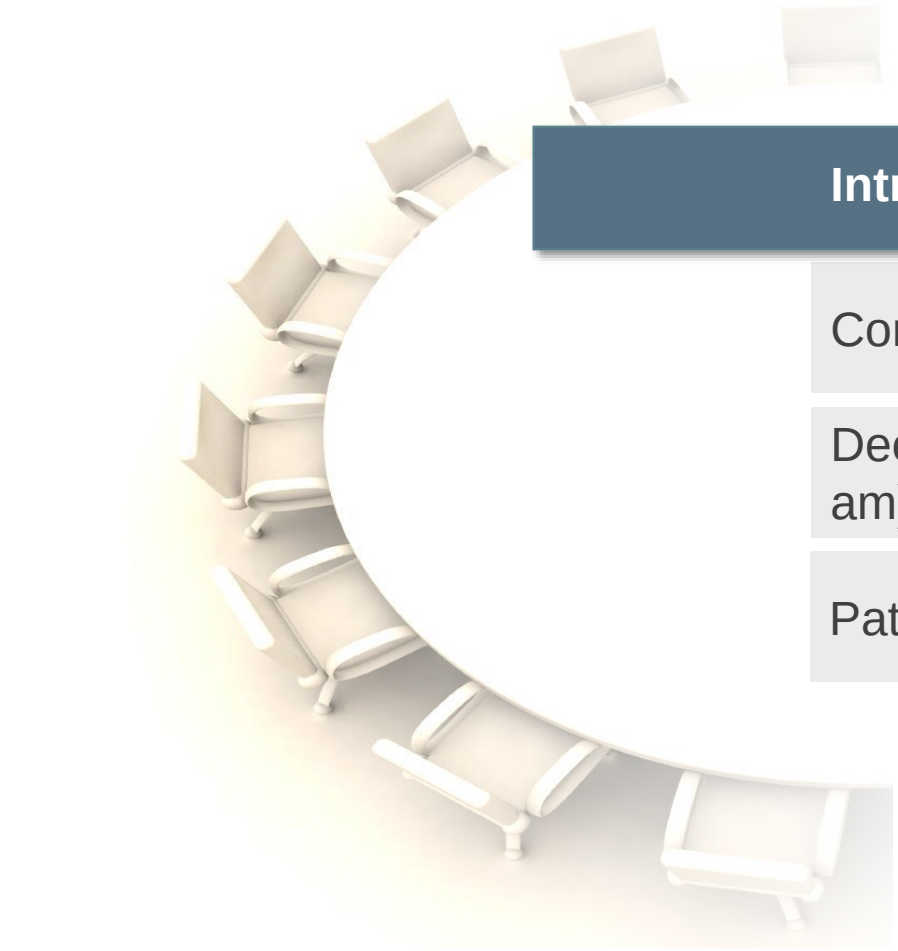
Delaware Center for Health Innovation

Cross-Committee meeting

July 15, 2015

Agenda for today



Introduction (9:00-9:30 am)

Committee updates (9:30-10:15 am)

Deep dives on cross-cutting topics (10:15-11:45 am)

Path forward (11:45 am-12:00 pm)

Goals for today

Share great progress and accomplishments over the past year

Promote a cross-committee discussion on issues at the intersection of different elements our strategy

Preview major milestones for the coming 3 months

Reminder: our aspiration and goals

Aspirations for Triple Aim

- Become 1 of the 5 healthiest states in the U.S.
- Achieve top performance for quality/patient experience
- Bring health care spending growth more closely in line with growth of economy
- PLUS ONE: Achieve higher provider experience

Specific Goals Reflected in Plan

- Create >$1 billion in total savings to the system through 2020
- Reinvest about half of savings in care delivery to ensure sustainability for providers
- Pass about half of savings on to consumers and purchasers to preserve affordability

Goals for Adoption to Achieve Plan

- Participation by all payers: Commercial, Medicaid, Medicare by 2016
- Participation by >70% of self-insured employers by 2018
- Adoption by >90% of PCPs by 2018
- Meaningful changes in capabilities/processes

Total investment: $130 million over 4 years

Our vision

- **All Delawareans will have a primary care provider,** and it will be simple for them to access care when they need it
- Providers will be **rewarded for innovative and efficient approaches** to delivering quality care
- When people need to go to the ER, they will **not need to repeat their medical history and prescription information**
- Providers will have the **time and resources to reach out to an elderly father after a hospital discharge** to make sure he receives a follow-up appointment with his PCP
- When a **mother needs help caring for her child with asthma, she will know where to turn**
- **Providers will work more closely together** so that patients will feel as though the individuals caring for them, including behavioral health providers, are part of a team
- **Employers will be able to continue providing health insurance** to their employees

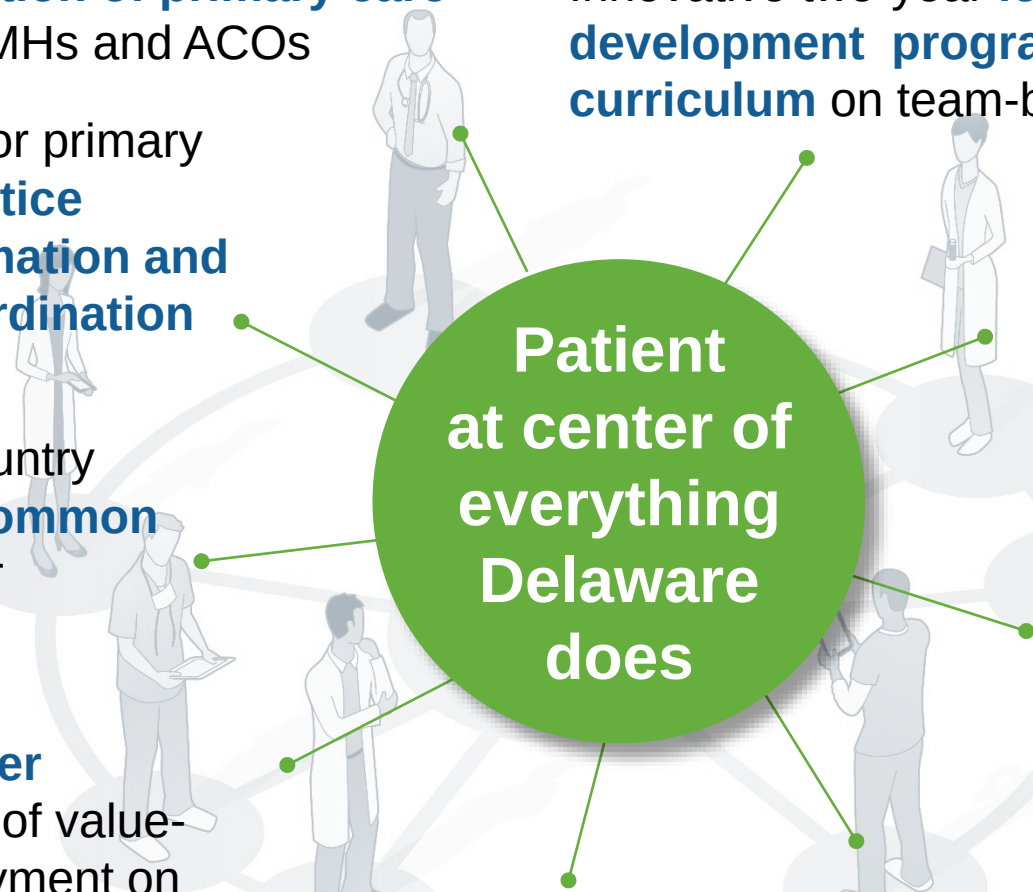
Delaware's strategy

Transformation of primary care through PCMHs and ACOs

Innovative two-year **learning and development program with common curriculum** on team-based, integrated care

Support for primary care **practice transformation and care coordination**

Scorecard, tools, data, and resources to support neighborhoods



First in the country multi-payer **Common Scorecard** for primary care

Integration of community-based health initiatives with delivery system focused on priority health needs

Multi-payer adoption of value-based payment on statewide basis

Care coordination funding in addition to outcomes-based payments

Medicaid MCO RFP, state employees, and QHP standards to drive adoption8

Where we are in our journey

2011-2014

Initial pilots and planning

- Individual physicians, societies, hospitals begin to adopt new models (e.g., PCMH, ACOs)
- Stakeholders shape Delaware State Health Innovation Plan through 50+ workgroups and public meetings
- Delaware Center for Health Innovation is formed as public-private partnership

2015

Design for scale

- Finalize details for core program elements to prepare for launch
- Test and refine Common Scorecard through staged rollout
- Begin practice transformation support for PCPs
- Facilitate provider education regarding new models

2016 onwards

Adoption at scale

- Funding for care coordination more widely available
- PCPs eligible for rewards tied to Common Scorecard
- Continuation of practice transformation support
- Healthy Neighborhoods initiatives launched
- Begin implementation of workforce strategy

DCHI was formed as a public-private partnership to help carry forward this work

5 Standing committees to develop a multi-stakeholder consensus on the different elements of Delaware's strategy

70 Stakeholders across Delaware on the Board and committees

51 Organizations represented

56 Meetings held by all committees and the Board of Directors

Over this time, we have accomplished a lot

Examples of current progress to implementation

- Finalized measures for initial version of Common Scorecard and began visits to participating pilot practices
- Defined milestones for practice transformation, published consensus paper, and developed input into request for proposals
- Aligned on priority themes for Healthy Neighborhoods and measures for Population Health Scorecard
- Determined elements of value-based payment models that would benefit from cross-payer standardization
- Finalized input for Health Professionals Consortium request for proposals
- Provided consumer input to other committees (e.g., Healthy Neighborhoods) and helped craft consumer outreach materials

And we have learned a lot

Examples of our learnings

- Our collaborative approach is our greatest asset
- We need to strike a balance between the pragmatic answer and the ideal one
- We need to take into account that the market still continues to be very dynamic across the health system (e.g., now at 6+ ACOs, 30+ NCQA-certified PCMH)
- We need to get into the technical details in order to get this right
- We cannot be afraid to discuss and tackle the hardest questions

Importance of keeping patient at center of everything we do

- All our work is **grounded in improving quality and affordability** for patients and consumers
- DCHI was formed with the **patient as the central focus**
- Components of our strategy are designed to support everyday health, prevention, and chronic disease management, which **addresses the needs of all Delawareans**
- It is important as we continue to shape our progress together that we **consider a people-focused strategy in everything we do**

The strength of our strategy is that many components apply to all Delawareans… (1/2)

Example elements of our strategy	Relatively healthy	At-risk	Acute needs	One or more chronic conditions	Special needs populations
Everyone has a PCP	✓	✓	✓	✓	✓
All providers on care team work together to help meet needs	✓	✓	✓	✓	✓
Same day appointments	✓	✓	✓	✓	✓
After-hours access to care	✓	✓	✓	✓	✓
Ability to reach provider by phone 24/7	✓	✓	✓	✓	✓
Providers are rewarded for quality and patient experience	✓	✓	✓	✓	✓

The strength of our strategy is that many components apply to all Delawareans… (2/2)

Example elements of our strategy	Relatively healthy	At-risk	Acute needs	One or more chronic conditions	Special needs populations
Proactive outreach to follow up after hospitalization	✓	✓	✓	✓	✓
Proactive approach to avoid unnecessary ER use	✓	✓	✓	✓	✓
Proactive outreach to support preventative care	✓	✓	✓	✓	✓
Community and social services integrated with care delivery	✓	✓	✓	✓	✓

… and there are also aspects that are targeted to particular populations

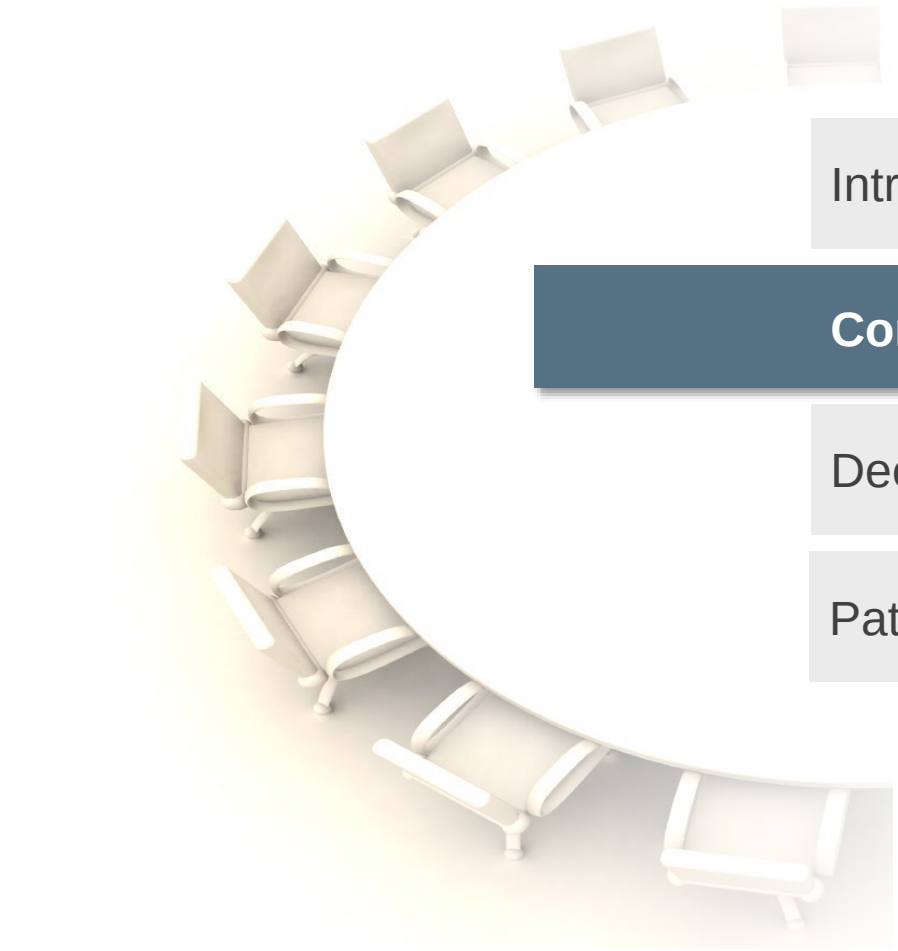
Example elements of our strategy	Relatively healthy	At-risk	Acute needs	One or more chronic conditions	Special needs populations
All providers on care team work together to help individuals with their most complex needs			✓	✓	✓
Health is managed across populations				✓	✓
Funding for behavioral health EMRs				✓	✓
Behavioral health integration				✓	✓

Our shared challenge today: keep a patient orientation

As we implement the components of our strategy, how can we…

- Comprehensively address the needs of **the patient and consumer?**
- Build towards meaningful improvements in the **way patients and their families will experience care?**
- Design initiatives that are **culturally competent?**

Agenda



Introduction

Committee updates (9:30-10:15 am)

Deep dives on cross-cutting topics

Path forward

Format for “gallery walk”

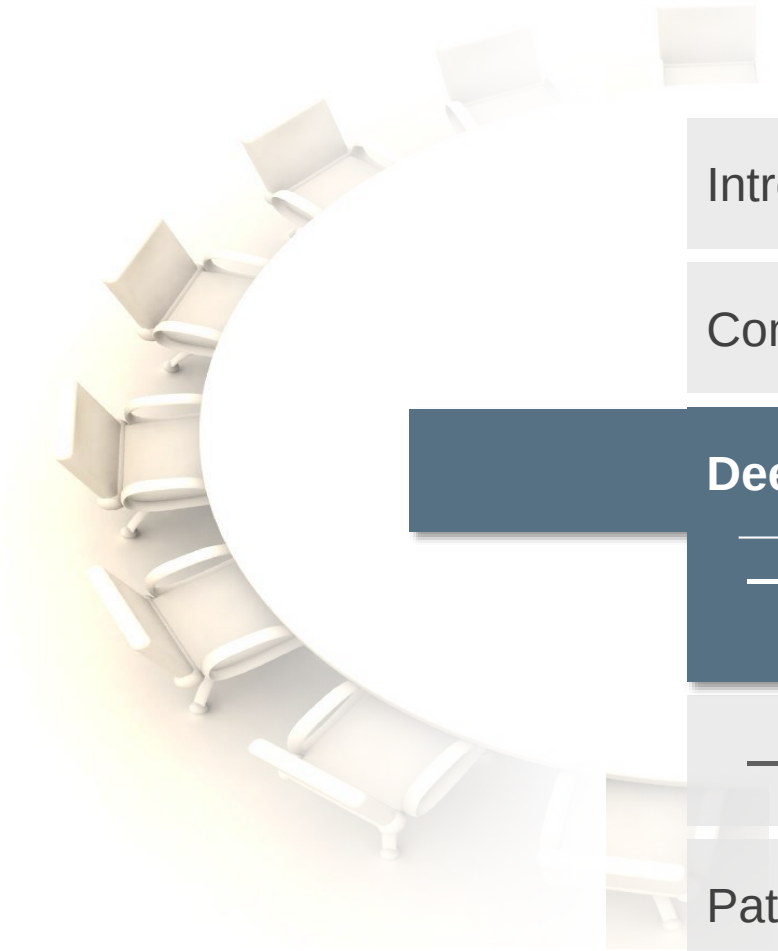
Purpose

- Update you on the work of each committee and the TAG
- Get your feedback on the important elements of our strategy

Instructions

- There are 6 numbered stations around the room
- Your packet includes a number, which is where you will start for the gallery walk
- At each station, there will be a few minutes of presentation from committee members
- When you hear the bell, please rotate clockwise around the room

Agenda



- Introduction
- Committee updates
- **Deep dives on cross-cutting topics**
  - **Advancing Primary Care (10:15-11:00 am)**
  - Healthy Neighborhoods
- Path forward

Goals for today's discussion

- Describe how all components of this work **integrate to support care delivery innovation**
- Gather **feedback on different components of support** for primary care innovation
- Share emerging perspective on approach to **payment reform**
- Discuss how to **coordinate overall approach to primary care innovation with continued acceleration of innovation** in Delaware (e.g., newly-launched ACOs)

Overview of Advancing Primary Care

- Aspiration is for **more coordinated and integrated care led by primary care practices** and their affiliated organizations (e.g., ACOs)
- Although there is significant innovation in the market, expectation is that **primary care providers have varied levels of experience** with coordinating care
- Delaware's strategy provides a **comprehensive set of enabling tools and resources** to support providers regardless of starting point
- Transformation is **enabled with funding and aligned incentives,** linked to common scorecard and milestones

Capabilities of Advanced Primary Care

1. Panel management

2. Access improvement

3. Care management

4. Team-based care coordination

5. Patient engagement

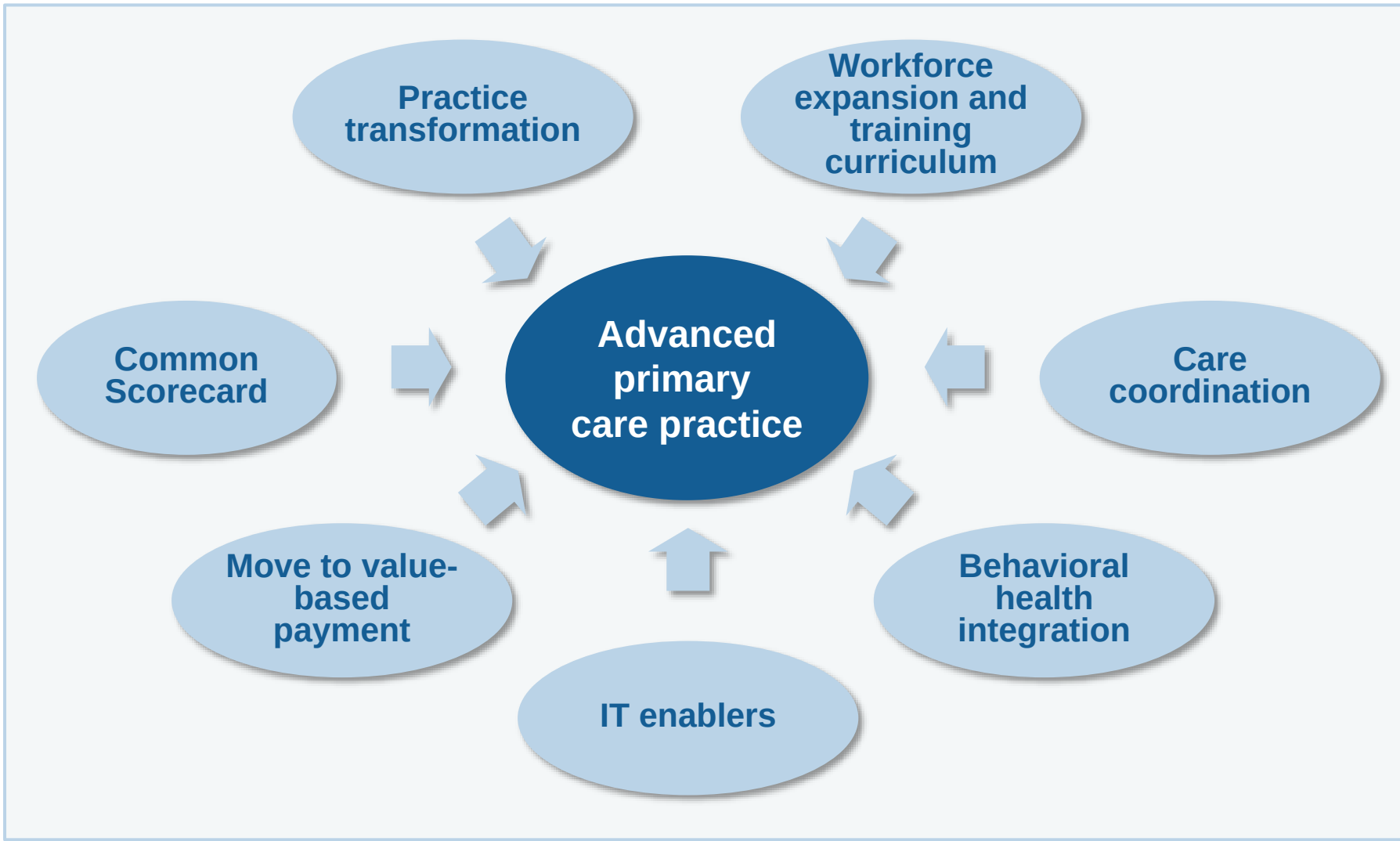
6. Performance management

7. Business process improvement

8. Referral network management

9. Health IT enablement

Enabling transformation of primary care



DCHI emerging consensus on payment (1/2)

Practice Transformation

- All primary care practices should be eligible to apply for SIM-grant-funded practice transformation support
  - Vendor(s) should provide standard level of support, curriculum tailored to individual practice's needs
- After meeting initial milestones, practices should become eligible for care coordination funding
  - Practices who have already transformed may be immediately eligible for funding for care coordination

Care Coordination

- All payers should fund care coordination activities integrated with primary care
  - Care coordination fees should be paid to primary care practices, who decide how to source care coordination
- Whenever possible, payers should structure care coordination payments as a risk-adjusted PMPM
- (continued)

DCHI emerging consensus on payment (2/2)

Care Coordination (continued)

- Funding should be sufficient to cover costs, with shared expectations regarding the scope and intensity
- For care coordination funding to be financially sustainable, need to see impact on quality **and** efficiency

Outcomes-based payments

- Payers should offer both Total Cost of Care (TCC) as well as Pay for Value (P4V) models for providers
- Both TCC and P4V models should require providers to meet goals for quality and efficiency, tied to the Common Scorecard
- TCC models should reward providers for controlling the rate of growth in total cost of care
- P4V models should reward providers for controlling ER visits and hospitalizations, as a proxy for TCC

Overview of practice transformation for primary care

- A 2-year journey to build capabilities for primary care, with milestones to measure progress
- All PCPs are eligible to enroll
- Practice transformation will begin with an assessment of starting capabilities and needs
- Vendor support will be both on-site and self-directed in order to build and strengthen capabilities; RFP has been released by the HCC
- Will be linked to enrollment and care coordination

Transformation Milestones – measure progress on population health management

6 months

1. Identify highest risk panel
2. Provide same-day appointments and/or after-hours access
3. Implement a process for following up after hospital discharge

12 months

4. Supply voice-to-voice coverage to panel members 24/7
5. Document plan for launching a multi-disciplinary care team for highest risk patients
6. Document plan to reduce emergency room overutilization

18 months

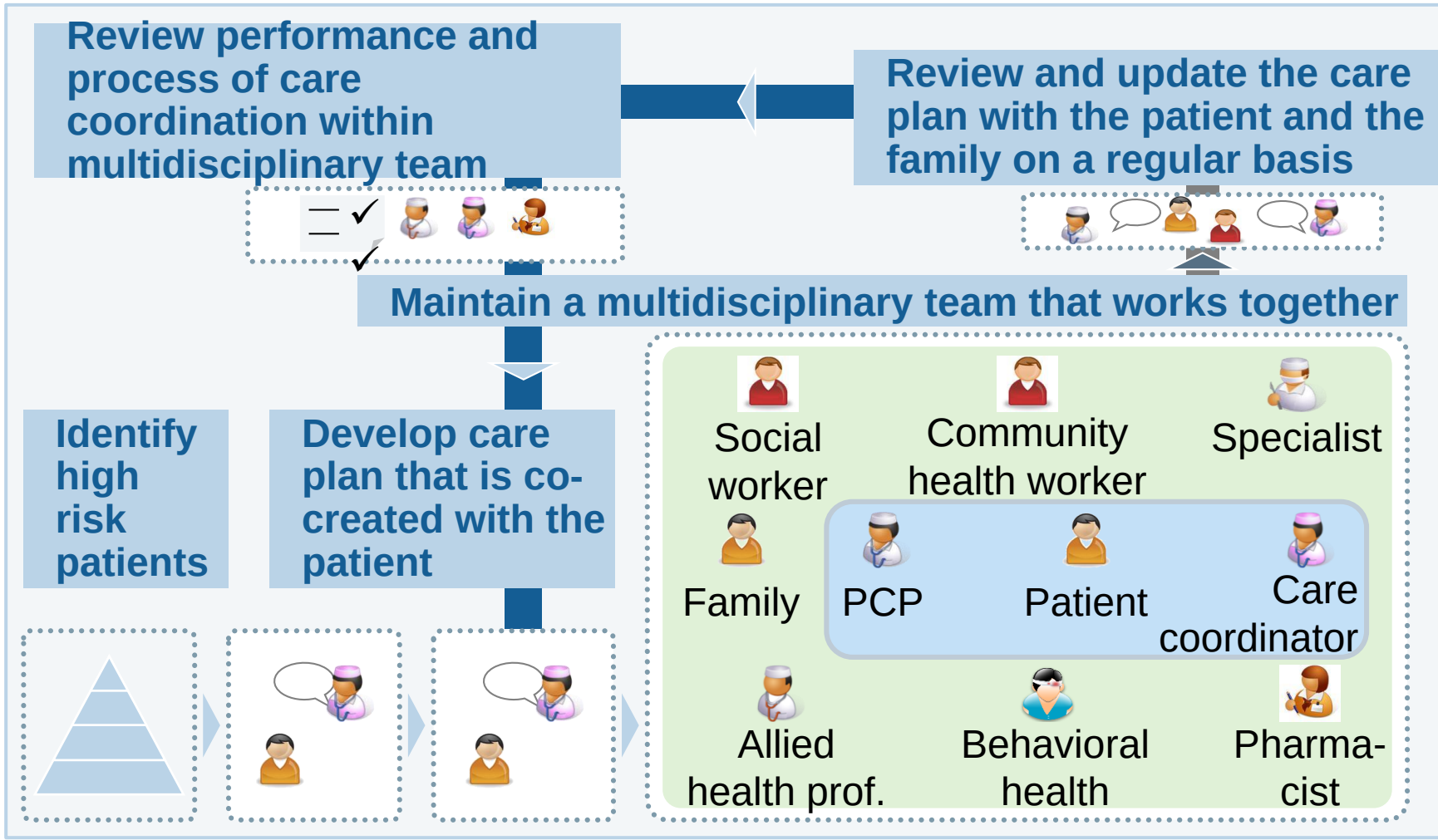
7. Implement a process for contacting patients who did not receive appropriate preventive care

24 months

8. Implement multi-disciplinary team for highest risk patients
9. Document a plan for patients with behavioral health needs

Coordinated care will build on the foundation of practice transformation

Overview: core elements of more coordinated care



Common Scorecard will tie to payment to incentivize high-quality healthcare

Vision of Common Scorecard

- The Common Scorecard will be a **single, integrated scorecard across all payers** that provides information about quality, utilization, and cost of care for **providers' entire panel** of patients.
- The goals is to enable a **common and streamlined approach for incentivizing value-based care delivery**.
- Over time, the scorecard will **replace the many reports providers currently receive** from payers

Overview of Version 1.0

- 19 measures of quality, utilization and cost, balanced across adult, pediatric, and elderly populations
- Currently focused on primary care
- Drawn from national measures and refined with clinician input, primarily claims-based (goal to link to clinical data over time)
- Single report across patient panel with ability to view by payer
- To be linked to payment over time

Approach for feedback on current draft of Scorecard

Approach for feedback

- Meetings and feedback with professional societies
- Discussions with payers and ACOs/CINs
- Feedback from providers testing the Scorecard including
  - In-person visits to individual practice sites
  - Group discussion
  - Survey
- Planned release for end of July, with continued input from testing providers

Opportunities to improve

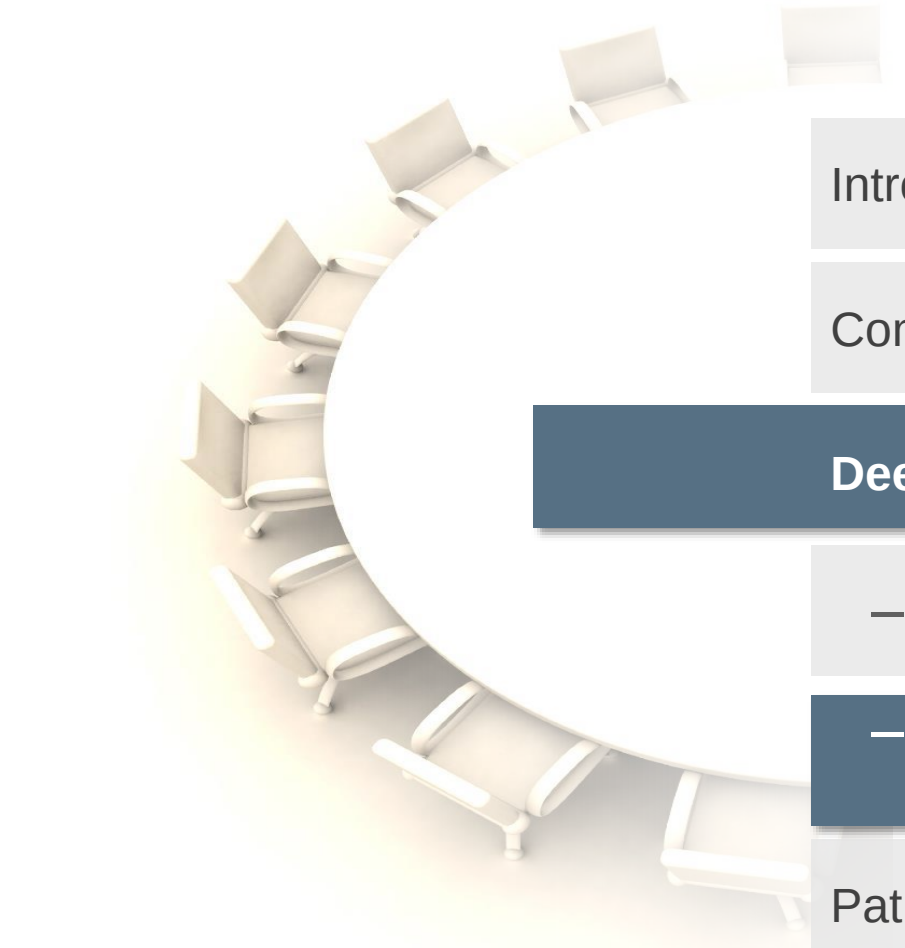
- Identified opportunity to be better **balanced between traditional quality measures and measures of population health** management
- Expressed desire to ensure that **measures are not just a coding exercise** but really measure better delivery of health care
- Noted that while claims are an imperfect source, they are available now – it will be important to test **how much administrative work this involves**
- Flagged importance of understanding the **timeline for integration with clinical data** and consider alternatives to using CPT II codes

Q&A

Topics for discussion:

- Are there parts of the plan for Advancing Primary Care that will be **particularly helpful in achieving the Triple Aim**?
- Are there **parts of the plan that are less helpful**, and why?
- How can we **best achieve patient/ consumer and clinician acceptance?**
- As you reflect on the way that the different components that Primary Care innovation is bringing together, **what do you think about your role in the process** (e.g., as part of an ACO, CIN, as a primary care provider, hospitalist, specialist)?

Agenda



Introduction

Committee updates

Deep dives on cross-cutting topics

- Advancing Primary Care
- **Healthy Neighborhoods (11:00-11:45 am)**

Path forward

Goals for today's discussion on Healthy Neighborhoods

- Provide context on Healthy Neighborhoods as part of **overall Delaware strategy**
- Share **overview of emerging operating model** for Healthy Neighborhoods and solicit input about neighborhood definition
- Discuss **approach for integration of Healthy Neighborhoods** with the care delivery system

What is a Healthy Neighborhood?

- Healthy Neighborhoods are local communities that come together to harness the collective resources of all of the organizations in their community to design and implement **locally tailored solutions to some of the state's most pressing health needs**
- Provides a **framework for collaboration** and **support to communities with resources and expertise** as they work to
  - enable healthy behavior
  - improve prevention
  - enable better access to primary care for their residents

Unique features of the Healthy Neighborhoods approach

- Brings together all of the organizations in a community to focus on common goals and interventions
- Integrates population health with the healthcare delivery system
- Provides full-time, dedicated leadership and staff
- Supports innovation with tools and resources
- Improves ability to access funding

Current view on how Healthy Neighborhoods will work

- There will be **8-12 neighborhoods,** across Delaware, organized by geography to promote integration with the care delivery system
- Led by a **Council of 8-12 individuals**, who represent local care delivery, payers, businesses, social support, and other organizations
  - The Council will be responsible for identifying the Healthy Neighborhoods Priority, creating a 3 year strategic plan, overseeing the implementation of initiatives and continuous monitoring and evaluation and sharing best practices
- Councils are assisted by **dedicated staff** to provide implementation support (e.g., project management and task execution), technical expertise (e.g., data and analytics), and funding support (e.g., grant-writing and grant management)

How Healthy Neighborhoods design promotes integration with care delivery

- Designed to **coincide with changes in payment and care delivery**
- Population health scorecard **measures prevention, chronic disease management, access in addition to social determinants** of health
- Priorities **map to the Common Scorecard**
- Neighborhoods **defined to include one hospital and one FQHC** wherever possible
- Councils must have **diverse membership**, including from the care delivery system
- Designed to enable **future sustainable funding models in partnership** with care delivery system

The priorities map to the Common Scorecard

Healthy Neighborhood priority	Example quality of care measure from Scorecard	Proportion of quality measures[1,2]
1 Healthy Lifestyles	Tobacco use: screening and cessation intervention	27%
2 Maternal & Child Health	Developmental screening in the first three years of life	53%
3 Mental Health & Addiction	Screening for clinical depression	13%
4 Chronic Disease Prevention & Management	Adherence to statin therapy for individuals with coronary artery disease	53%

All quality measures on current Scorecard draft correspond to at least one of the priority areas

1 Excludes 4 measures that are for Total Cost of Care and Utilization
2 Some measures apply to multiple categories and total is therefore >100%

Approach to sustainable funding

Near-term options

Project-based grants
existing or new grants used to fund specific initiatives

Programmatic funding
new or continuing grants intended to fund a coordinated portfolio of Healthy Neighborhood work

DCHI, DPH (and other state agencies), and SIM support for staff and technical resources

Long-term – getting to sustainable funding

Examples of sustainable funding

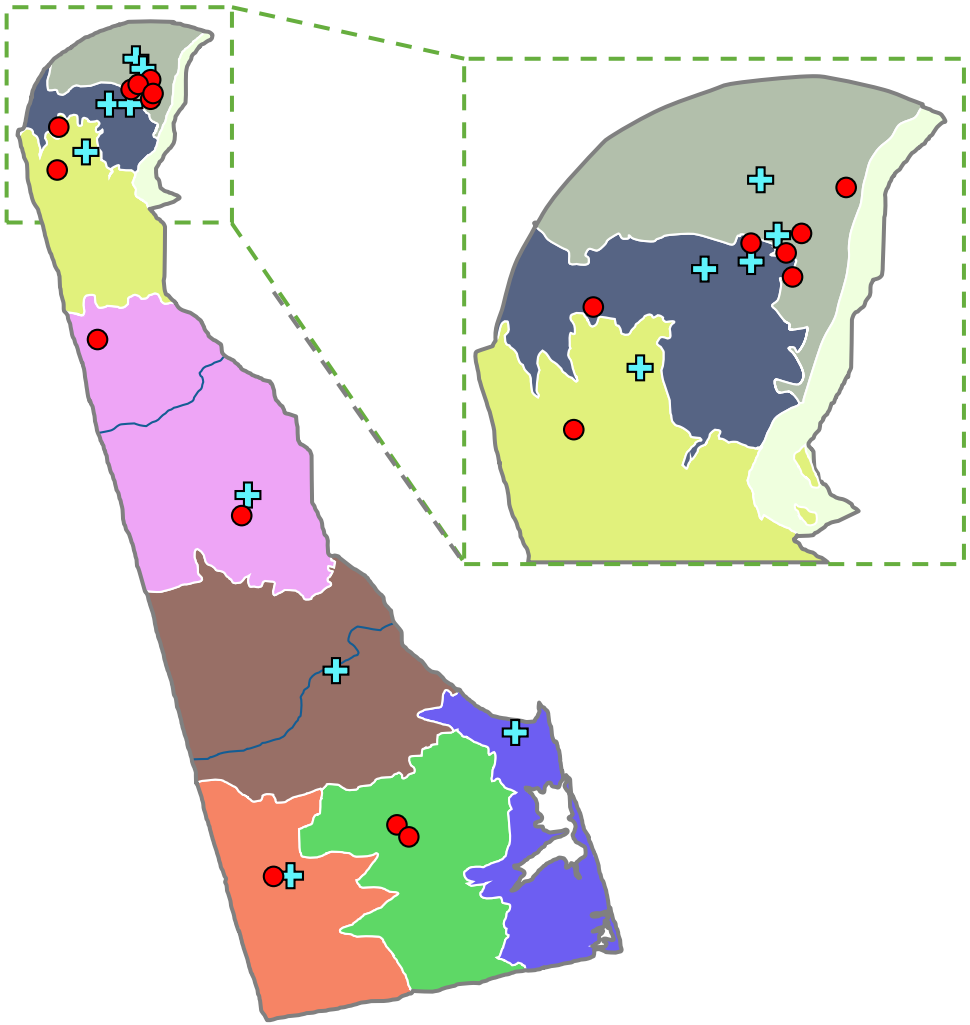
- **Provide services** to health systems or other health-related organizations
- **Share savings** with payers of providers for achieving positive outcomes
- **Obtain financing** from private investors (e.g., social impact bonds)

Approach to be developed

Overview of approach to defining neighborhoods

- **Goal:** to achieve geographic areas with roughly equal population that also includes a hospital site and FQHC site wherever possible
- **Methodology to get to illustrative view:** An algorithm was used to divide Delaware into Neighborhoods consisting of (1) contiguous census tracts and (2) roughly equal population
  - Neighborhoods were further modified according to the following prioritization:
    1. Include a hospital and FQHC in each neighborhood
    2. For neighborhoods in which #1 not possible, include only a non-specialty hospital
    3. For neighborhoods in which #1 or #2 not possible, include only an FQHC

Illustrative: boundaries formed by delivery system alignment



Implications for Healthy Neighborhoods:

- 8 Neighborhoods of 50,000-200,000 people, each including hospital and/or FQHC[1]
- Initial feedback was positive regarding general boundaries, size of Neighborhoods and inclusion of delivery systems
- Will continue to evolve thinking, especially around dividing Wilmington and Northern Kent

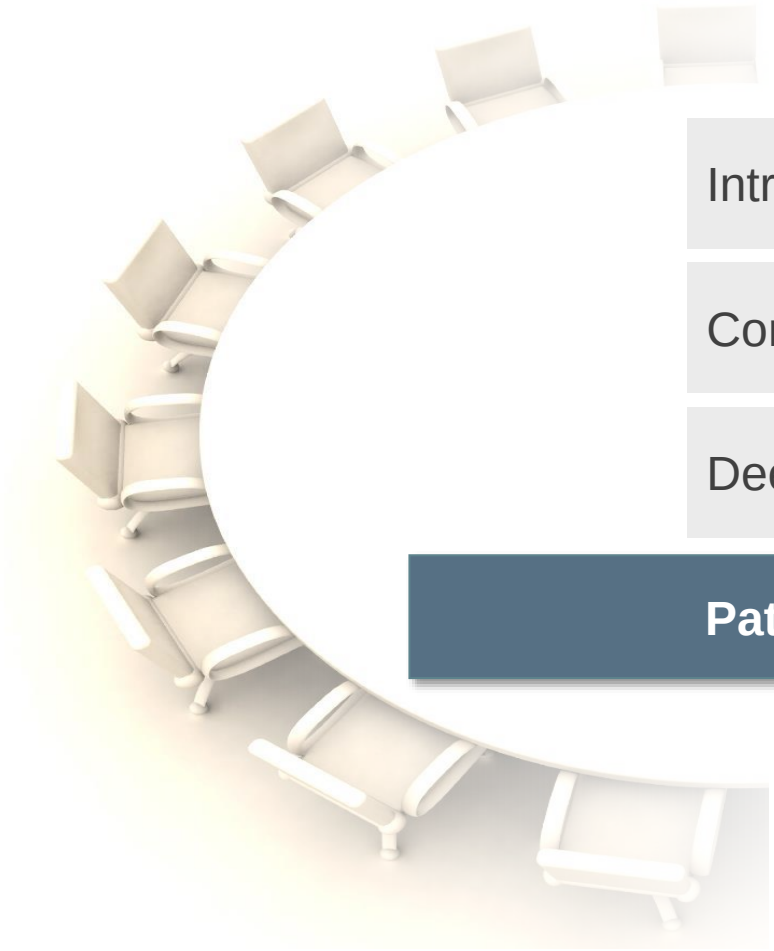
1 Veteran Affairs and Nemours/Alfred I. DuPont hospitals represented on map but not included into algorithm due to service of specialty populations
SOURCE: National Provider Identification Database (NPIDB), Esri geographical information services (ArcGIS)

Q&A for Healthy Neighborhoods

Topics for discussion:

- What are **additional ways to foster integration** between Healthy Neighborhoods and the care delivery system?
- How do we make it exciting and relevant to **encourage diverse groups of organizations in Delaware to come together and form Healthy Neighborhoods?** How can we spread the word?
- What feedback do you have on the emerging approach to **define neighborhood boundaries?**

Agenda



Introduction

Committee updates

Deep dives

Path forward (11:45 am-12:00 pm)

Next steps

- Please make sure to turn in your feedback form on your way out
- Please share any feedback and input you were not able to raise today with the DCHI Board and staff (*info@dehealthinnovation.org*)
- Next cross-committee meeting:
  Thursday, October 22nd (to be confirmed)