Delaware Center for Health Innovation

Board Meeting

August 12, 2015

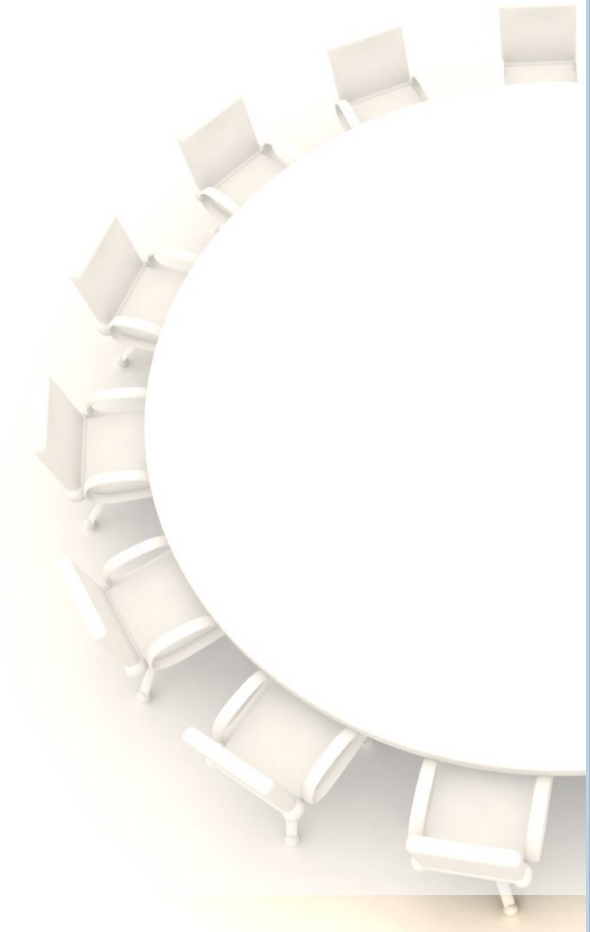
Agenda

Topic

Call to order
Status updates
Board business
Draft approach for Healthy Neighborhoods and Care Coordination
Cross-Committee debrief
Public comment

Summary of July DCHI Board meeting

- Provided updates on **recent progress**, including:
  - Overview of work across DCHI from the past year
  - Committee activities
  - Common Scorecard testing
  - ED recruitment, infrastructure, and branding & website
- Previewed **July 15 Cross-Committee meeting**, including:
  - **Structure of meeting**: introductory overview of Delaware's strategy, "gallery walk" to review committee activities, and two deep dives on cross-cutting topics with time for Q&A
  - Plan for **presenters**
- Discussed **funding and budgeting** approach, including:
  - Investments and sources of funding
  - Different DCHI financial roles in SIM program
  - Process for allocation of CMMI grant funds
  - DCHI operating budget



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Committee updates (1/2)

For update today | For extended discussion

Committee	Update	Path forward
Workforce	▪ Discussed further workforce capacity requirements based on population projections ▪ Reviewed workforce implications from Healthy Neighborhoods strategy ▪ Developed draft consensus papers on learning (curriculum for care coordination) and capacity planning ▪ Discussed updates on credentialing	▪ Align workforce learning consensus paper draft with draft of care coordination consensus paper ▪ Gather further feedback on capacity planning draft ▪ Continue follow-up on credentialing and data for capacity planning
Patient and Consumer	▪ Discussed health literacy program and implications for patient and consumer advisory work for DCHI ▪ Reviewed approach for patient/consumer communications strategy	▪ Provide further feedback on communications strategy and develop next draft ▪ Update glossary of terms
TAG	▪ Shared a live demo of the Common Scorecard ▪ Discussed approaches to delivering attribution lists	▪ Collection and integration of provider feedback from Scorecard access ▪ Determine the payer requirements for hosting attribution files in the Scorecard interface

Committee updates (2/2)

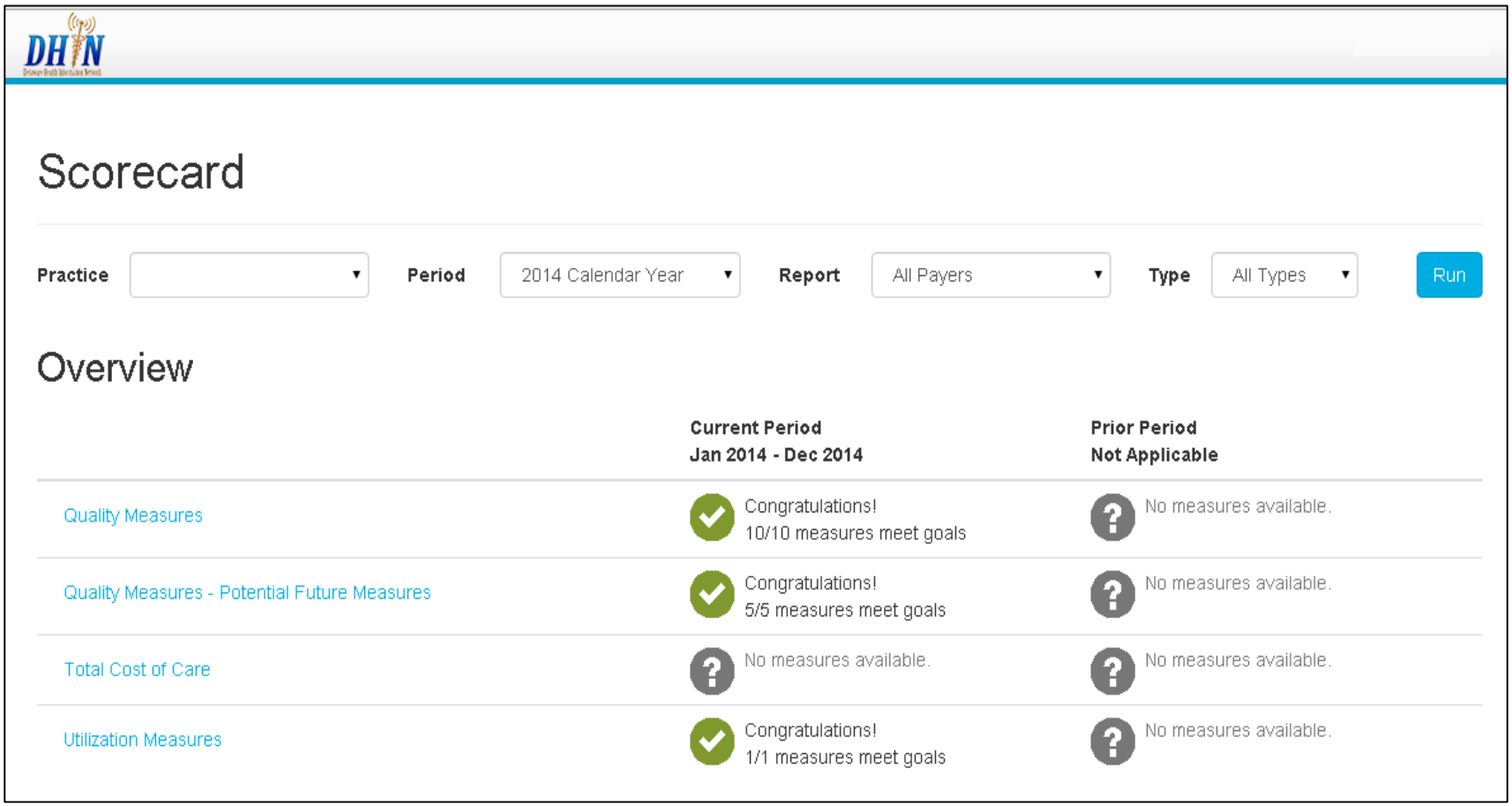
For update today | For extended discussion

Committee	Update	Path forward
Payment	▪ N/A (July meeting was cancelled) ▪ Upcoming topics include payment tie to Scorecard as well as pay for value model (utilization based) design elements	▪ Discuss frameworks for tying the Common Scorecard to a payment model, including areas for standardization in these frameworks
Clinical	▪ Discussed emerging consensus Care Coordination design decision around definitions, Care Coordination vendors services, and approach to participation in Care Coordination ▪ Discussed common challenges in Delaware of behavioral health and collaboration between primary and behavioral care providers, including input from Cross-Committee meeting	▪ Discuss approach to roll out of practice transformation ▪ Discuss transition to Common Scorecard Version 2.0 ▪ Launch behavioral health integration working group and continue discussion of behavioral health integration strategy
Healthy Neighborhoods	▪ Discussed operating model paper, including creating neighborhood boundaries ▪ Discussed phased approach to rollout ▪ Presented to Delaware Healthcare Association	▪ Finalize Neighborhood boundaries ▪ Plan awareness and education campaign ▪ Create timeline for phased rollout

Scorecard testing status update

Topic	Update
Release to testing practices	▪ On August 7, the Common Scorecard was released to the practices participating in the testing phase ▪ The Scorecard contains data from two payers: – 10 measures displayed for one payer and 14 measures displayed for the other ▪ The DHIN Helpdesk is responsible for answering questions from providers, including triage of questions as required to DCHI or payer representatives ▪ Attribution list functionality (expected to release in September) is pending payer review of vendor PHI processes
Scorecard feedback	▪ Conducted visits with 16 of the participating practices ▪ Engaged in active feedback process with providers in advance of visits, including addressing detailed questions raised by practices via email ▪ Upon interacting with their Scorecard, testing practices have been asked to provide feedback across: – Measure relevance to the practice – Accuracy of data and attribution (forthcoming) – Clarity and functionality of user interface

Practice overview section



Measure performance

Quality Measures

No goal defined yet | Below goal by 1-5% | Below goal by 6-15% | Below goal by 15+% | No Data

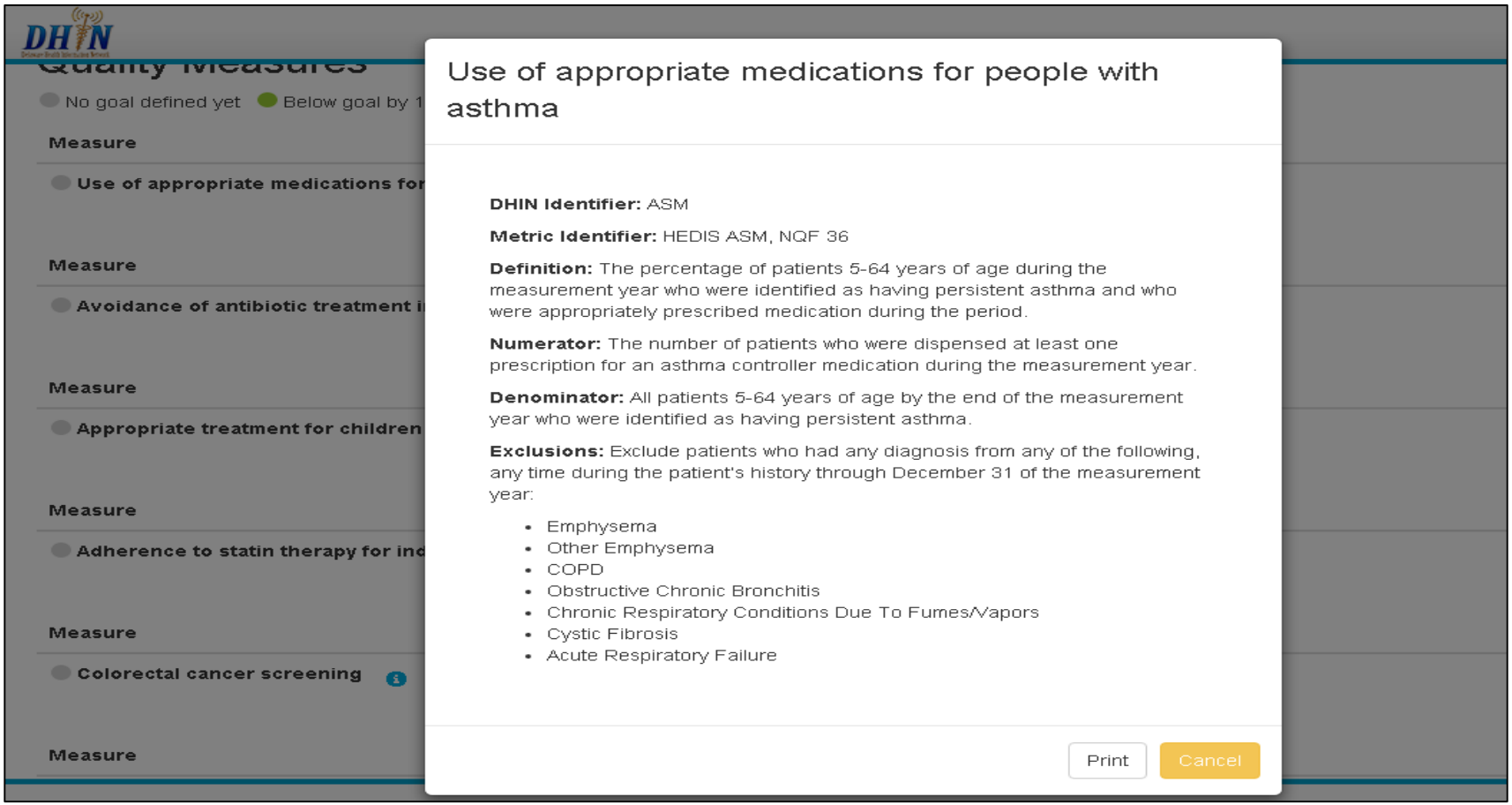
Measure	Performance in current period
Use of appropriate medications for people with asthma	34 / 43 = 79.1% Goal = 0%

Measure	Performance in current period
Avoidance of antibiotic treatment in adults with acute bronchitis	1 - (127 / 144) = 11.8% Goal = 0%

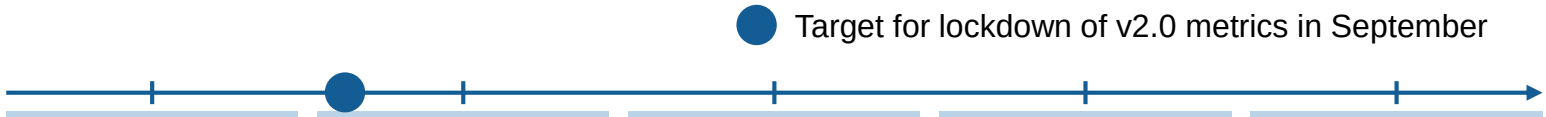
Measure	Performance in current period
Appropriate treatment for children with upper respiratory infection	1 - (6 / 26) = 76.9% Goal = 0%

Measure	Performance in current period
Adherence to statin therapy for individuals with coronary artery disease	0 / 159 = 0% Goal = 0%

Measure detail



Timeline for Common Scorecard



	Jul 2015	Oct 2015	Jan 2016	April 2016	Jul 2016
Reporting period	▪ Jan-Dec ‘14	▪ Jan-Dec ‘14 Jan-Aug ‘15	▪ Jan-Dec ‘14 Jan-Nov ‘15	▪ Jan-Dec ’14 ▪ Jan-Dec ’15 ▪ Jan-Feb ‘16	▪ Jan-Dec ’14 ▪ Jan-Dec ’15 ▪ Jan-May ‘16
Audience	▪ Testing practices	▪ Testing practices	▪ Testing practices	▪ All PCPs statewide	▪ All PCPs statewide
Metrics	▪ Quality ▪ Process	▪ Utilization/ TCC	▪ v1.0 metrics	▪ v2.0 metrics	▪ v2.0 metrics
New function-ality	▪ Aggregate performance ▪ Payer performance	▪ Attribution lists	▪ Practice transformation milestones ▪ Practice aggregation	▪ Practice enrollment ▪ Additional payers	▪ Patient experience

Feedback to be incorporated

Feedback from payers and providers

- Limit reliance on CPT-II data
- Increase alignment with existing scorecards, e.g. (MSSP, Mednet ACO, PCMH, MU)
- Reduce the number of measures that may suffer from incomplete reporting due to measure specification details (e.g., influenza)
- For better balance, include more "women's health" and "access to care" measures
- Consider the implications for scoring or tying payment to measures that represent new expectations for PCPs or require documentation in a different way

Summary of proposed changes

- Reduce number of measures requiring additional steps to capture clinical data
- Recommend "reporting only" for measures without baseline data (e.g., depression screening and fluoride varnish)
- Substitute measures within similar conditions/ classifications to facilitate data capture but maintain relevance to patient care
- Add an access-to-care measure such as follow-up within 7 days after hospital discharge (or similar)
- Add measures that broaden scope of the Scorecard to areas such as Women's health and align with other existing quality initiatives in the State

- **Clinical Committee plans to review Draft of Version 2.0 at next meeting (August 18th)**
- **Follow-up discussion on recommended changes for V2.0 at September Board**

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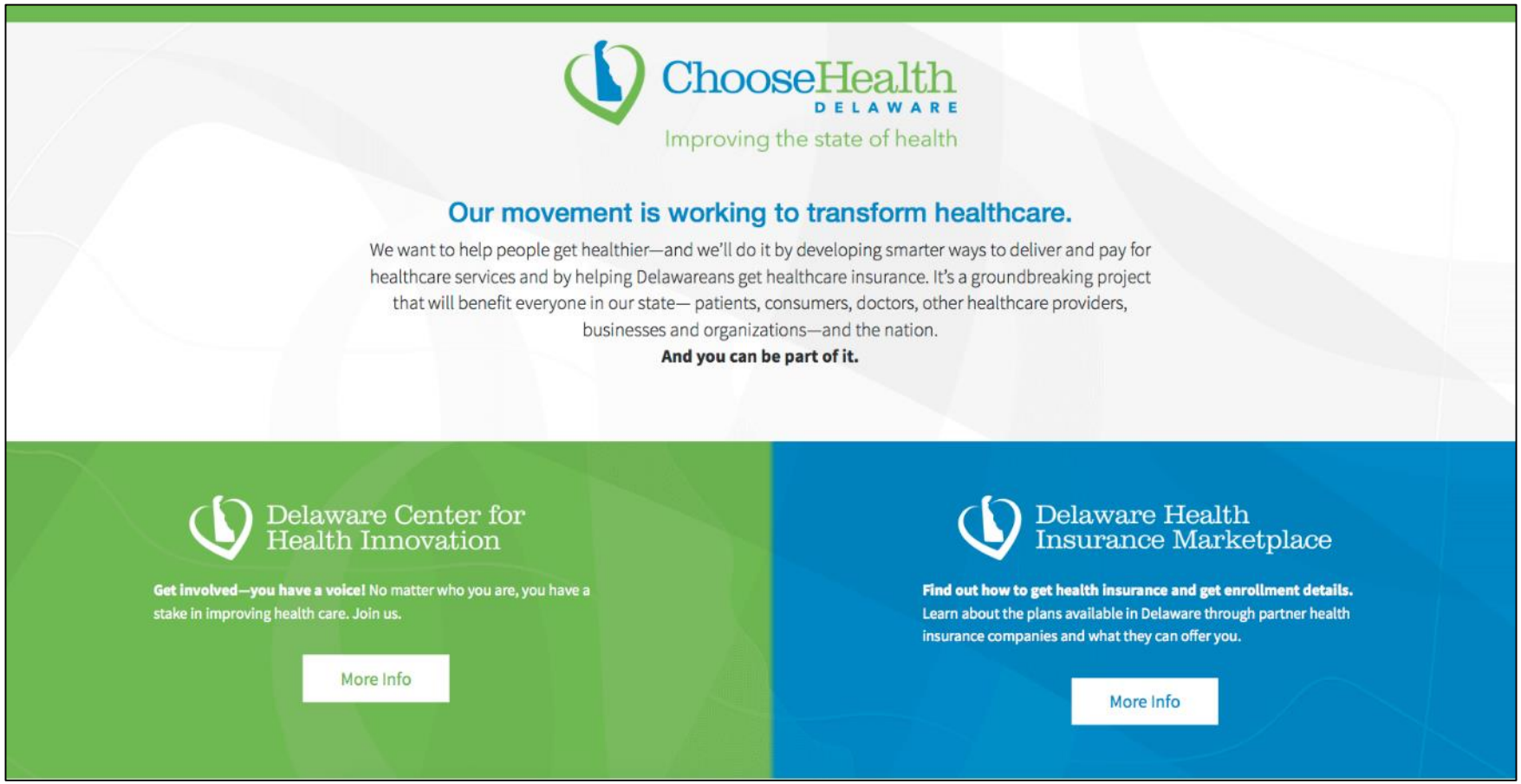
Board business & DCHI start-up activities

Category	Item	Status
Staff recruitment	▪ Executive Director recruitment	▪ Interviews in-progress
Infrastructure	▪ 501(c)(3) status	▪ Application drafted
	▪ D&O insurance	▪ Working with legal team on coverage
Branding and communications	▪ Branding & website	▪ Website “phase one” in-progress
Committee membership	▪ Approve updated roster	▪ Roster is available at your seats for review and approval

Website demo



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Progress against our goal: to ensure availability and adoption of value-based payment

DRAFT FOR INPUT

	Availability: "By 2016, all payers should offer both TCC and P4V for primary care"	**Adoption:** "By 2018, adoption of >80% (of PCPs, population, healthcare spending)"
Medicare	▪ Medicare Shared Savings Program expanded to 3 tracks of TCC models, broadly available ▪ No P4V alternative currently offered in DE, subject to State application for demonstration/waiver	★ Adoption may exceed 50% by 1/1/16 – Delaware may be The First State with all Medicare-participating hospitals in MSSP – Additional non-hospital ACOs formed by Aledade and United Medical Group
Commercial (Highmark)	▪ Highmark TCC model exclusively through MedNet ACO ▪ PCMH pilots initiated pre-2014	▪ Moderate adoption of TCC in 2014; no expansion in adoption in 2015, to date ▪ Practices enrolled in P4V pilots pre-2014; no new practices added in past 12 months
Medicaid (Highmark)	▪ Commitment to DMMA to offer both TCC and P4V – Negotiating TCC separately with providers – P4V model meant to be a program	▪ Highmark new to Medicaid 1/1/15 ▪ Active negotiations with select providers on TCC models ▪ No providers added to P4V in past 12 months
Medicaid (United)	▪ Commitment to DMMA to offer both TCC and P4V – Negotiating TCC separately with providers – Negotiating P4V separately with providers	▪ Initial discussions with select providers for both TCC and P4V models
Commercial (Aetna)	▪ Both TCC and P4V models offered outside DE ▪ DCHI not aware of models offered in DE	▪ Unknown

Care Coordination consensus paper: overview

Topics covered

- Introduction
- Vision for care coordination
- Funding principles
- Support model
- Provider participation

Purpose

- Elaborate on perspective started in Practice Transformation consensus paper further toward Care Coordination
- Develop sustainable multi-payer and provider alignment on key elements of Care Coordination related to expectations, funding, support, and participation
- Seeks feedback from providers, purchasers, payers, and other health care organizations about the proposed approach and areas of alignment

Care Coordination consensus paper: common processes

Purpose

- Develop common vocabulary for describing Care Coordination
- Provide high-level blueprint for development of Care Coordination capabilities
- Emphasize that PCPs may choose different ways to operationalize Care Coordination
- All PCPs may not implement all 12 of the the common processes

Common processes

1. Identify high-risk patients
2. Enroll the patient in the Care Coordination program
3. Identify the patient's health and psychosocial goals
4. Develop a care plan that is co-created with the patient
5. Maintain a multidisciplinary team that works smoothly together
6. Provide medication management
7. Ensure access to opinions of clinical specialists
8. Ensure access to behavioral health, community, and population health support resources for those who need them
9. Develop a care transition plan to ensure continuous care and community support
10. Discuss cases in regular conferences
11. Review and update the care plan with the patient and the family on a regular basis
12. Review the performance and process of Care Coordination within the multidisciplinary team

Care Coordination consensus paper: funding

Purpose

Provide principles that payers and providers can refer to in planning and negotiating Care Coordination funding

Funding principles

1. Payers should define objective criteria based on which primary care providers shall be deemed eligible for care coordination
2. Payers are encouraged to qualify PCPs for care coordination funding if they successfully complete the 12-month DCHI milestones for practice transformation
3. Some providers may be deemed ready for care coordination in less than 12 months' time
4. Payers should establish objective criteria which need to be met by providers to sustain care coordination funding
5. Care coordination funding may be super-ceded by broader capitation arrangements or other outcomes-based payments

Care Coordination consensus paper: cost estimates

Purpose

- Introduce the link between cost levels and scope and intensity of Care Coordination
- Provide reasonable reference points for cost of Care Coordination that payers and providers could use for planning and negotiations
- Emphasize that while some providers might push for higher funding levels, many of them acknowledge that Delaware practices may not be able to maintain corresponding levels of scope and intensity of Care Coordination

Cost and funding relative to expectations for scope and intensity of care coordination services

Approach	Description
High expectations	▪ Focus on 10-20% of population ▪ The estimated cost of $7-12 PMPM (or 1-2% of the total cost of care)
Moderate expectations	▪ Focus on 5% of the individuals with the greatest need and willingness to participate ▪ The estimated cost of $3-5 PMPM (or 0.5-1.0% of the total cost of care)
Targeted expectations	▪ Event-driven focus on high-risk patients (e.g., hospital and ER discharges ▪ The estimated cost of $1-2 PMPM (or 0.1-0.2% of the total cost of care)

Care Coordination consensus paper: provider eligibility

Purpose

Provide a framework for alignment around shared expectations for eligibility to receive care coordination funding

Eligibility principles

1. Payers should define objective criteria based on which primary care providers shall be deemed eligible for care coordination
2. Payers are encouraged to qualify PCPs for care coordination funding if they successfully complete the 12-month DCHI milestones for practice transformation
3. Some providers may be deemed ready for care coordination in less than 12 months' time
4. Payers should establish objective criteria which need to be met by providers to sustain care coordination funding
5. Care coordination funding may be super-ceded by broader capitation arrangements or other outcomes-based payments

Care Coordination consensus paper: support model

Purpose

Describe areas and tools for support of Care Coordination implementation that are available/ planned to be made available to practices

Practice needs	Current/ planned supporting resources
1. Projecting costs and funding	▪ Cost and funding analytical framework (DCHI) ▪ Proposals for technology/services (prospective "vendors")
2. Selecting a sourcing strategy	▪ Directory of available resources to be developed (DCHI) ▪ Coaching in selecting the strategy appropriate to each PCP practice (SIM-funded practice transformation vendors)
3. Hiring/ training staff	▪ Common curriculum for training/retraining on the skills and competencies for Care Coordination (DCHI Workforce Cmte)
4. Identifying and integrating with community resources	▪ Directory of community resources developed by each Healthy Neighborhood (DCHI Healthy Neighborhoods Cmte
5. Access to data	▪ Initial list of high-risk patients (payers) ▪ Admission, Discharge, Transfer data (DHIN) ▪ Quarterly data on Common Scorecard performance (DHIN) ▪ Training to make effective use of practice-level data (SIM-funded practice transformation vendors) ▪ Funding for EHRs for Behavioral Health providers (SIM funds)

Discussion question: provider eligibility

Question: Should all payers adopt the same criteria for provider eligibility for Care Coordination funding?

Potential answer	What you would have to believe
▪ All payer adopt standard criteria as proposed by Clinical Committee (achievement of Practice Transformation milestones #1-5)	▪ Consistent expectations/ signal on incentives broadens provider buy-in and adoption ▪ Consistent communication messages increase pace of provider adoption ▪ Standardization provides operational simplifications that remove provider and payer adoption barriers
▪ Payers may have different criteria	▪ Adherence to single Delaware standard may complicate payer contracting with multi-state self-insured employers

Discussion question: scope, intensity, and funding level

Question: Should all payers adopt the same expectations for Care Coordination scope and intensity as well as for the associated funding level?

Potential answer	What you would have to believe
▪ All payers should adopt "moderate expectations" as proposed by Clinical Committee	▪ Parity avoids "free rider" problems or potential for competitive disadvantage in payer pricing ▪ Funding commitment broadens provider buy-in and adoption as well as enhanced investment planning ▪ Consistent communication messages increases pace of provider adoption ▪ Standardization provides operational simplifications that remove provider and payer adoption barriers
▪ Payers may have different Care Coordination funding levels, but they are appropriately calibrated to expectations on Care Coordination scope and intensity	▪ Adherence to single Delaware standard may complicate payer contracting with multi-state self-insured employers ▪ Even at different funding levels, providers can still calibrate scope and intensity to funding level provided by each participating payer

Healthy Neighborhoods status update

Recent progress

- Completed draft operating model white paper
- Finalized draft map of Neighborhood boundaries, incorporating socioeconomic status, healthcare seeking behavior, and traditional groupings of communities
- Initiated productive dialogue with hospital CEOs at Delaware Healthcare Association
- Began drafting phased rollout approach white paper

What we are hearing

- While stakeholders agree on aspiration for all Delawareans to be in a Neighborhood, high need areas should be prioritized
- Hospitals are eager to collaborate, with a particular opportunity in helping them meet their community benefit requirement
- Given importance of sustainable funding, Neighborhoods should be ready to engage in emerging payment innovations (e.g., shared savings) when and where possible
- The term ‘Neighborhoods’ implies smaller groupings than the planned areas of 50-100k residents (consider the term ‘Communities’)

Next steps

- Finalize operating model paper for approval at September Board meeting
- Continue development of phased rollout approach paper
- Develop plan for selecting Phase I site(s) and begin outreach
- Continue conversations with state agencies, hospitals and other partners

Elements for defining approach to Neighborhoods

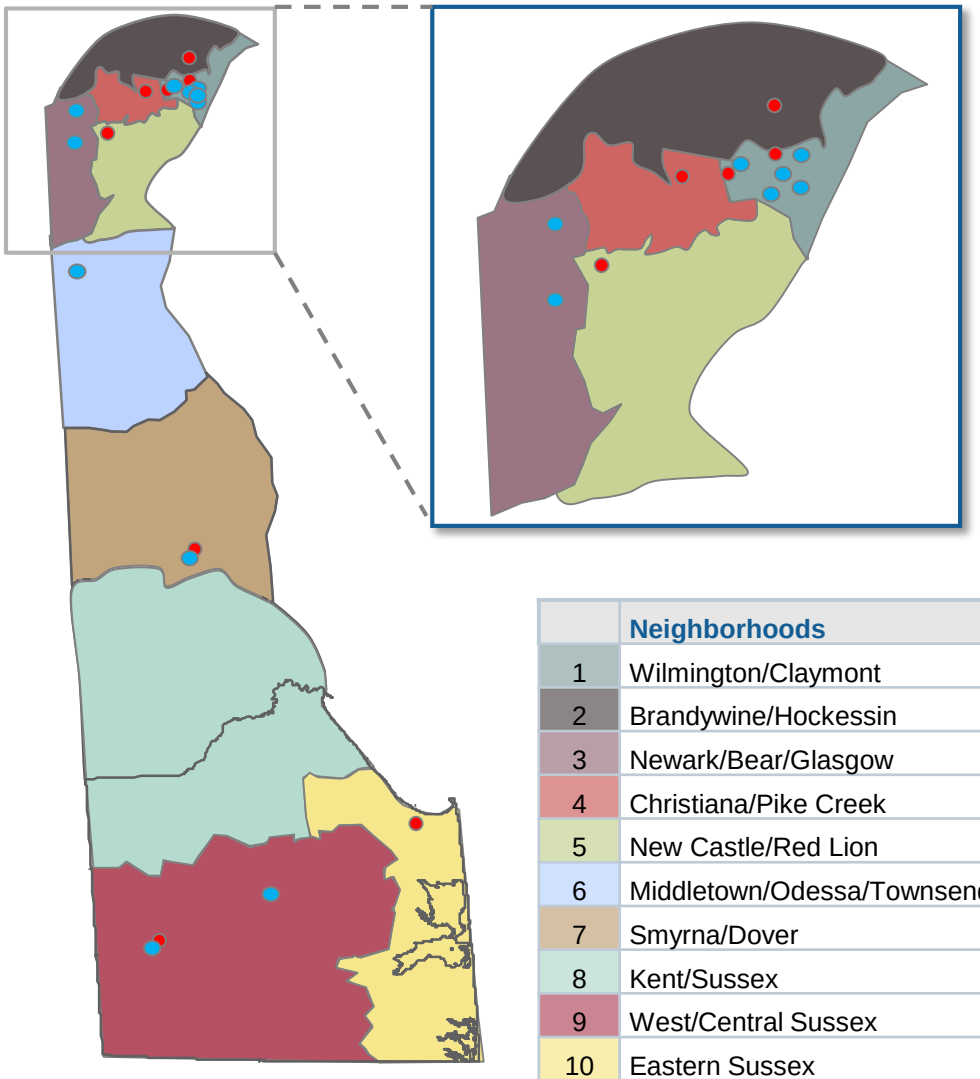
	Operating Model white paper	Phased rollout white paper
Purpose	▪ Articulate organizational design parameters ▪ Provide blueprint to engage stakeholders ▪ Synthesize Committee thinking developed over past 1-2 years	▪ Describe process for initial roll out of Healthy Neighborhoods ▪ Provide detailed start-up information for potential participants
Key decision areas	▪ Neighborhood boundaries ▪ Council responsibilities, size, and membership ▪ Governance structure ▪ Staff and resources available for support ▪ Identification of partner organizations	▪ Goals and timeline for Phase I roll out ▪ Requirements for and benefits of participation ▪ Awareness and education campaign ▪ Timeline of Phase I ▪ Expectations for support from partner organizations

Based on this guidance, **Neighborhood Councils** will work with community members and local organizations to develop a customized strategy that will include:

- Community needs assessment (using existing data where possible)
- Identification of existing resources and initiatives
- Priority area selection
- Intervention design

Next draft of Healthy Neighborhoods map

Hospitals
FQHCs



Methodology

- Algorithm used to divide Delaware into Neighborhoods of contiguous census tracts with approx. 50,000-100,000 residents
- Map hand-adjusted by census tract to reflect socioeconomic status, healthcare seeking behavior, and traditional groupings of communities
- Hospitals and FQHCs listed in Neighborhoods associated with their highest patient volume
- Hospitals focused on specific populations (e.g., pediatrics and veterans) relevant for all neighborhoods, exact scope of engagement TBD

	Neighborhoods	Population[1]	Hospital(s)	FQHC(s)[2]
1	Wilmington/Claymont	99,000	Christiana, St. Francis	WFH, HJMC
2	Brandywine/Hockessin	77,000	Christiana, St. Francis	WFH, HJMC
3	Newark/Bear/Glasgow	109,000	Christiana, St. Francis	WFH
4	Christiana/Pike Creek	103,000	Christiana, St. Francis	WFH, HJMC
5	New Castle/Red Lion	97,000	Christiana, St. Francis	WFH, HJMC
6	Middletown/Odessa/Townsend	49,000	Christiana, Bayhealth	WFH
7	Smyrna/Dover	103,000	Bayhealth, Christiana	WFH, LRHC
8	Kent/Sussex	88,000	Bayhealth	LRHC, WFH
9	West/Central Sussex	99,000	Nanticoke, Beebe	LRHC, WFH,
10	Eastern Sussex	68,000	Beebe	LRHC

1 Rounded to nearest thousand
2 Hospital and FQHCs listed at organization level
3 HJMC= Henrietta Johnson Medical Center; WFH= Westside Family Healthcare; LRHC= La Red Health Center

SOURCE: National Provider Identification Database (NPIDB), Esri geographical information services (ArcGIS)

Request for input

- Goal is to finalize v1.0 of the operating model paper with Board approval next month
- We would appreciate any feedback you have over the next few weeks, in particular related to:
  - The overall approach
  - Draft neighborhood boundaries
  - How Healthy Neighborhoods integrates with transformation in care delivery system

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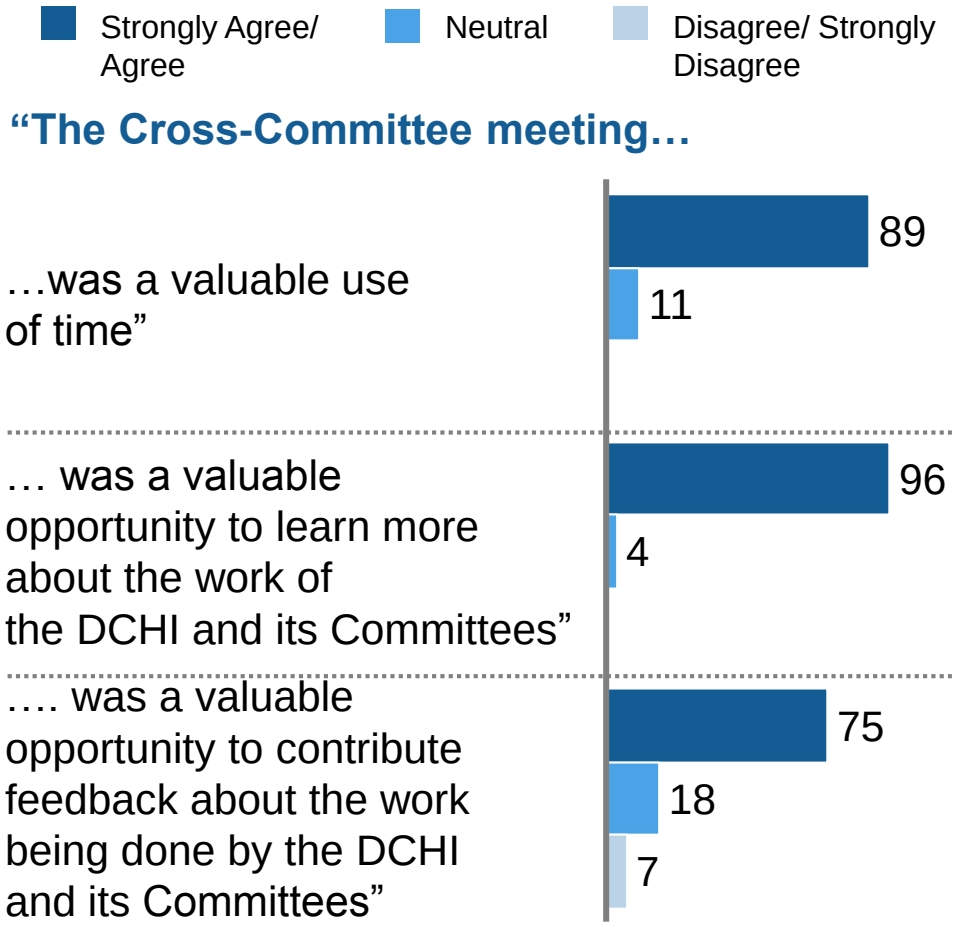
Cross-Committee meeting overview

- **Agenda and format:** Three-hour meeting, including introduction on how DCHI's strategy addresses all Delawareans, "gallery walk" committee updates and deep-dives on cross-cutting topics (Advancing Primary Care and Healthy Neighborhoods)
- **More than 80 attendees** across Board, Committees, broader set of SIM contributors and public
- Representation from **membership of every Committee**
- More than **150 comments submitted** on post-it notes during the gallery walk section
- **Next meeting planned for October/November 2015**

Feedback from participants

Survey results, % of respondents[1]



Feedback received in survey:

- "Good balance between formal presentation and 'walk-around' with opportunity for questions and discussion"
- "This meeting was extremely helpful. The type of 'deep dive' that was done with healthy neighborhoods would be helpful for all of the committees, though I do realize that would mean the meeting would have to be longer"
- "Gallery walk was helpful but needed a bit more space in the room and more time at each station"
- "I am still unclear of how all of the committees 'fit together'. Maybe that could be a topic at the next meeting?"

1 Survey sent out to all attendees after the meeting; n = 28

Key themes raised in Cross-Committee (1/2)

	Comments provided during Gallery Walk
Interest in creating stronger links between traditional healthcare delivery system and others in the community	"Include community health workers as cultural brokers, liaisons and connectors to the health system, and health educators"
	"We need to improve the opportunities for communication between behavioral health professionals and primary care providers"
Making the Common Scorecard "actionable"	"As a provider I need to be able to see who of my patients are causing my scores to decrease and I need to know how to change their scores"
	"We need mechanisms to track outcomes of patient engagement in linkage to the Common Scorecard"

Key themes raised in Cross-Committee (2/2)

	Comments provided during Gallery Walk
Communication about innovative healthcare models to providers and patients	"There are many different initiatives (ACO, PQRS, PCMH, this work). Providers have initiative overload"
	"Workforce learning and relearning curriculum should address: what is a medical home? Is it different for pediatrics, or from practice to practice?"
Importance of addressing dual-eligible population	"Providers need to understand and correctly assist those who are dual-eligible—they are currently falling through the cracks"
	"Our workforce learning curriculum should address dual-eligibles; they are small in numbers but one of the costliest groups. There is poor coordination and understanding of what services are covered"

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Upcoming DCHI Committee Meetings

Payment Model Monitoring

- August 12, 4:30pm
- UD STAR Campus

Healthy Neighborhoods

- August 13, 3:15pm
- UD STAR Campus

Clinical

- August 18, 5:00pm
- UD STAR Campus

Patient and Consumer Advisory

- September 3, 1:00pm
- Edgehill Shopping Center

Please check the State's public calendar (egov.delaware.gov/pmc/) for the latest information about all DCHI Board and Committee meetings