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

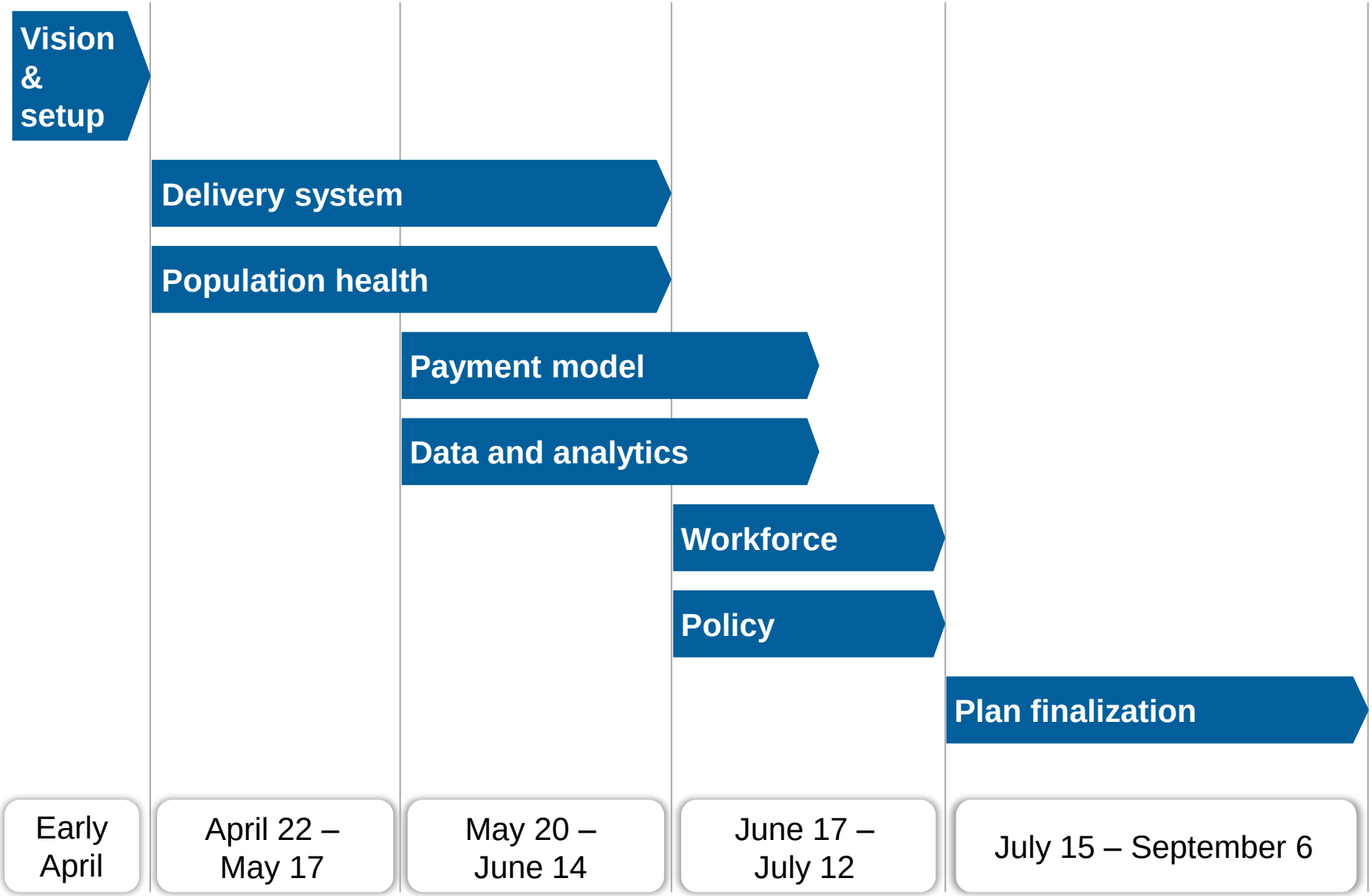
State Innovation Model (SIM) Update

July 16th, 2013

Agenda

1	Introduction and recap: where we have been	20 mins
2	Status update: where we are today	20 mins
3	Looking ahead: questions for your consideration	20 mins

Reminder: where we are in this journey



How we've worked together so far, by the numbers

PRELIMINARY

6 workstreams

32 meetings totaling more than ***60*** hours

More than ***100*** people in at least one session

More than ***40*** organizations in at least one session

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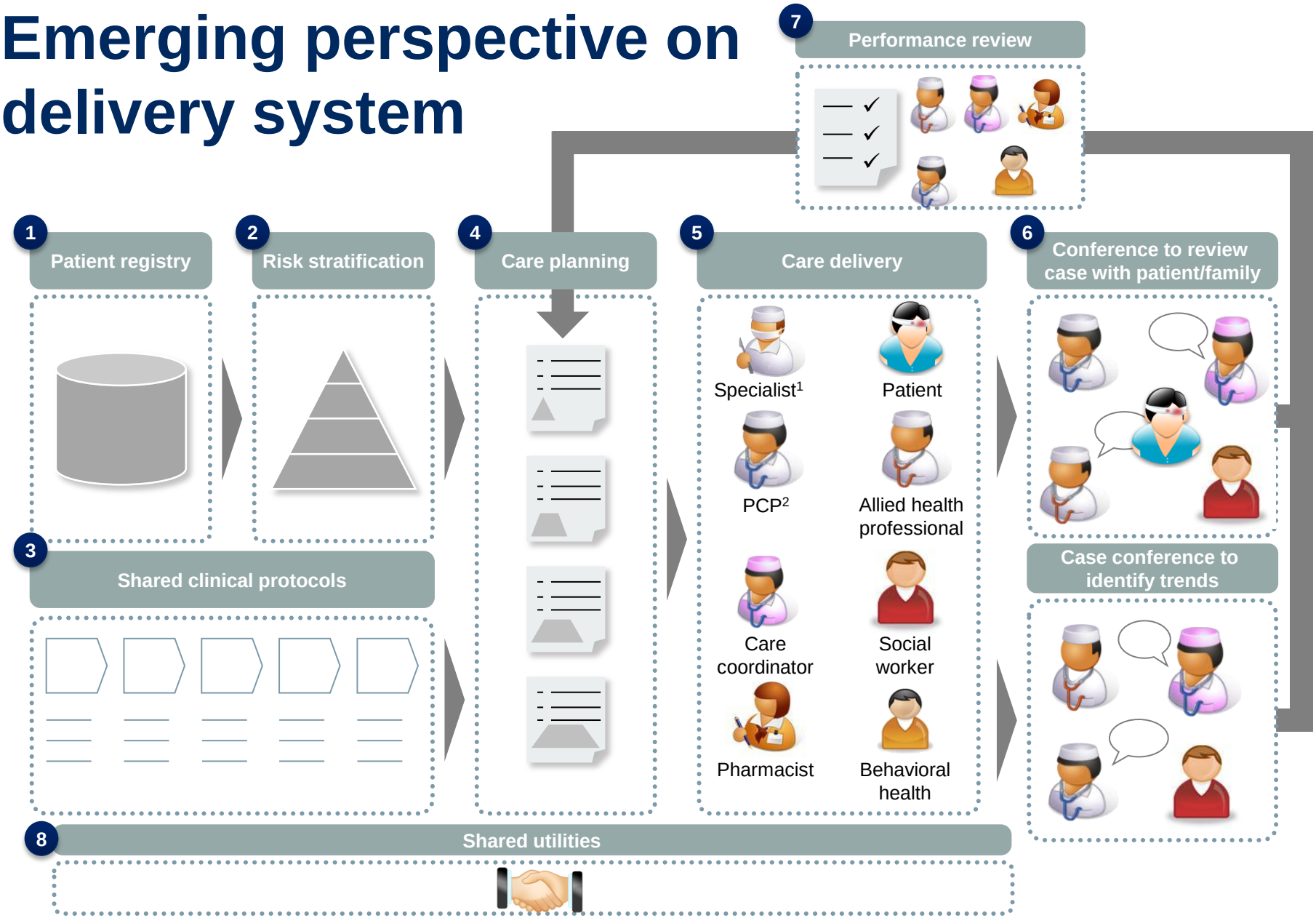
Executive summary: the emerging answer

1. Focus on high risk, high cost patient segments with care coordination (i.e., adults/elderly and children with high risk chronic conditions)
2. Effective diagnosis and treatment across the board supported with guidelines and transparency in reporting
3. Shared utilities in select areas to support this type of care (e.g., risk stratification, care coordination, practice transformation)
4. A population health model that brings together resources into “health neighborhoods” that focus on health and wellness, and integrate with the delivery system
5. Transition to a multi-payer outcomes-based payment model that incentives quality and total value of care; emerging preference for more formal provider structures to support clinical integration and take accountability in this outcomes-based model
6. Data-enabled transformation, leveraging the DHIN to support greater flow of information among providers, supported by a multi-payer provider portal
7. Innovative steps to developing new skills and capabilities to build a workforce that can support the components (e.g., team-based care, care coordination) of this model
8. Patient engagement strategy that empowers patients to better manage their own health
9. Commitment to transparency across the system
10. Initiatives to support transformation, including streamlined/system efficiency, procurement/contracting that supports system change and policy response to enable changes

Emerging perspective on delivery system



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

Requirements for care delivery system

	Description
Patient registry	▪ Maintenance of system-wide patient registry (e.g., DHIN)
Risk stratification	▪ Common approach to risk stratification (e.g., through shared utility) ▪ Level of coordination resources varying based on patient risk level
Shared clinical protocols	▪ Consensus-driven, standard care packages and clinical guidelines focused on high cost, high variation areas
Care plans	▪ Focus of care planning and coordination on top 5-15% of patients
Care delivery and access	▪ Care coordinator role defined by task and skill requirements ▪ Delivery teams able to connect to primary care, specialty services, and community services (e.g., a social worker) ▪ Potential co-location of mental health and primary care ▪ Provision of enhanced hours and ancillary services outside ED
Team-based care/case conferences	▪ Gathering and disseminating best practices in protocols
Performance review	▪ Governance structure to facilitate rapid information sharing
Shared utilities	▪ Shared utilities to support a variety of needs system-wide

Shared utilities and care delivery

Definition

- Common tools and services that support all providers in the state in delivering care consistent with aspirations for the delivery system

When relevant

- Prioritize shared utilities in situations where:
  - Fulfilling delivery system requirements requires significant transformation
  - There are areas in which organizations would benefit from sharing resources (i.e., where substantial investment is needed and individual practices are sub-scale)
  - Administrative simplicity that comes from uniform approach is desired

Potential utilities

- Potential technology-driven utilities:
  - Risk stratification
  - Care gaps
- Potential service utilities:
  - Guidelines/protocols
  - Care coordination
  - Transformation support
  - Learning collaboratives

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

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

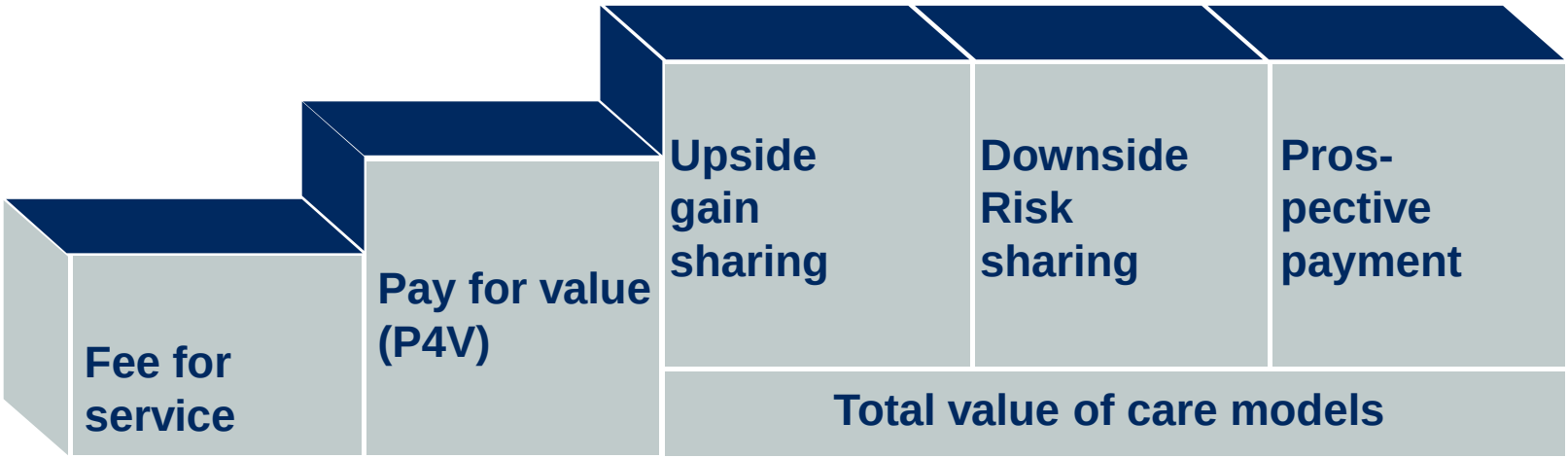
Community assessment/planning

- 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

Reward structure options for payment

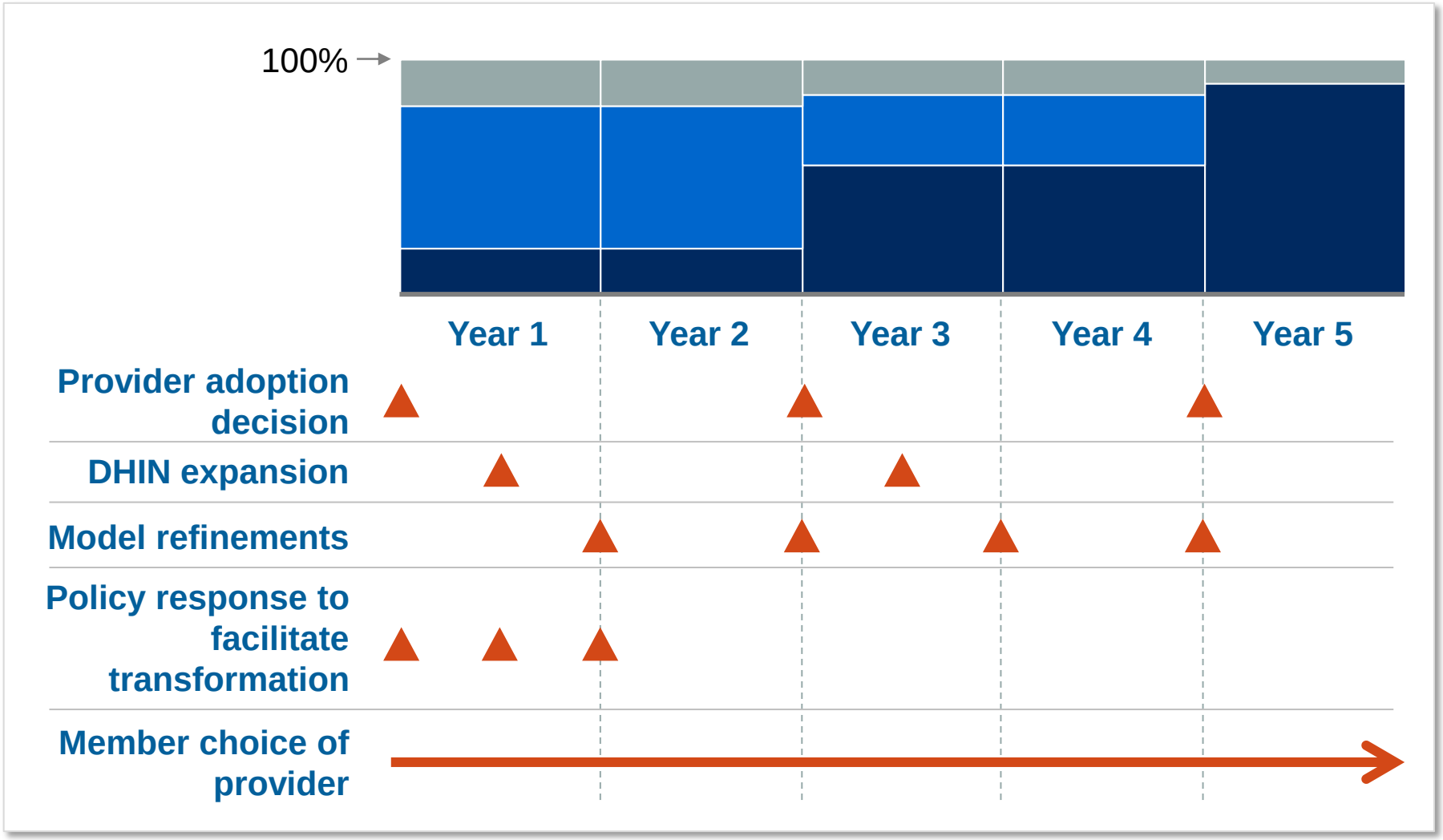


Potential on-ramps (goal of reaching a total value of care model)

- **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 value of care models**, would measure **total cost** for payment (reporting **utilization** for information)

ILLUSTRATIVE

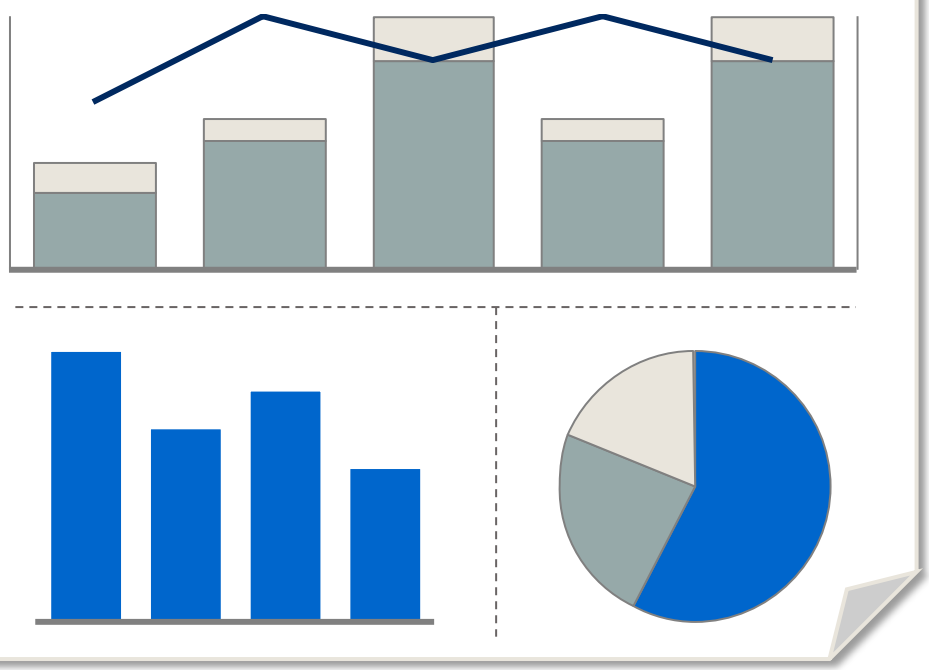
Example of how transformation could unfold in DE



Common scorecard

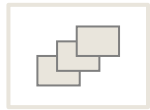
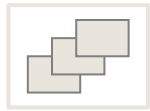
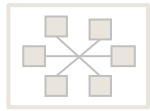
ILLUSTRATIVE

Example scorecard



- Build common scorecard with broad input that aligns with targeted list of common, national measures
- As much as possible, align scorecard across providers and payers to foster consistency and simplicity

Organizing models

	Name	Overview	Description	Potential Organizer
Single corporate entity	1 Large physician practices		▪ Larger practices / provider organizations with shared reimbursement	▪ Provider leadership/ champion
Single corporate entity	2 Hospital-based health system		▪ Hospital system including employed physicians and outpatient services	▪ Health system
Formal/Joint venture	3 ACO		▪ Provider organizations united in a contractual relationship for reimbursement	▪ Provider organizations ▪ Hospital / health system ▪ Community groups
N/A	4 Not participating		▪ Providers not participating in total cost of care model	▪ None

Synthesis of group discussion on required data and analytics standardization

Mostly consolidated

Standardized but not consolidated

Not standardized or consolidated

Example options for standardization (not exhaustive)

Components	I Coordinated	II Standardized output	III Shared infrastructure
Stakeholder capabilities			
Provider/payer/patient conn. (e.g., provider portal)			
Payer infrastructure			
▪ Reporting (e.g., performance reports)			
▪ All other tools/capabilities (e.g., care gaps analysis)			
▪ Data (e.g., claims)			
Provider/patient care mgmt (e.g., care mgmt tools)			
Provider/provider infra. (e.g., HIE)			

Synthesis of distinctiveness discussion

	Why a source of DE distinctiveness?	How will DE approach creating distinctiveness?
Build on existing connectivity	▪ **Leveraging DHIN** which has high adoption, wide range of data, and growing capabilities – **Broad adoption** (98% healthcare providers, 100% hospitals) – 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 and payers to support payment innovation (e.g., provider metrics and performance reports) ▪ Collect **ambulatory data** via EMR-enabled bi-directional communication to improve care management ▪ Integrate **claims** and **clinical data** to improve patient cost/quality transparency
Empower patients with transpare-ncy tool	▪ Synergies with DE's goal of **empowering patients** in new care delivery and payment models ▪ A patient tool (iTriage) in **development** ▪ **Enabled** by DE's health data infrastructure (e.g., DHIN, select public health databases)	▪ Develop messaging system to allow direct communication between **providers and patients** for engaged **decision making** ▪ Connect HIE to tool to provide personal and **migratable clinical data** ▪ Feature automated system for checking symptoms and guidance to **24/7 central steerage channel** (e.g., web, phone line)

Workforce needs from delivery workstream

Delivery system component	Description of role and/or skills needed to support component
Care coordinators	▪ Defined by role ▪ Provides care coordination to entire state's top 5-15% highest risk adults and elderly, and children ▪ May be located in variety of settings (e.g., in PCP office, shared across PCPs, at hospital, at behavioral health specialist)
Multi-disciplinary teams	▪ Aspiration for care to be delivered through multi-disciplinary teams ▪ Team composition may vary but likely will include broad set of potential healthcare workforce (e.g., pharmacists, nurses, PCPs, social workers, mental health professionals) ▪ Specific new skills and capabilities are needed regarding a) an awareness of the makeup of the full team and b) efficiently and effectively working in teams ▪ Enhanced capacity in the areas of behavioral health and dental
Effective diagnosis and treatment	▪ Specific new skills and capabilities to reduce unwarranted variation in care for focused set of priority areas ▪ Additional skills and capabilities to support providers' practicing at the top of their license

Potential workforce levers

Lever	Description	Illustrative recommendations
Education	▪ Change curricula to address needed skills	▪ Specialties with >25% over/under-supply ▪ Annually refresh workforce gaps forecast
Attraction/ recruiting	▪ Increase supply of targeted clinicians	▪ Attraction campaigns for undersupplied roles and geographies
Training	▪ Teach new professional development skills	▪ Shift training to new settings ▪ Licensure training opportunities
Regulation	▪ Change licensing, recertification, etc.	▪ Certify new, necessary roles ▪ Refine recertification/license requirements
Incentives	▪ Address attraction and professional behavior[1]	▪ Financial or other support (e.g., care coordination, back-end shared savings)
Productivity	▪ Improve clinician productivity	▪ Reconfiguration of roles, organization, infrastructure and technology
Service reconfiguration	▪ Introduce improved workforce models	▪ Team-based care with informal regional networks, expert workforce input, and/or practice transformation vendor support

1 Payment model features heavily in SIM grants so this document does not explore explicitly

Elements of emerging answer potentially requiring policy support

Workstream	Areas that likely need policy support
Delivery system	1 Expanding access to care, including primary care, dental, and behavioral health (e.g., multi-state licensing, global credentialing) 2 Establishing shared utilities – Establishing data and privacy rules to support IT-driven utilities (e.g., risk stratification) – Establishing/defining governance for each (e.g., learning collaboratives) – Enabling procurement (e.g., to pre-qualify vendors) – Providing resources for each
Population health	3 Creating Healthy Neighborhoods – Establishing governance structure for the program – Designating zones – Defining and training community health workers
Payment model	4 Enabling the payment model – Establishing the framework for provider organizations that share risk – Creating a policy environment that allows for payer alignment

Remaining work

- Finalize design in each workstream
- Develop implementation plan
- Build budget
- Get feedback on first draft (to be circulated shortly)

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Question for discussion

- How should we best engage the broader public with the emerging plan?

Looking ahead: question for discussion

- Which of these elements do you think will really make DE distinctive? Which excite you the most?
- What types of goals would we set for the overall effort? (e.g., to make Delaware the healthiest state in the nation)