areas that drive cost – draft

Clinical risk grouper health status	Medicaid lives, 2012 Total (Thousands)	Medicaid lives, 2012 *Percent*	Average per patient, 2012 ($)	Spend, 2012 Total ($ M)	Spend, 2012 *Percent*	CAGR[1], average per patient, 2009-12
Healthy	85.0	*43%*	2,557	217.2	*18%*	-5%
Single minor chronic disease	17.8	*9%*	2,816	50.1	*4%*	1%
Minor chronic diseases in >1 organ systems	5.0	*3%*	3,568	17.8	*1%*	3%
Significant chronic disease	50.6	*26%*	5,370	271.9	*22%*	-3%
Significant chronic disease in >1 organ systems	31.7	*16%*	11,454	363.4	*30%*	1%
Dominant chronic disease in >2 organ systems	2.9	*1%*	29,943	87.0	*7%*	1%
Dominant/Metastatic malignancy	1.2	*1%*	29,981	35.5	*3%*	-1%
Catastrophic	4.0	*2%*	41,814	168.4	*14%*	8%
Blank	0	*0%*	32,402	0.3	*0%*	-%
Total	**198**		**6,121**	**1,212**		**0%**

1 Annualized growth rate

SOURCE: Delaware Medicaid claims data, 2009-2012

3.1.3 Care coordination: seeing change through patient experience

EXAMPLE

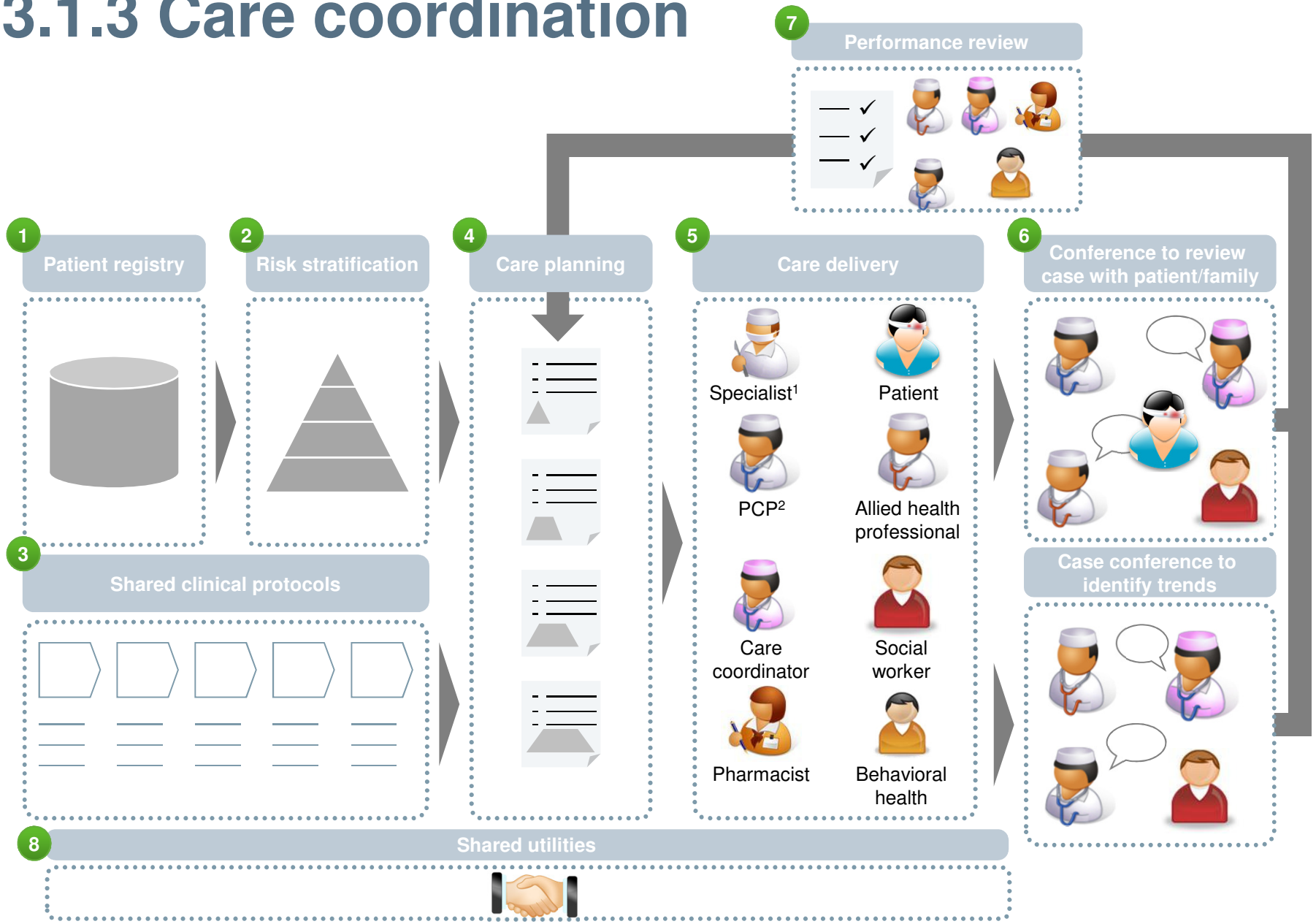
Today…

- Every new person I see asks me the same questions all over again
- I never get to see the same people even though I'm having the same things done again and again
- I'm confused about what options are open to me and how I'll deal with my conditions over the next few years
- No-one takes overall responsibility for helping me
- Different staff don't seem to talk to each other

Future…

- I only have to give my name and address once. And everyone I interact with knows what I've covered with other staff
- I have a plan to look after myself, which I really feel in control of
- The nurse at my practice just called to remind me that my yearly check is due next month. And I know to call my care co-ordinator if I find things are getting worse
- My pharmacist checks that I'm taking my pills because she notices if I haven't picked up my regular prescription
- If I need something, my care co-ordinator can organize it straight away - I don't have to wait for another assessment

3.1.3 Care coordination

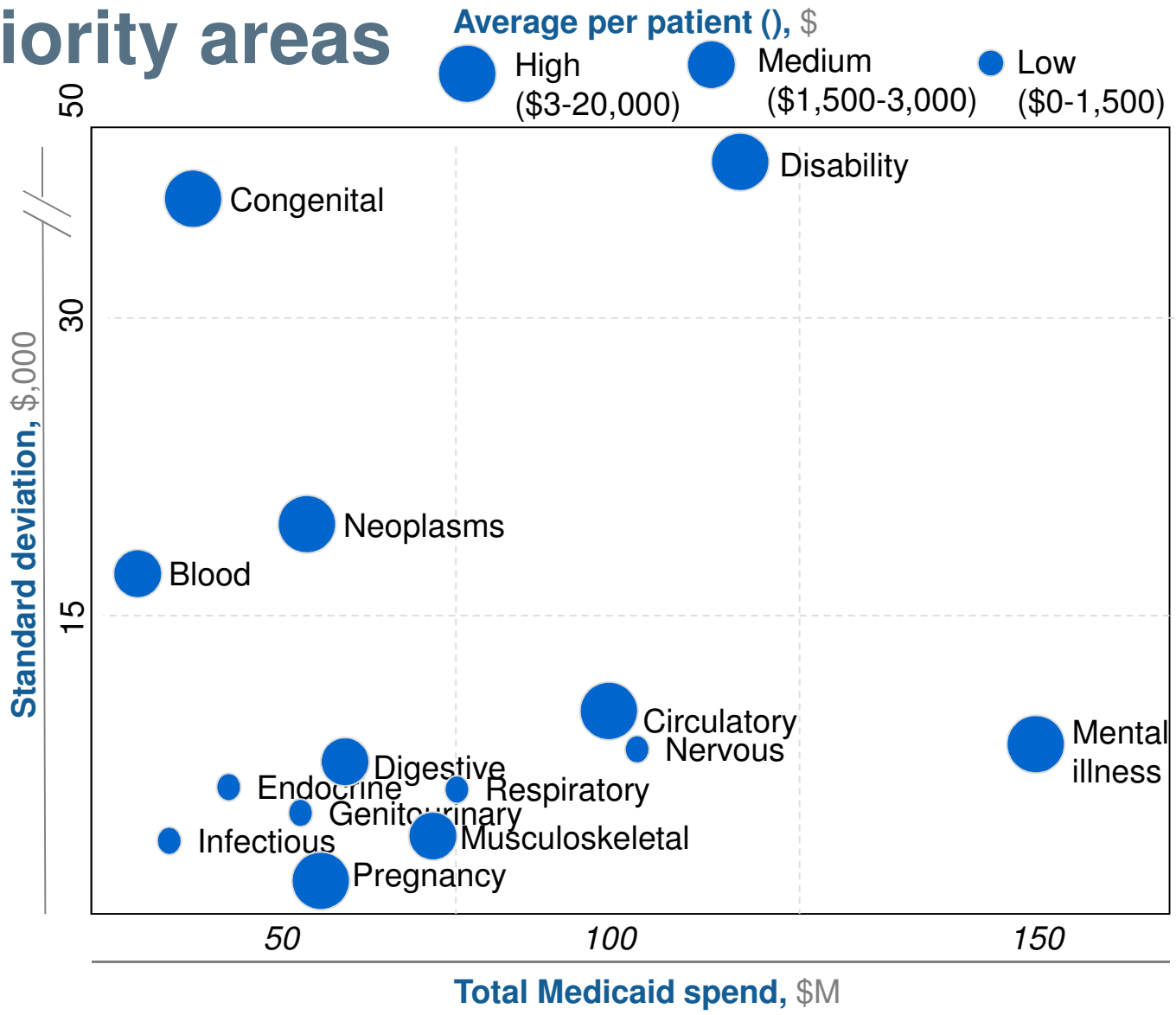


1 Specialists in both inpatient or outpatient settings
2 Includes primary care physicians, advanced practice nurses, physicians assistants

3.1.4 Effective diagnosis and treatment – selecting priority areas

Criteria for selecting areas of focus for effective diagnosis and treatment

- High cost
- High variation
- Guidelines would have significant impact
- Clear measures exist



SOURCE: 2012 DE State Medicaid data

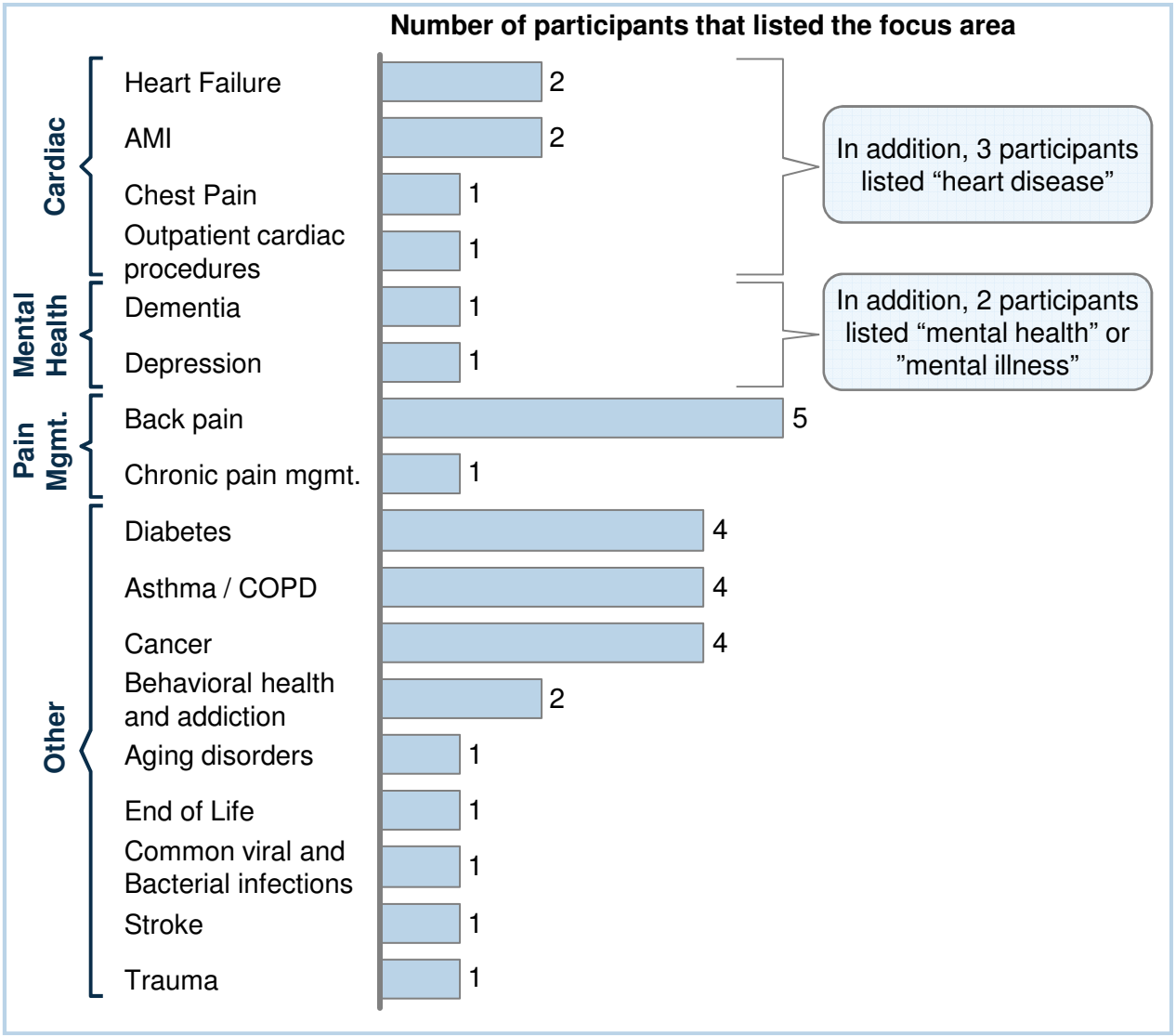
3.1.4 Example national study on variations in procedures and conditions

	Episode type	No. of episodes	Episode costs by percentile,$ 10th	50th	90th	Percentage of median episode cost 10th percentile cost	90th percentile cost
Common chronic conditions	Asthma	141,073	98	358	1,535	27	428
	Complex asthma	135,676	122	598	2,309	20	386
	Diabetes	227,730	251	1,103	3,750	23	340
	Hyperlipidemia	712,143	103	463	1,354	22	292
	Hypertension	654,414	149	498	1,469	30	295
	Complex hypertension	174,600	188	653	1,915	29	293
	Migraine headache	106,181	94	397	2,006	24	505
Major procedures	Cardiac catheterization (diagnostic)	25,788	3,901	6,324	13,101	62	207
	Cardiac catheterization with drug stent	2,099	16,092	23,744	36,487	68	154
	Cervical spine fusion	2,909	17,092	26,227	41,431	65	158
	Decompression of herniated disk	5,399	7,237	10,303	17,680	70	172
	Knee arthroscopy with ligament repair	8,594	7,730	11,008	19,264	70	175
	Knee arthroscopy with meniscectomy[1]	23,039	3,409	4,895	9,110	70	186
	VaginaL delivery	45,373	6,149	8,549	12,090	72	141
	Complex vaginal delivery	11,264	7,965	10,656	16,253	75	153

Note: All conditions and procedures reflect a low level of severity or complexity except where indicated.
1 Meniscectomy is removal of a torn meniscus (cartilage that cushions the knee)

SOURCE: "Wide Variation In Episode Costs Within A Commercially Insured Population Highlights Potential To Improve The Efficiency Of Care," *Health Affairs,* 2012.

3.1.4 Initial areas of focus



Based on the data and discussion, the delivery system workstream expressed interest in focusing on the following areas:

- Chronic conditions
- Palliative/end of life care
- Back/joint pain
- Perinatal care
- Cardiac-related illnesses

3.1.4 Effective diagnosis and treatment – leverage existing guidelines

Choosing Wisely
An initiative of the ABIM Foundation

American Academy of Family Physicians
AMERICAN ACADEMY OF FAMILY PHYSICIANS

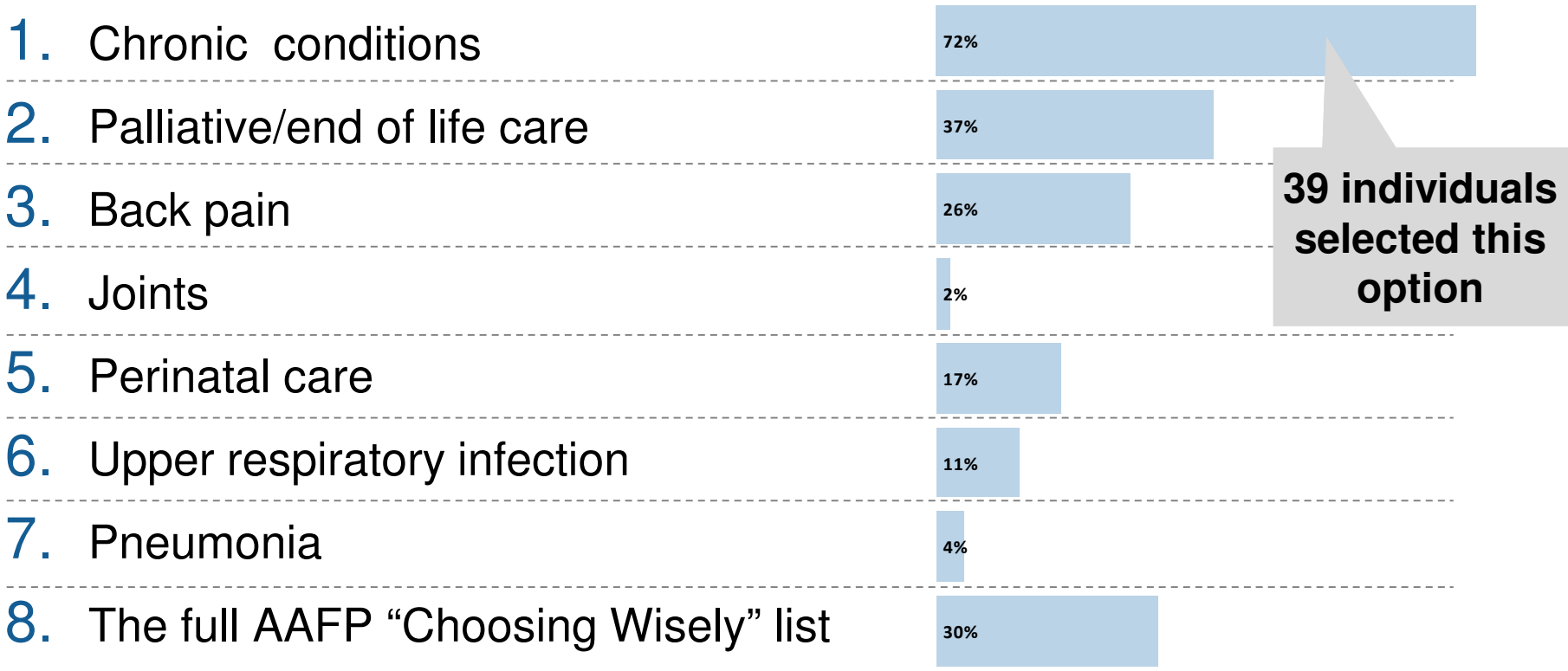
1. Early imaging for low back pain[1]
2. Antibiotics for acute mild-to-moderate sinus infections
3. X-ray absorptiometry (DEXA) screening for osteoporosis
4. Annual electrocardiograms (EKGs) and other cardiac screening
5. Pap smears for young women with hysterectomy for non-cancer disease
6. Elective inductions of labor or Cesarean deliveries before 39 weeks
7. Elective inductions of labor or Cesarean deliveries between 39 and 41 weeks
8. Screening for carotid artery stenosis (CAS)
9. Screening elderly women for cervical cancer
10. Screening younger women for cervical cancer with HPV testing, alone or in combination with cytology

1 See complete version of the AAFP Choosing Wisely list in Appendix;
http://www.aafp.org/dam/AAFP/documents/about_us/initiatives/choosing-wisely-five-questions.pdf

Discussion and feedback

TO GENERATE DISCUSSION ONLY – NOT FOR DECISION-MAKING

What is the priority area(s) for effective diagnosis and treatment?



Each participant can vote for 3 options

3.1.5 Shared platforms

PRELIMINARY

IT-based shared services	▪ **Risk stratification:** develop an IT platform to help providers identify, estimate, and direct resources most efficiently to the highest-need patients ▪ **Care gaps:** leverage IT to identify and help providers address gaps in patient care through automated electronic alerts
Other services	▪ **Protocols/guidelines:** outline conditions/procedures that would benefit from a standard medical approach, and develop, distribute, and regularly update guidelines ▪ **Care coordination:** help practices with care coordination through pre-qualification of vendors to supply care coordinators ▪ **Transformation support:** support practices' transformation to more effective care coordination through pre-qualification of vendors (or direct support) in coaching on relevant topics (e.g., practice transformation, and team-based care) ▪ **Learning collaboratives:** promote learning and the sharing of best practices on care delivery statewide

3.1.6 What this means for the multi-disciplinary team (selected members)

ILLUSTRATIVE

	Primary care provider	Specialist	Care coordinator	Nurse
Risk stratification	Understands which patients to devote additional coordination resources to	-	Understands which patients to devote additional coordination resources to	-
Care gaps	Receives alerts identifying when patients are not receiving the kind of care their condition would suggest	-	-	Receives alerts identifying when patients are not receiving the kind of care their condition would suggest
Protocols/ guidelines	For a focused set of conditions, receives comprehensive set of steps/reminders to support treatment	-	-	-
Care coordination	Receives assistance in identifying and hiring care coordinators	-	Prequalified to serve in this role	-
Transforma-tion support	Receives coaching and assistance in effective team-based care	-	Receives coaching and assistance in care coordination and effective team-based care	Receives coaching and assistance in effective team-based care
Learning cooperative	Is able to share best practices statewide for coordinating care and effective care and treatment, specific to their role			

3.1.7 Metrics: towards a common scorecard

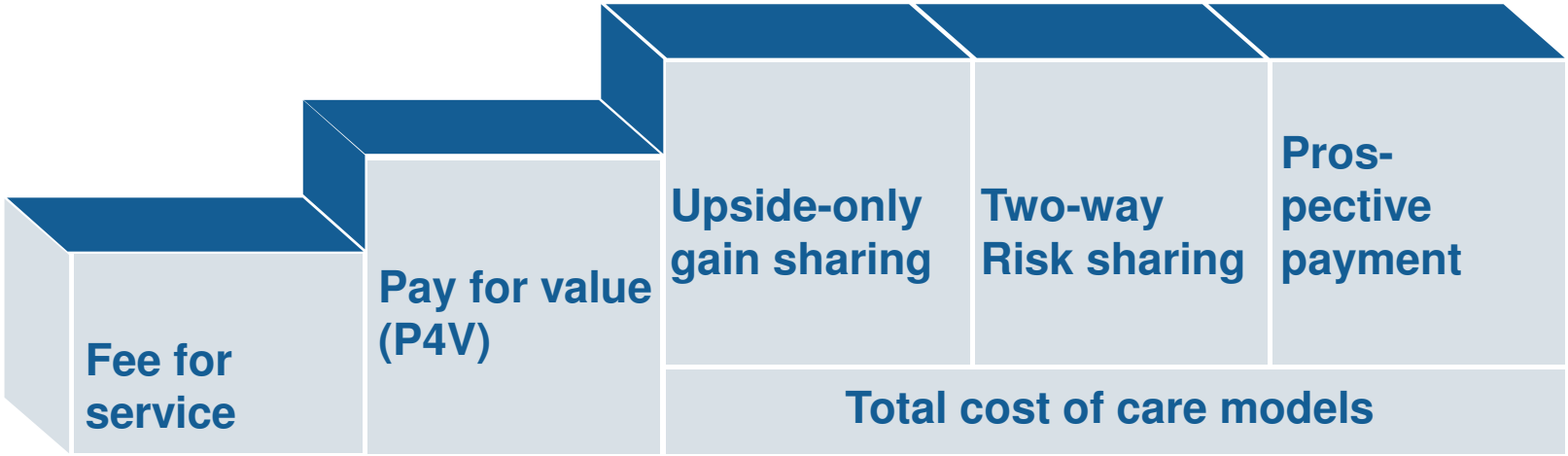
ILLUSTRATIVE

Category	Examples
Transformation	▪ Document coordination and consultation between clinicians at various transition points in care ▪ Meaningful use of data
Access	▪ Average wait time in office ▪ Average wait time to get appointment (e.g., days/weeks) ▪ Access to providers on nights and weekends ▪ % of practices accepting new patients
Process	▪ Timely referral to hospice for end of life patients ▪ Triage and rapid response to urgent problems ▪ % of patients in top 10% of risk with developed care plans ▪ % adherence with care plan ▪ % adherence with AAFP Choosing Wisely list
Outcomes	▪ Vaccine rates ▪ Prenatal care in the first trimester ▪ Basket of HEDIS metrics
Patient satisfaction	▪ Net Promoter Score
Cost	▪ Total medical expenditures (TME) ▪ TME growth rate vs. GDP

3.3.1 Payment principles

1. Population based as core foundation
2. Multi-payer alignment
3. Common vision that includes accountability and total cost of care
4. Multiple transition paths
5. Continues improvement, with established checkpoints
6. Balanced rules for payment model participation
7. Design for scalability from the outset
8. Strive for administrative simplicity
9. Plan for the transition costs
10. Role for fee-for-service
11. Flexibility
12. Incentives aligned with care for the highest risk patients

3.3.2 Proposed payment model that incentivizes both quality and lower costs



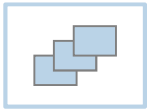
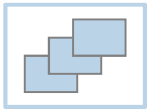
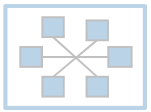
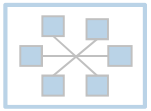
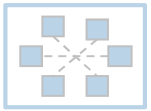
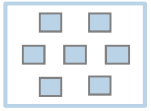
Potential on-ramps (goal of reaching a total cost of care model)

- **All** would be measured against **same scorecard of metrics**
- **All** would require meeting **quality measures** to qualify for gains
- For **P4V**, would measure **utilization** for payment (reporting **total cost** for information)
- For **total cost of care models**, would measure **total cost** for payment (reporting **utilization** for information)

3.3.2 Proposed payment model – tracks

Pay for value (P4V)	▪ Incentives for reducing resource utilization while meeting quality metrics, on top of FFS payments ▪ Goal of transitioning to gain-sharing when ready
Total cost of care	▪ **Upside only** – Share proportion of total cost of care savings (contingent on also meeting quality goals) – Prototypical model is Medicare Shared Savings Program upside option – up to 50% of savings shared (up to 10% of total projected spending) ▪ **Two-way risk sharing** – Share proportion of total cost of care savings (contingent on also meeting quality goals) as well as any losses – Prototypical model is Pioneer ACO – up to 70% of savings/losses (up to 15% of total projected spending) – Potential shift to prospective payment

3.3.3 Proposed provider organizing models

	Name	Overview	Description	Organizer
Single corporate entity	1 Large physician practices		▪ Larger practices / provider organizations with shared reimbursement	▪ Provider leadership/ champion
	2 Hospital-based health system		▪ Hospital system including employed physicians and outpatient services	▪ Health system
Formal / Joint-venture	3 ACO with hospital		▪ Provider organizations united for reimbursement coordinated around hospital	▪ Hospital / Health system
	4 ACO without hospital		▪ Provider organizations united for reimbursement without hospital	▪ Provider organizations ▪ Community groups
Virtual	5 Virtual panels of provider organizations		▪ Small provider organizations join to create scale for transformation, risk	▪ Payer, provider organization, or vendor
N/A	6 Not participating		▪ Providers not participating in total cost of care model	▪ None

3.3.3 How attribution works (an example)

Example: Attribution in Medicare Shared Savings Program

- Patients continue to choose the health care provider they see (subject to any insurance coverage restrictions, as at present)
- Patients are attributed to the Primary Care Provider (i.e., to the Primary Care Provider's ACO) who billed the majority of the primary care services they received over an evaluation period
- Historical data is used for preliminary attribution (so that providers know who they need to coordinate care for, and to make estimates for providers joining program)

DE methodology to be determined

SOURCE: CMS

3.3.3 Experience for patients

ILLUSTRATIVE

- Patients continue to be able to choose (or change) the health care provider they see, subject to any insurance coverage restrictions - as at present
- The providers they see are incentivized to coordinate care and focus on value

3.3.3 Experience for primary care providers

ILLUSTRATIVE

	For private practice primary care providers	For employed primary care providers
How do we participate in the new model?	▪ Form/join ACO with other providers or hospital for total cost of care model ▪ Opt to participate in pay-for-value model independently	▪ Can participate in either model if employing system participates
How does this affect the care we provide?	▪ See patients as usual ▪ Now incentivized to coordinate care and improve quality and cost for attributed patients (in total cost model)	▪ See patients as usual ▪ Incentives depend on employing system
How does this change reimbursement?	▪ Independent (P4V only) – Continue to receive FFS – Rewarded for managing utilization ▪ In ACO – Continue to receive FFS[1] – ACO bears risk and distributes any savings/losses	▪ Distribution of rewards/losses depends on employing system

1 Does not apply to capitated model

3.3.3 Experience for specialists

ILLUSTRATIVE

	Compete for referral volume	Join ACO
How do I participate?	▪ Compete for patient volume by providing high value (high quality at low cost) care	▪ Form/join ACO with primary care provider which has a sufficient number of attributed patients
How does this affect the care I provide?	▪ See patients as usual ▪ Incentivized to provide high value care (as referring primary care providers are accountable for total cost of care provided)	▪ See patients as usual ▪ Now incentivized to work with PCPs to improve value (quality and cost) for ACO's attributed patients
How does this change my reimbursement?	▪ No change	▪ In ACO – Continue to receive FFS[1] – ACO bears risk and distributes any savings/losses

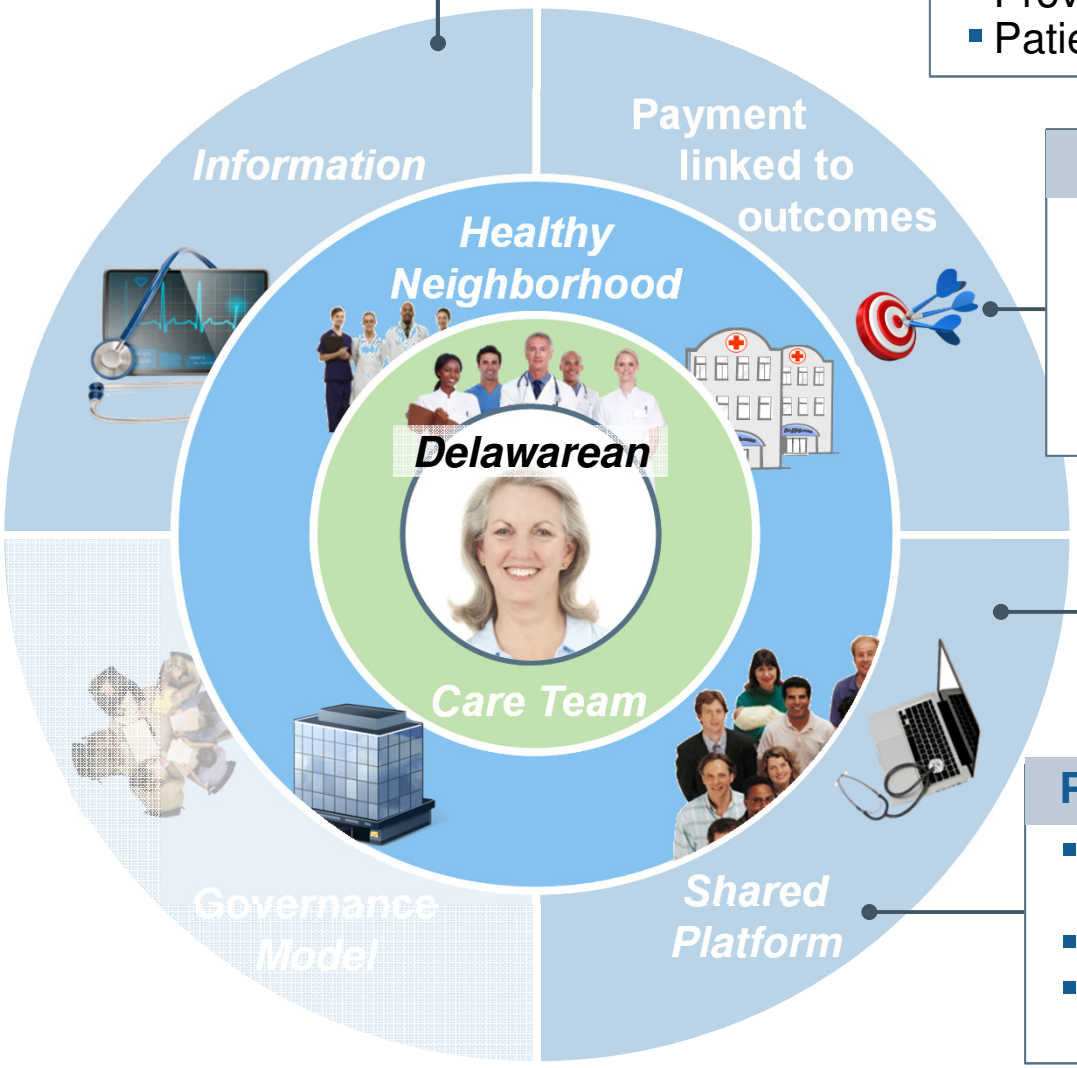
1 Does not apply to capitated model

3.3.3 Experience for hospitals / health systems

ILLUSTRATIVE

	Compete for referral volume	Join ACO
How do I participate?	▪ Compete for patient volume by providing high value (high quality at low cost) care	▪ Form/join ACO with minimum attributed population – with employed PCPs – by contracting with private practice primary care providers
How does this affect the care I provide?	▪ See patients as usual ▪ Incentivized to provide high value care (as referring providers are accountable for total cost of care provided)	▪ Hospital and physicians continue to see patients as usual ▪ Now incentivized to coordinate care and improve quality and cost (in total cost model)
How does this change my reimbursement?	▪ No change	▪ Accountable entity (ACO or health system) receives FFS and any shared savings/losses (distribution agreed among providers) ▪ If prospective payment is reached, ACO / health system received fixed payment for attributed patients

3.4.2 DE capabilities to support innovation



Provider/provider infra.

- Provider information exchange
- Patient registry

Payer infrastructure

- Claims-based algorithms for ACO development (e.g., risk stratification)
- Analytics based on claims to target clinical interventions (e.g., alert generation)

Payer/provider/patient connectivity

- ACO administration infrastructure
- Patient engagement technology

Provider/patient care management

- Provider alerts when patients require intervention
- Steerage to 24/7 clinical access
- Enhanced care mgmt. and workflow tools

3.4.2 Staged approach to roll-out

Likely SIM timeframe

	Stage 1 (~1 year) Pop. based health tech	Stage 2 (2-3 years) Care coordination tech	Stage 3 (3+ years) Whole pop. tech
1 Payer infra.	▪ **Claims-based algorithms** (e.g., patient attribution, performance, payment)	▪ Enhanced analytics to **target interventions** (e.g., care gaps, alerts)	
2 Payer/ provider/ patient connec-tivity	▪ **Two-way** portal for data collection/metrics reporting ▪ **Engagement and transpar-ency** tools to empower consumers (e.g., clinical)	▪ **HIE-enabled** communication for clinical data collection/ metrics reporting ▪ **Advanced data visualization** for providers	
3 Provider/ patient care mgmt	▪ **Alerts** providers to required interventions ▪ Steer to **24/7 clinical access**	▪ **Enhanced** care mgmt. and workflow tools (e.g., communication, analytics to target care)	▪ **Remote monitoring; telemedicine**
4 Provider/ provider infra.	▪ **Admission/discharge** data sharing ▪ Real time **EMR-based** clinical data exchange	▪ **Comprehensive clinical patient registry** ▪ Connect to **Federal network**	▪ **Whole population registry**
DE capa-bilities	▪ **Government claims database**	▪ **Multi-payer claims database** ▪ **Inventory** of community assets	

3.4.2 Standardization themes

HIGHLY PRELIMINARY

	Description
Guiding principles	▪ **Minimize duplication** by setting high bar for consolidation ▪ Consider **system-wide benefits** of standardization (e.g., APCD) ▪ Focus on bringing **best of breed solutions** to DE, rather than developing in-state (e.g., DHIN does not to do any development, integration only) ▪ Ensure that standardization plans **address sustainability** (e.g., funding for shared utilities)
Support range of providers	▪ Encourage tech-enabled providers to leverage their **existing tools** ▪ Identify **staged approaches** to support sub-scale providers
Areas adjust-ed to greater standardiz-ation	▪ **Standardize patient attribution** algorithms to align provider roles in care ▪ **Standardize definitions** of care gaps to ensure consistent practice ▪ Encourage **standard output** format from **EMRs** to support automated metrics collection
Areas adjust-ed to less standardiz-ation	▪ Sustain independent **tools and algorithms** (e.g., proprietary payer care gap identification) and ensure **standardized display** to minimize provider confusion; standardization possible long term ▪ Manage **24/7 clinical access** at the provider level (e.g., providers own night time call line)

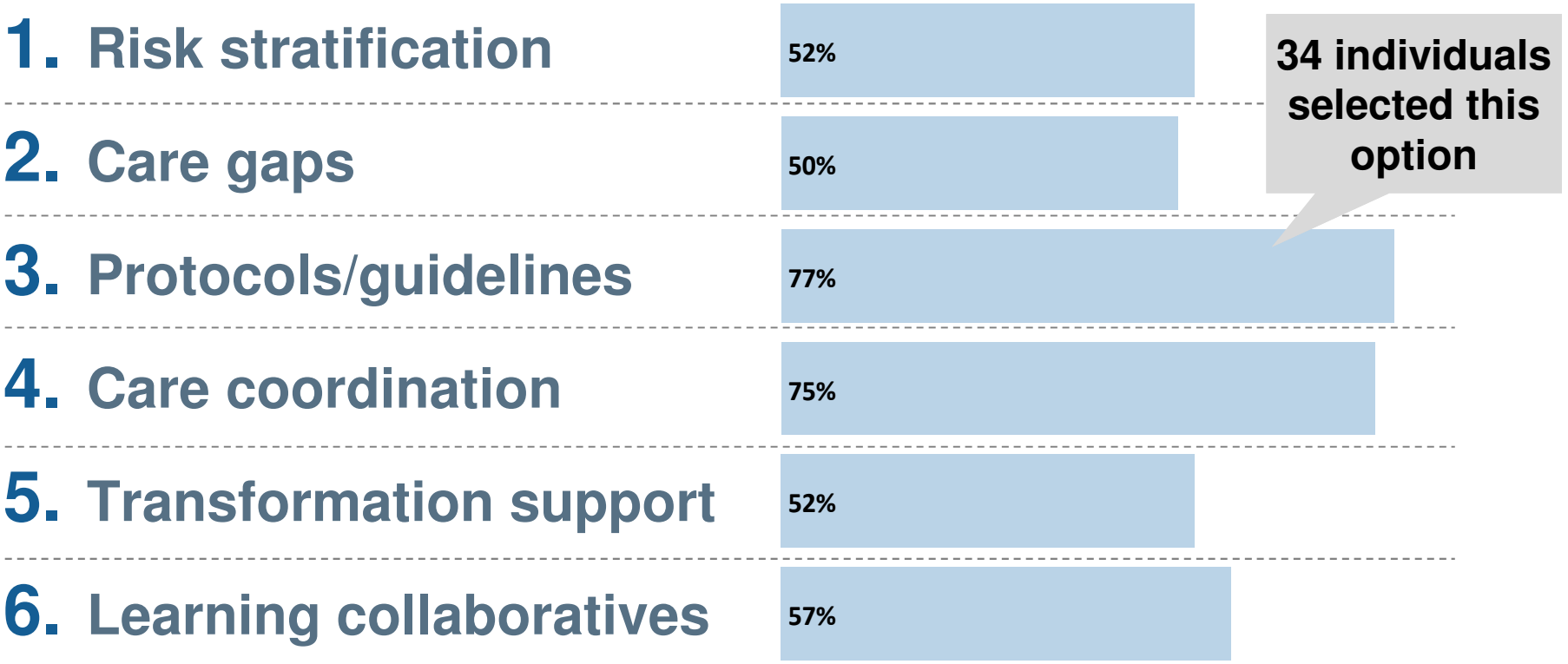
3.4.2 Distinctiveness synthesis

	Why a source of DE distinctiveness?	How will DE approach creating distinctiveness?
Build on existing connectiv-ity	▪ **Leveraging DHIN** which has: – **Broad adoption** (98% healthcare providers) – Wide range of **clinical data** (e.g., 99% lab results) – **Expanding** capabilities (e.g., notification system)	▪ **Create single provider portal** to exchange information between providers/payers to support innovation (e.g., metrics and performance reports) ▪ Collect **ambulatory data** via EMR-enabled bi-directional communication to improve care management ▪ Integrate **claims** and **clinical data** to improve cost/quality transparency
Empower patients with transpare-ncy tool	▪ Synergies with DE's goal of **empowering patients** in new care and payment models ▪ A patient tool (iTriage) in **development** ▪ **Enabled** by DE's health data infrastructure (e.g., DHIN)	▪ Develop direct messaging communication system between **providers and patients** for engaged **decision making** ▪ Connect HIE to tool to provide personal and **migratable clinical data** ▪ Feature system for checking symptoms and guidance to **24/7 central steerage channel** (e.g., web, phone line)

Feedback on shared platforms

TO GENERATE DISCUSSION ONLY – NOT FOR DECISION-MAKING

To what extent do you support a shared platform in the following areas? (multiple choice)



3.5 Population health summary

Outline

1. Concerted focus on keeping people healthy
2. Purpose is to ensure
   - seamless integration and coordination of Delivery System model with community
   - all Delawareans understand importance of primary and preventive care and how to access and navigate community and health systems
3. Built around "healthy neighborhoods" to create a forum for organizations (e.g., schools, non-profits, employers) to support population health
4. Neighborhoods will
   - integrate care delivery system and community resources
   - focus on health & wellness, messaging, and access
   - aspire towards statewide health and wellness goals
   - tailor the approach for reaching these goals to the needs and resources of each locality

To further emphasize

- **Mobilize communities** to address their most important determinants of health
- Emphasis on providing individuals with resources to stay healthy through strong **integration** with **community-based** services
- **Complementary** to additional important health promotion and disease prevention efforts

3.5 Emerging vision for population health

Establishment of zones and designation of local champions

Assessment of community needs and local action plan creation

Utilization of community health workers to promote integration

Creation of directories cataloging services offered regionally

Data at the neighborhood level and score-cards for evaluation

Platform for sharing of best practices across the state

- Emerging perspective for a balance between common framework and approach (e.g., on a few common outcomes, method of change) with significant room for local tailoring

3.5 Healthy Neighborhoods potential structure

6 core program components

- Designation of zones and local champions
- Assessment of community needs and local action plan
- Utilization of community health workers to support integration
- Creation of directories of regional services offered
- Data at the neighborhood level and scorecards
- Platform for sharing of best practices across the state

An example of how it could work

Required DE-wide interventions

Program administration and oversight

- Designate Healthy Neighborhood Champion organizations in each DE zone
- Fund champions to design and execute community action plans

Coordination/program evaluation

- Establish priority focus areas
- Develop capability to measure neighborhood-level outcomes
- Create common scorecard
- Provide technical assistance
- Provide platform for sharing best practices

Healthy Neighborhood Champion role

Community assessment/planning

- Assemble local coalition from diverse stakeholders
- Assess landscape
- Develop integrated plan for improving performance

Implementation

- Recruit and train community integration workforce (e.g., volunteers)
- Train providers about community resources
- Track and report progress against target metrics

3.5 Questions for discussion

- What should be the governance structure, both within healthy neighborhoods and across these neighborhoods (e.g., who oversees them, how are they supported, what is the role of public health)?
- How do healthy neighborhoods interact with the health care delivery system?
- How much do healthy neighborhoods cost?
- How are they funded?
- Any other initial responses or feedback?

3.6 Health Care Commission's Health Care Workforce Committee – Recommendations

1. Fully implement the Institute of Medicine's recommendation to build an infrastructure for the collection and analysis of professional health care workforce data
2. Support and continue to expand Delaware's health information technology infrastructure
3. Support state-of-the-art health care workforce education and training programs
4. Ensure a supportive regulatory and policy environment for health care professionals
5. Ensure integrated and supportive practice environments for health care professionals
6. Create and implement a comprehensive health care workforce recruitment strategy

SOURCE: DE Health Care Commission Health Care Workforce Recommendations Draft (December 2012)

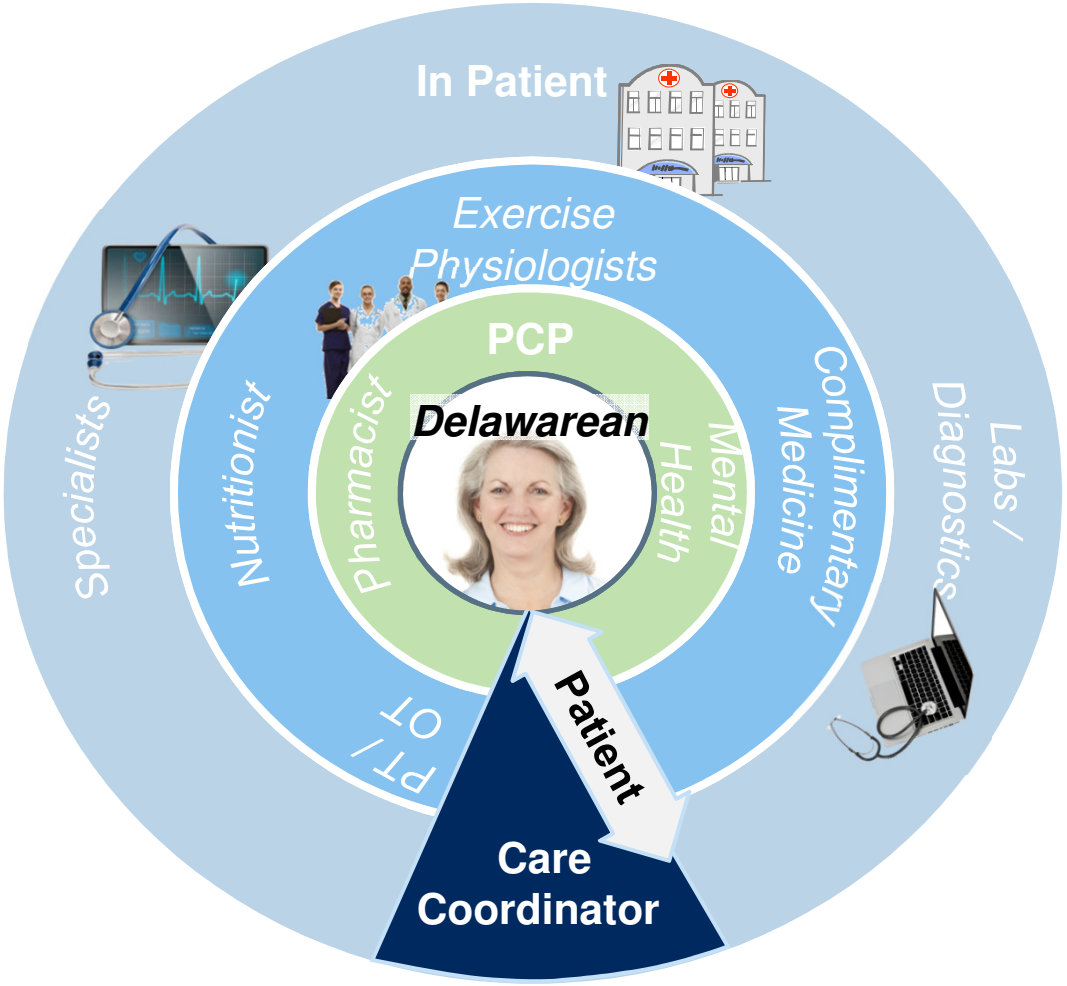
3.6 DE's healthcare workforce – existing needs

- Nearly half of all PCP locations in Delaware employ no other members of the care team, suggesting small, fragmented practice sites
- Age and chronic illness will continue to have a significant effect on DE's health care needs
- There are existing workforce shortages in some DE counties across certain specialties in particular (e.g., primary care, dentistry, behavioral health)

1 Below national average

SOURCE: Delaware Health Care Commission Health Care Workforce Report; Health Care Workforce Recommendations, December 2012; Toth: Primary Care Physicians in DE (2011)

3.6 Additional needs for team-based coordinated care



Workforce goals

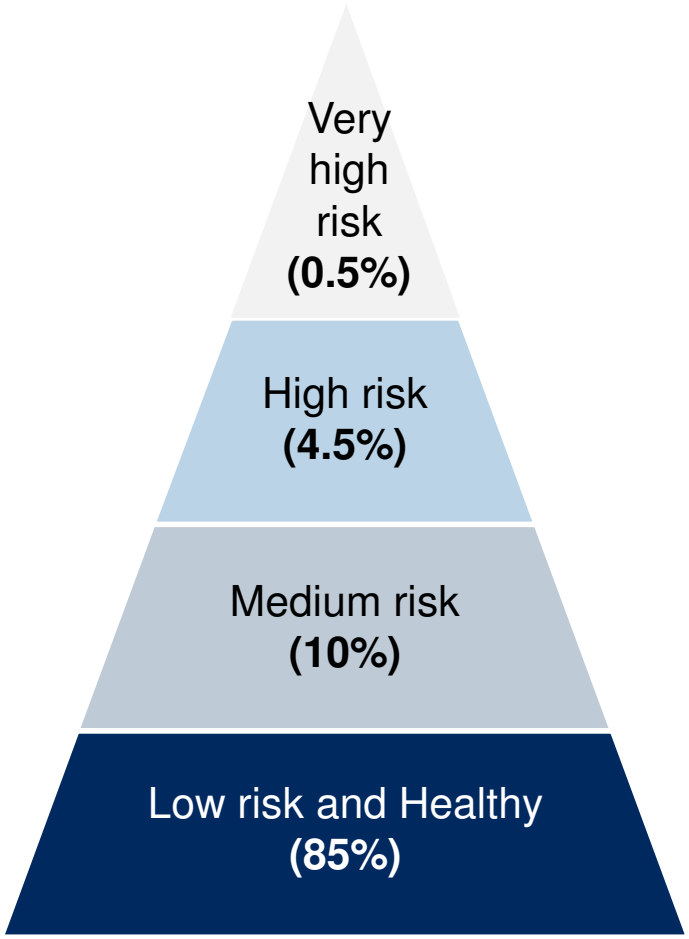
Develop **sustainable** model for a **flexible** workforce characterized by

- Care coordination across the population continuum with varying levels of care and modalities of service
- Shift activities to practice at the top of license and parcel out lower level activities to others
- Community workforce to enable healthy neighborhoods

3.6 Detail on delivery system requirements

Components	Required supporting role / skills
Care coordinators	▪ Defined by role and skill, not license or job title ▪ High level care coordinators for top 5-15% highest risk of population, but care coordination as well for healthy, lower risk group, focused on prevention and lowering risk of disease ▪ Possibly located in various settings (e.g., PCP office, shared across PCPs, hospital, behavioral health specialist)
Multi-disciplinary teams	▪ Multi-disciplinary team composition may vary based on patient need, but likely includes broad workforce (e.g., pharmacists, nurses, PCPs, social workers, mental health professionals) ▪ New skills and capabilities needed regarding – an awareness of the full team makeup – efficiently and effectively working in teams ▪ Enhanced capacity in behavioral health and dental
Effective diagnosis and treatment	▪ New skills and capabilities to – reduce unwarranted variation in care for priority areas – support providers' practicing at the top of their license

3.6 Care coordination and pop. health capacity

Example risk pyramid	Description	Estimated # required[1]
	Care coordinators ▪ defined by role and skill, not license or job title ▪ primarily connected with ambulatory setting ▪ additional high-intensity case management at health system and/or payer for acute needs	~500
	Community Health Workers for healthy neighborhoods to promote wellness and prevent disease progression	TBD?

1. Applies panel sizes of 50:1 for very high risk, 150:1 for high risk, 500:1 for medium risk, and 1000:1 for low risk population. Assumes 2012 Delaware population of 917,092 from U.S. Census Bureau (http://quickfacts.census.gov).

3.6 Challenge: building new skills and meaningful careers

How to build new skills?

- Training modules designed specifically to expand capabilities of individuals at all levels
- Modules include focus on team care and team delivery, communication, patient-focused care

How to build new pipeline?

- Consider licensing requirements
- Understand what new workers we need – what does their education and training look like

Need to consider across broad range of providers, patients, and families

3.6 Potential strategies – for discussion

	Example strategies
Attract broader health care workforce	▪ Position DE as a **"learning state"** by – Developing **common set of innovative learning goals** shared by each academic institution and provider – Targeted **marketing campaign** ▪ Streamline and simplify licensure and credentialing requirements
Enable effective care coordination	▪ Streamline existing care coordination to optimize current capacity – Develop **common set of standards** around care coordination responsibilities in each care setting – **Create transparency** (potentially through DHIN) for patients and providers about their full care teams (e.g., so hospital discharge planner knows if patient has PCMH care coordinator) ▪ Create sustainable pipeline of new care coordinators by **developing training** / **re-training modules** at DE institutions ▪ Support healthy neighborhoods by **developing inventory of community health workers** and **common roles and responsibilities**

3.7 Policy – elements of emerging answer requiring policy support

Workstream	Areas that likely need policy support
Delivery system	1 Addressing access through licensing and credentialing, in particular in primary care and dentistry 2 Establishing shared utilities – Expanding capacity and establishing governance and privacy rules via DHIN to support IT-driven utilities (e.g., risk stratification) – Developing the Health Care Value Institute – Identifying sustainable funding mechanisms
Population health	3 Creating Healthy Neighborhoods – Identify a governance structure for the program – Designate zones – Defining and training community health workers
Payment model	4 Enabling the payment model – Working with provider organizations to develop a framework to share risk – Creating a policy environment that allows for payer alignment

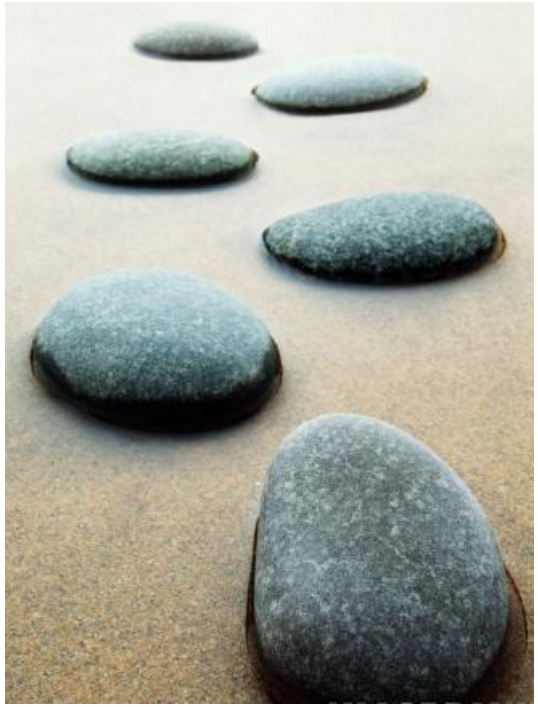
4.2 Implementation – levers to drive change

Levers

- Engage broad range of stakeholders
- Prioritize scaling up items that work already
- Use data and transparency through expanded set of tools
- Make changes to payment model, driven by key players
- Support change in practice activities on the ground

4.3 Rollout timeline after September

ILLUSTRATIVE



Now until September

- Refining Plan including key outcomes, milestones, a budget for taking this forward and agreed measures for funding immediate priorities.
- Developing overall governance and budget
- Developing detail on the patient activation strategy

September 2013 until December 2013

- Developing application for CMMI testing grant, Developing legislation required to enable the Plan
- Engaging CMS in aligning Medicare payment models with plans of the state
- Open enrollment for health insurance marketplace begins

January 2014 until June 2014

- Introducing legislation (if necessary)
- Standing up new governance mechanisms
  Starting efforts to put in place common platform
- Conducting detailed modeling and analysis to develop shadow payment mechanisms for providers
- Executing on the DHIN technology roadmap

June 2014-June 2015

- Year 1 of the plan (which may involve shadow payments)
- Delivering on the first year of the DHIN's technology roadmap

4.5 Budget required

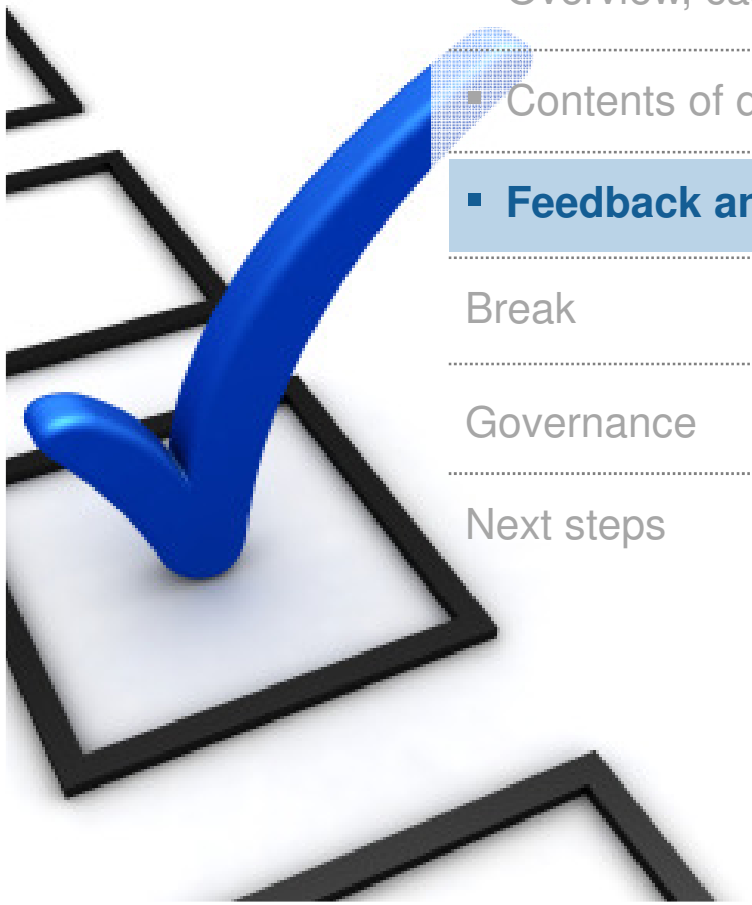
FOR DISCUSSION

Example budget requirements

- Data infrastructure
- Data collection
- Personnel
- Delivery transformation
- Governance
- Evaluation
- Other

- SIM grant
- In-kind
- State funding
- Federal match
- Third party funding

Agenda for today



Introduction and recap	8:00
Transformation vision and draft plan	
▪ Overview, case for change and DE context	8:30
▪ Contents of draft plan	8:50
▪ **Feedback and discussion**	**10:45**
Break	11:00
Governance	11:15
Next steps	12:00

Delaware's health care transformation

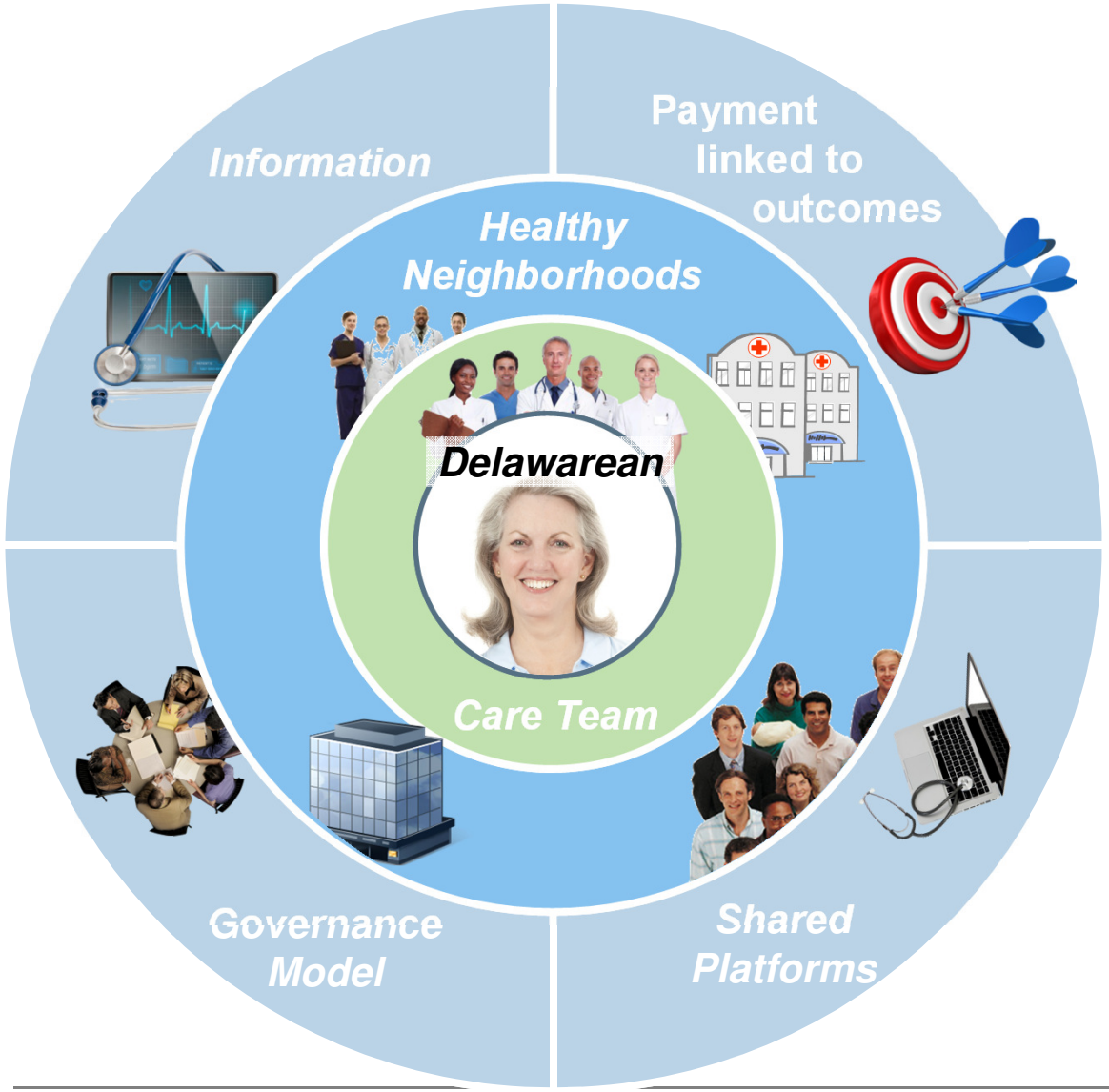
Aspiration

- Delaware aspires to lead the nation in innovation and impact on each dimension of the Triple Aim:
  - improving the health of Delawareans
  - improving the patient experience of care
  - reducing health care costs

Specific goals

- Delaware will be the **healthiest state in the nation**
- Delaware's **health outcomes** will rank among the **top ten percent nationally**
- Delaware will **significantly reduce** health care **expenditures**

Vision for Delaware's health transformation



Vision:

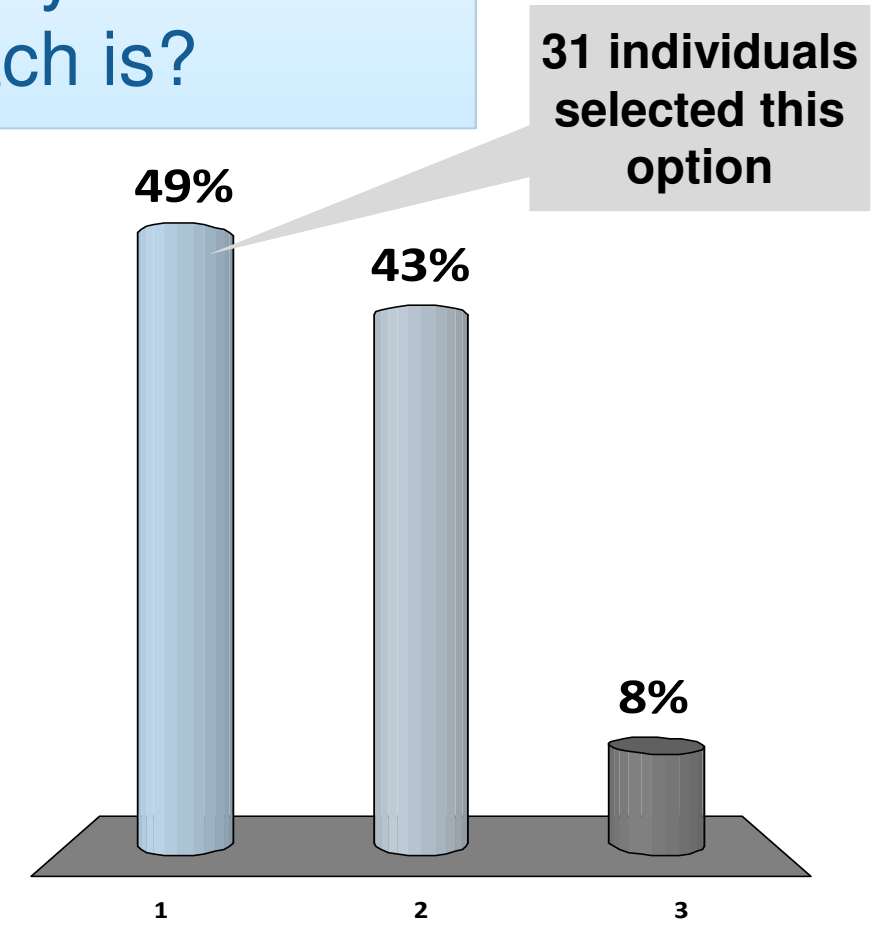
- **person-centered** care with patients empowered and engaged in their own care
- multi-disciplinary **care team**
- **healthy neighborhood** that includes providers, employers, community groups and others
- **information** to enable delivery and payment transformation
- payment that incentivizes **value**
- **shared platform** of resources
- **governance model** to ensure change

Discussion and feedback

TO GENERATE DISCUSSION ONLY – NOT FOR DECISION-MAKING

Based on what you've heard today, how **transformative** do you think Delaware's approach is?

1. Will transform Delaware
2. Should have some impact – but we could do more
3. Unlikely to have impact

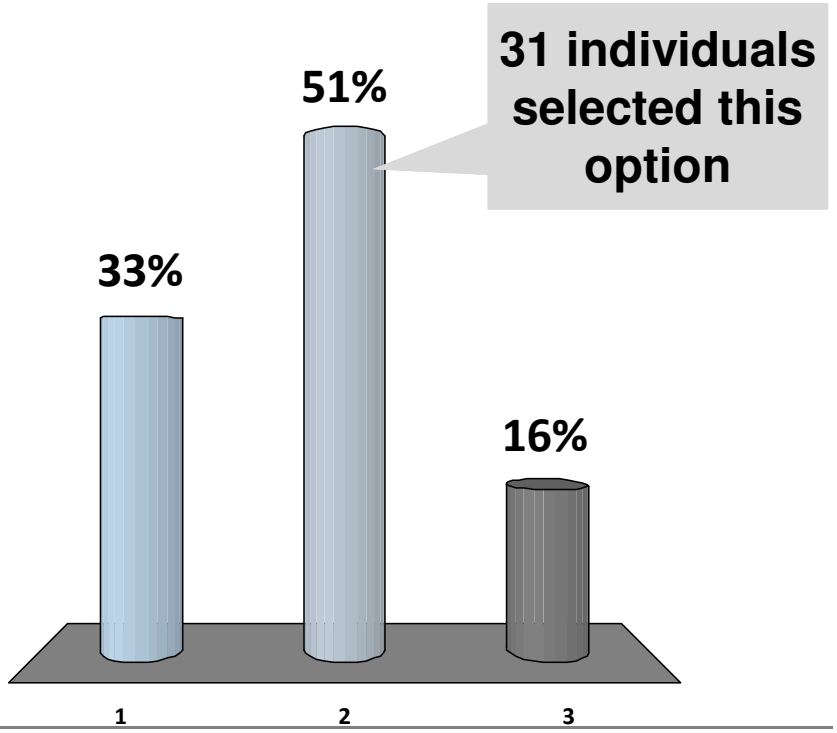


Discussion and feedback

TO GENERATE DISCUSSION ONLY – NOT FOR DECISION-MAKING

How well does the approach incorporate your perspectives about current constraints, transition requirements, flexibility, etc.?

1. Very well
2. Fairly well with some room to improve
3. Not well at all



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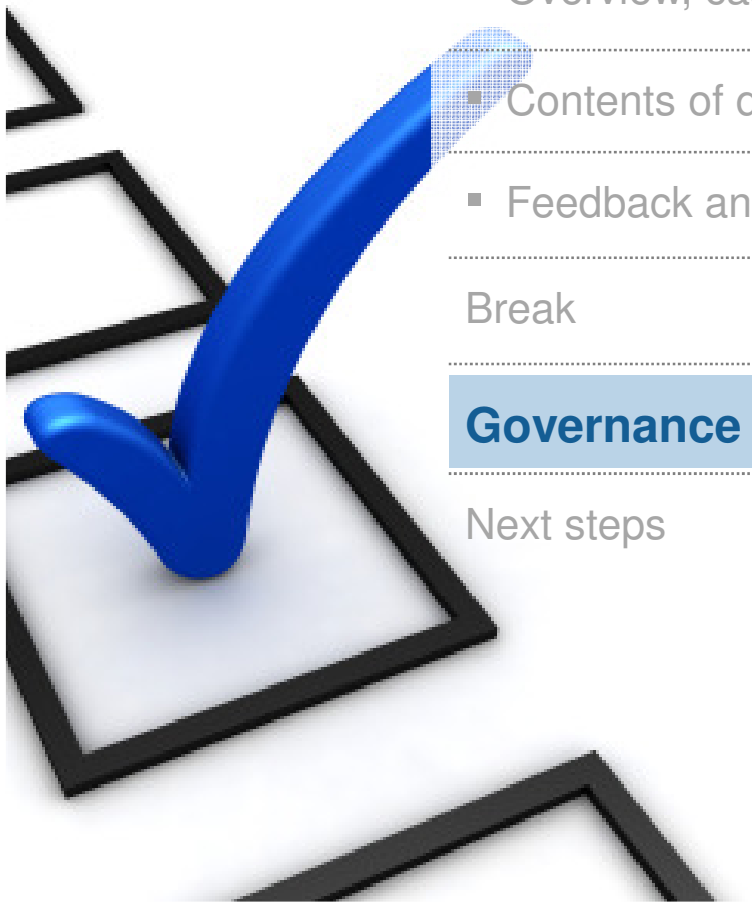
Agenda for today



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Ideas for governance of health care transformation

HIGHLY PRELIMINARY

Additional discussion following

Health Care Commission

- Policy committee established by the DE General Assembly
- Charged with developing a pathway to basic, affordable health care for all Delawareans
- Composed of four state officials, including the Secretary of Health & Social Services, and six private citizens appointed by the Governor or leader of the House or Senate
- Manages key healthcare policy and bodies in the state – including the DE Health Resources Board and the state's new exchange

Health Care Value Institute

- Clinician-focused and -led institute dedicated to providing services in support of innovative health care delivery in Delaware
- Will have responsibility for providing non-IT-related shared services to support care coordination and effective diagnosis and treatment
- Composed of payers, providers, patients, and state representatives

DHIN

- Established by the DE General Assembly
- Was the first operational statewide health information exchange in the country
- Delivers more than 11 million clinical results and reports each year to nearly 660 practices and health care organizations across DE
- Has an enrollment of over 98% of Delaware providers (as of Dec. 2012)

Starting the conversation on the Health Care Value Institute: draft for discussion

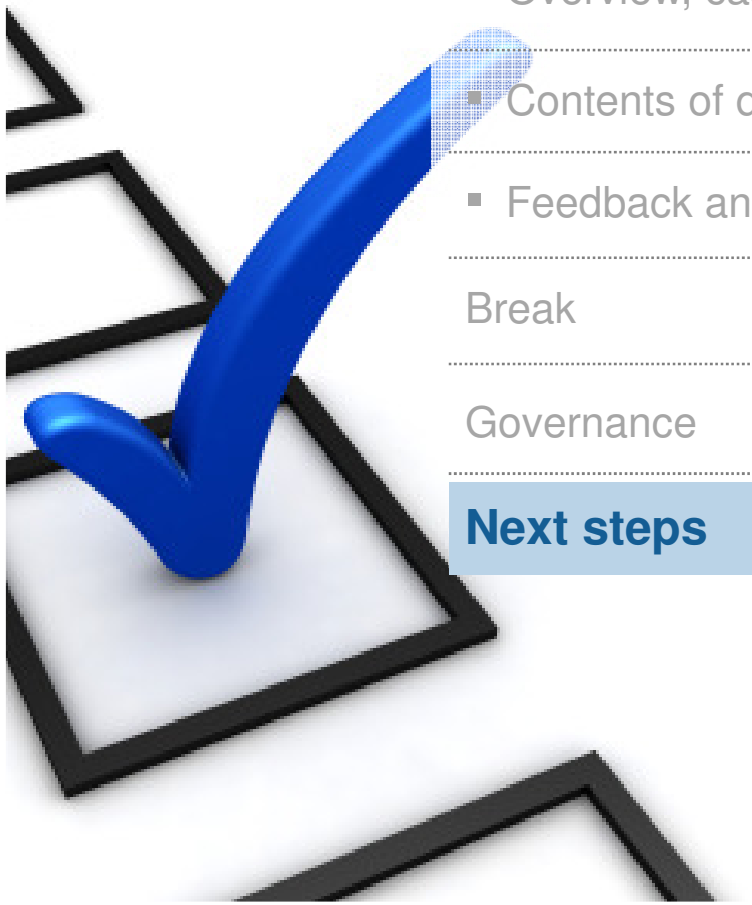
HIGHLY PRELIMINARY

Structure	▪ Governed by Board, appointed by the Governor; includes patient representatives, providers, payers, employers, etc ▪ Supported by small team of full-time staff who directly and through procurement ensure each service is delivered to Delaware's payers, providers, and patients
Responsibilities	▪ Driving towards the Triple Aim and enhanced health care quality and outcomes ▪ Establishing and managing each element of shared platform: ▪ Oversees and publishes annual scorecard ▪ Would house Healthy Neighborhoods program
Membership	▪ Patient representatives ▪ Providers ▪ Payers ▪ State representatives
Establish-ment and funding	▪ Established by the Legislature ▪ Funded by participating providers and payers

For each area, what do you think the answer should be?

Discussion

Agenda for today



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Timing


Final All-workstream meeting **July 23rd**
Final workstream sessions **Varies**
Public comment period **August 9th to September 5th**
July
Aug
Sept
August 7th Health Care Commission
Second draft of Plan
September 5th Health Care Commission
Plan submitted