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

State Innovation Models (SIM) Workstream Kickoff

May 7th, 2013

PRELIMINARY PREDECISIONAL WORKING DOCUMENT: SUBJECT TO CHANGE
PROPRIETARY AND CONFIDENTIAL

WELCOME

Agenda

▪ **Introduction**	***10:00***
▪ Context for health transformation	*10:15*
▪ Break	*12:00*
▪ Lessons learned	*12:45*
▪ Workstreams	
– Delivery system	*1:30*
– Population health	*2:15*
– Break	*3:00*
– Payment model	*3:15*
– Data & analytics / workforce / policy	*4:00*
▪ Wrap-up	*4:45*

Objectives for today

1. **Understand the context for health transformation in Delaware**
2. **Kickoff each workstream**
3. **Share working approach for developing transformation plan**

Our goal: achieving the "Triple Aim"

1. Improving patient experience of care (including quality and satisfaction)

2. Improving the health of Delawareans

3. Reducing health care costs

SIM: an opportunity to help achieve our goal

- **Nearly $300M in grants** to support state-based models for multi-payer payment and health care delivery system transformation

- **25 states awarded Model Design, Pre-testing or Testing grants**

- Innovation plans must
  - Be **Governor-led** and **multi-payer**
  - Achieve the **Triple Aim**
  - Incorporate broad range of **stakeholder input**

SOURCE: CMMI State Innovation Models announcement

Themes from May 2nd HCC meeting

Themes

- Opportunity to improve access to care across provider types, conditions, and segments of the population
- Enhanced care coordination and integration will be critical to success
- Patients have an important role in health system improvement and transformation
- Incentives should be aligned with outcomes
- We have many ongoing programs and strengths to build from

SOURCE: Healthcare Commission (May 2nd)

Guiding principles

Impact	▪ Develop a health care transformation strategy that is **multi-payer and multi-stakeholder** and focuses on **achieving the "Triple Aim"** ▪ **Be one of the leading states** in innovation and impact ▪ Achieve measurable results in **three years** through practical implementable goals ▪ Meet the near term objective of developing the State Innovation Plan while focusing on the **primary goal of transforming Delaware's health care**
Approach	▪ Focus on the **best interests of all Delawareans** and respect the voice of consumers (not just traditional stakeholders) ▪ Have no "**sacred cows**" ▪ Make use of **best practice** where possible, applying pragmatic judgment ▪ Focus on **getting to a practical plan**, rather than a long conceptual debate

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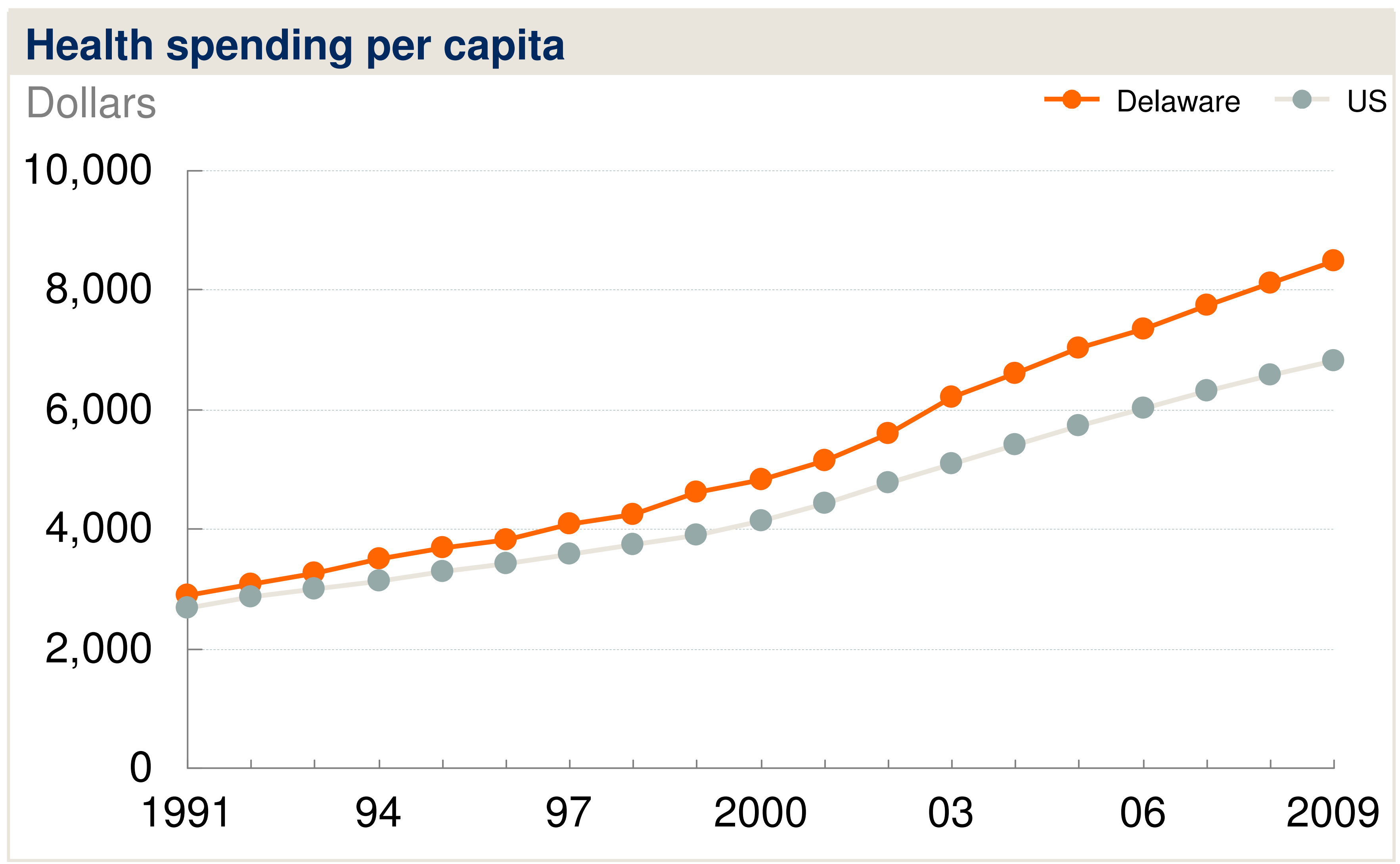
Context for DE's health transformation

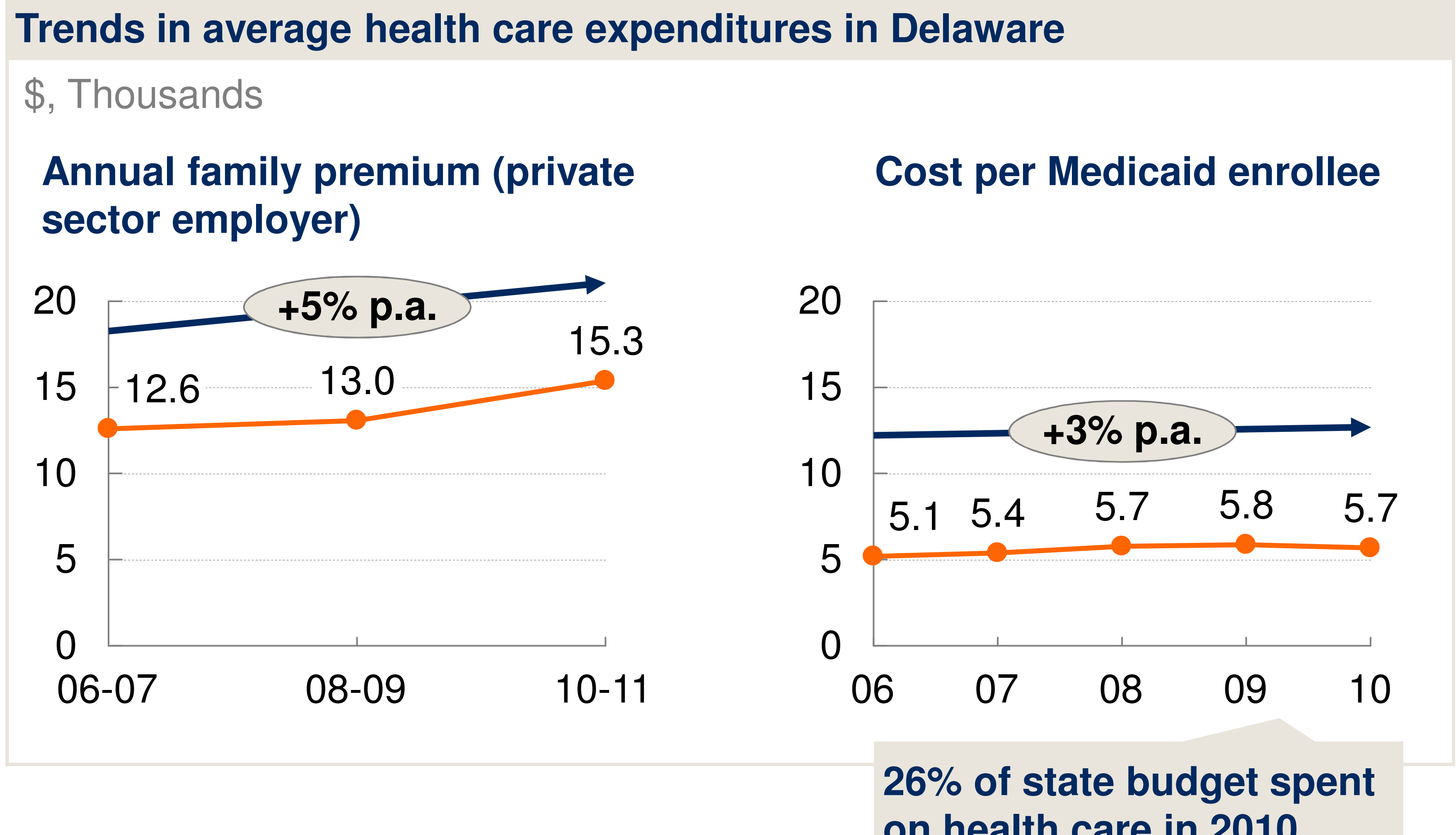
Elements of "Triple Aim"	Where we are today
Cost	DE's health spending is 25% greater than US average
	2 Cost growth is high across segments
	3 Health spending creates a significant cost burden, which has eroded real income gains nationally, and may put DE on an unsustainable cost trajectory
Health and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

Spending is 25% higher than US average



SOURCE: Kaiser Family Foundation

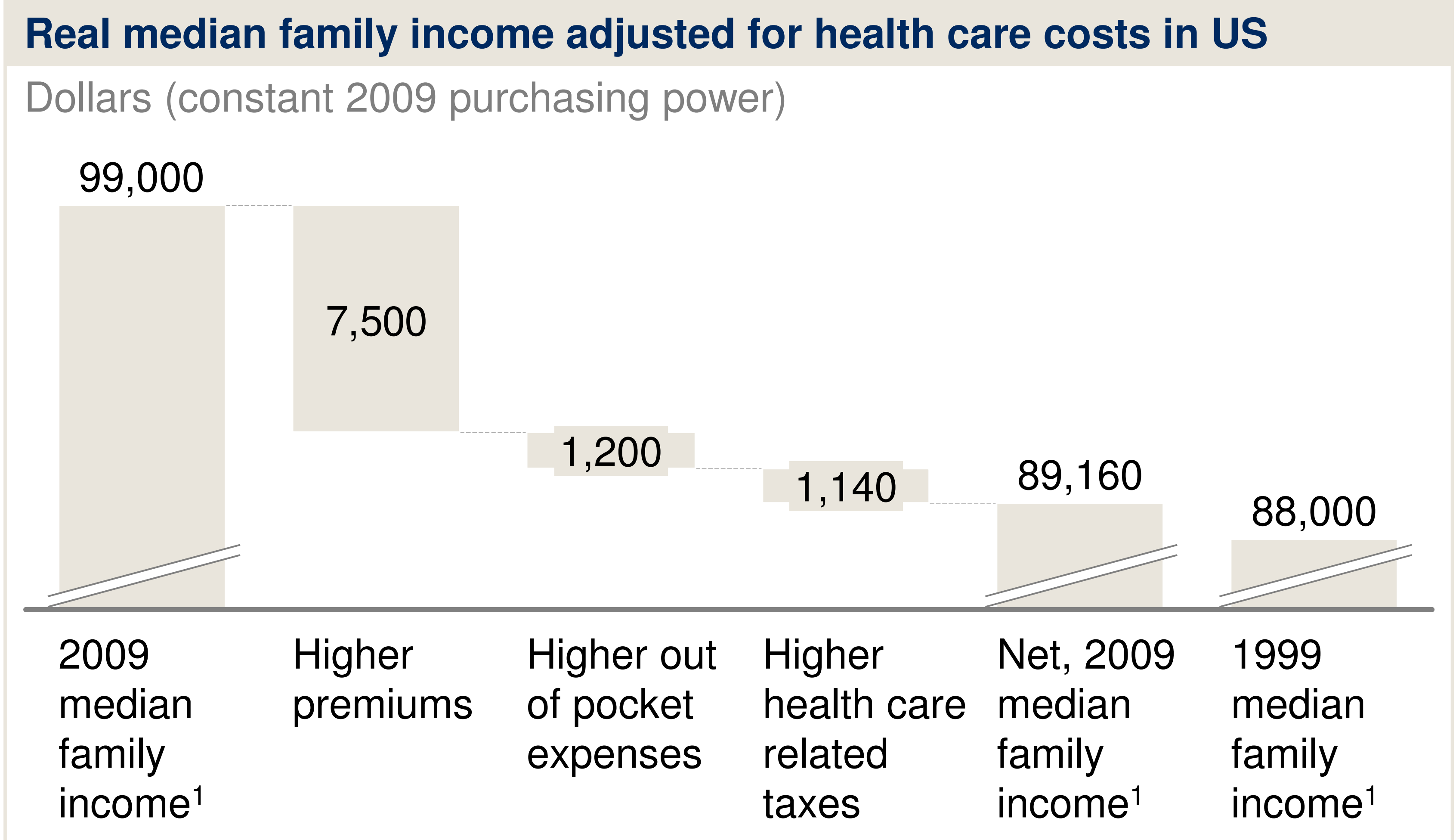
2 Cost growth high across segments



26% of state budget spent on health care in 2010

SOURCE: State-Level Employer-Sponsored Insurance Coverage (ESI), SHADAC, 2013; Medicaid.gov: Delaware U.S. Census Bureau: State and Local Government Finance

3 Nationally, this cost burden has actually eroded income gains…

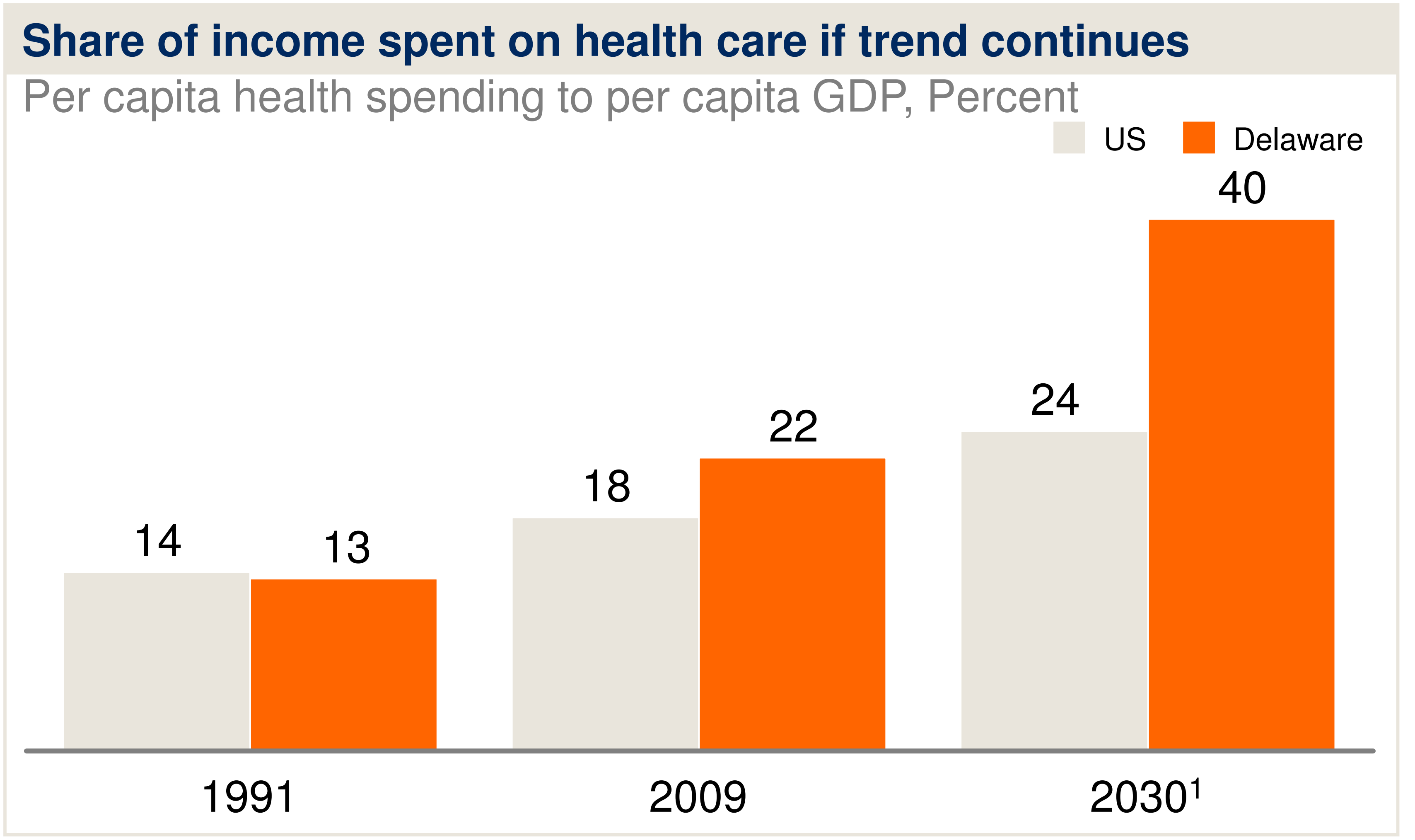


1 Sample includes only American families with employer-based health insurance; income adjusted for several factors (including employer paid health insurance premiums)

SOURCE: Auerbach, Kellermann, "A Decade of Health Care Cost Growth has Wiped out Real Income Gains for an Average U.S. Family", Health Affairs, 2011

3 ...and in DE, current cost trajectory may not be sustainable

ILLUSTRATIVE

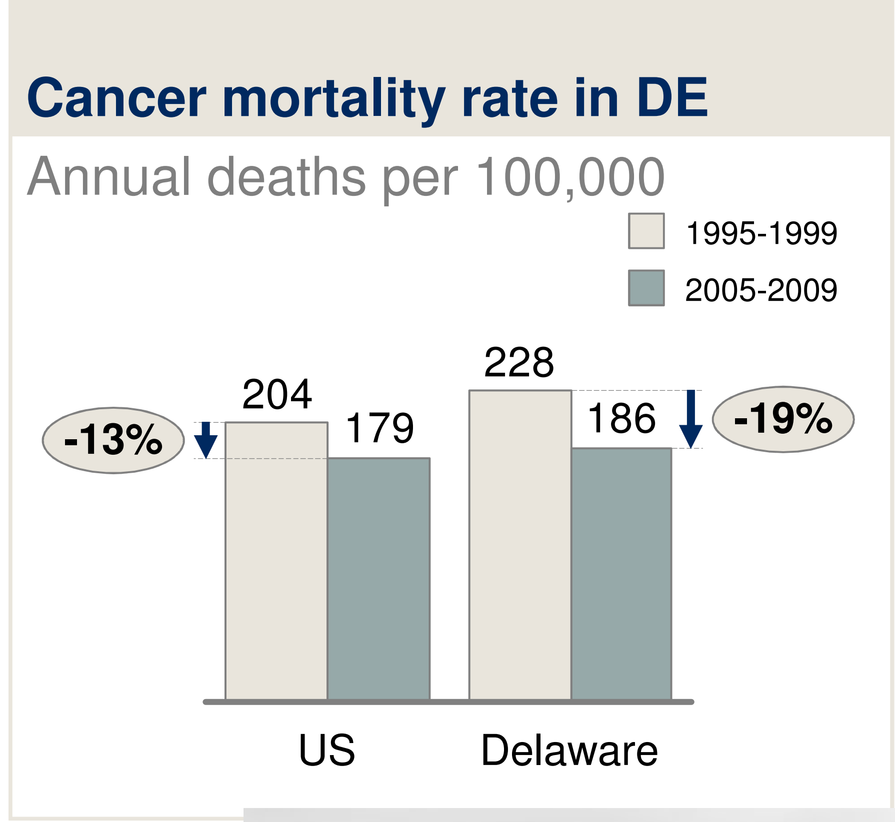


1 Assume that 2009-2030 CAGR for Delaware and US health care costs and GDP is the same as their respective 1991-2009 CAGR

SOURCE: Kaiser Family Foundation

4 Although there have been major improvements in some areas like cancer

Cancer mortality rate in DE



Reduction in mortality rates by demographic group, DE

Percent change in cancer death rate, 1995-1999 versus 2005-2009

Group	Percent change
Men	-22%
Women	-17%
African Americans	-33%
Caucasians	-16%

"Delaware sees progress in fight against cancer"
– The Washington Post, May 1st, 2013

SOURCE: DHSS Report – Cancer Incidence and Mortality in Delaware, April 2013

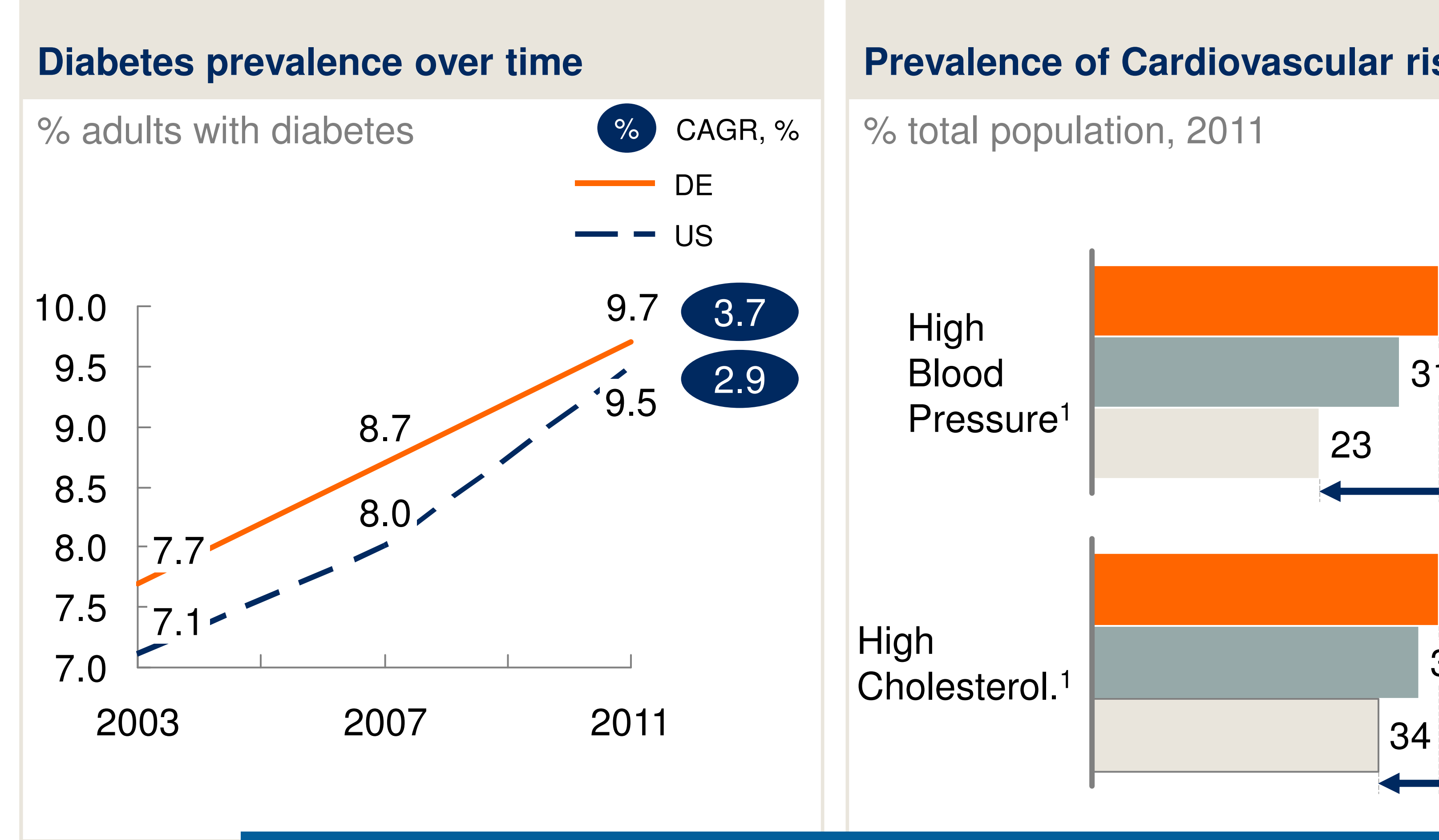
4 Despite the higher spending, DE still has generally average outcomes…

2010 Health outcomes

	Delaware	US
Low birth weight as % of births	8.9%	8.1%
Infant mortality	7.7%	6.2%
Heart disease deaths per 100,000	175.7	179.1
Suicide deaths per 100,000	11.3	12.1
Cancer deaths per 100,000	185.7	172.8

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

5 ...a significant chronic disease burden

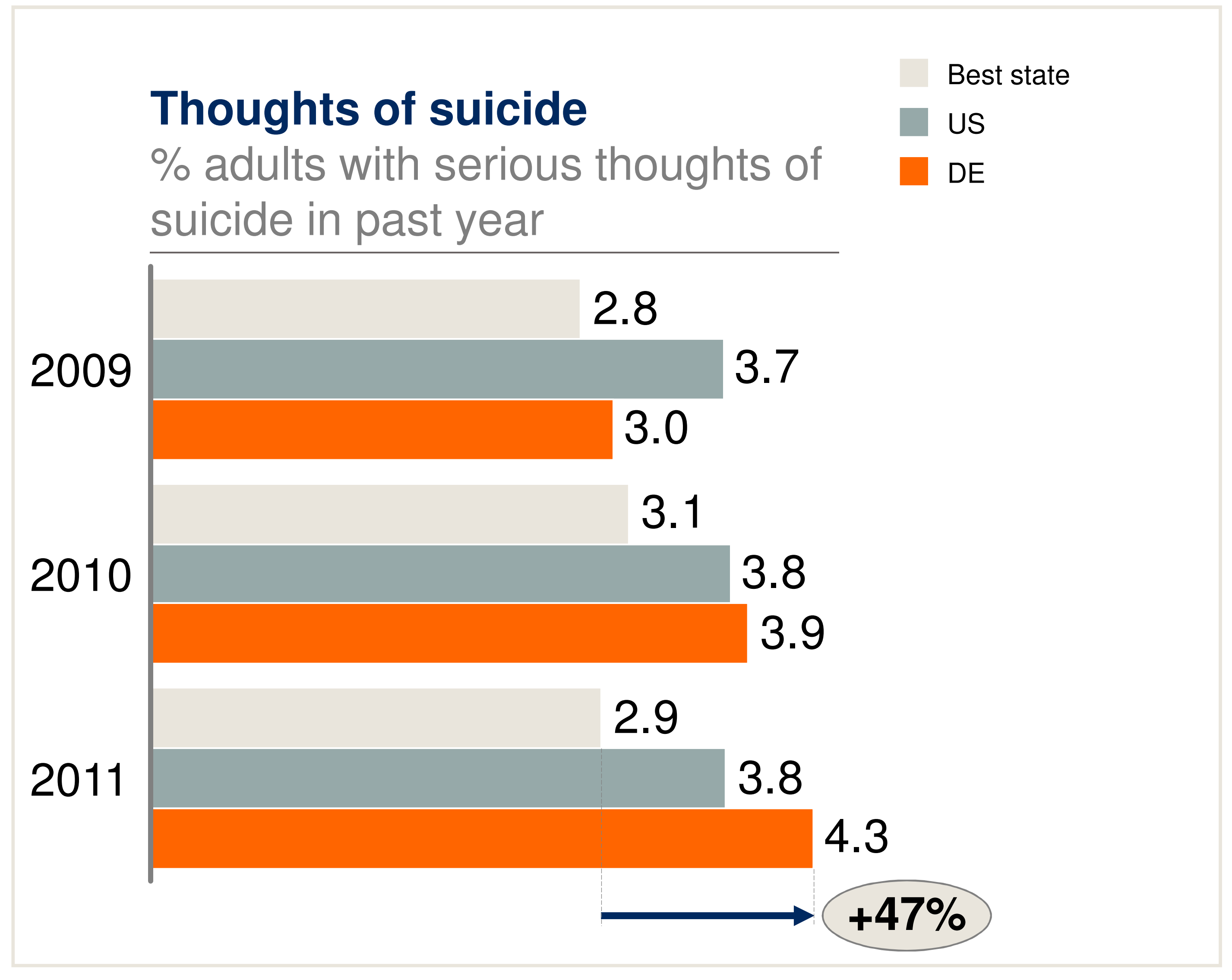


- Ranks 28th among States for adult Diabetes prevalence
- Ranks 41st among States for high blood pressure and cholesterol

1 Respondents >=18 years old, who have been told by doctor that have High Blood Pressure or High Cholesterol levels

SOURCE: BRFSS, America's Health Rankings, CDC Behavioral risk factor surveillance

5 …and increasing mental health needs



SOURCE: SAMHSA – Substance Abuse and Mental Health Services Administration

5 Risk factors like obesity continue to rise

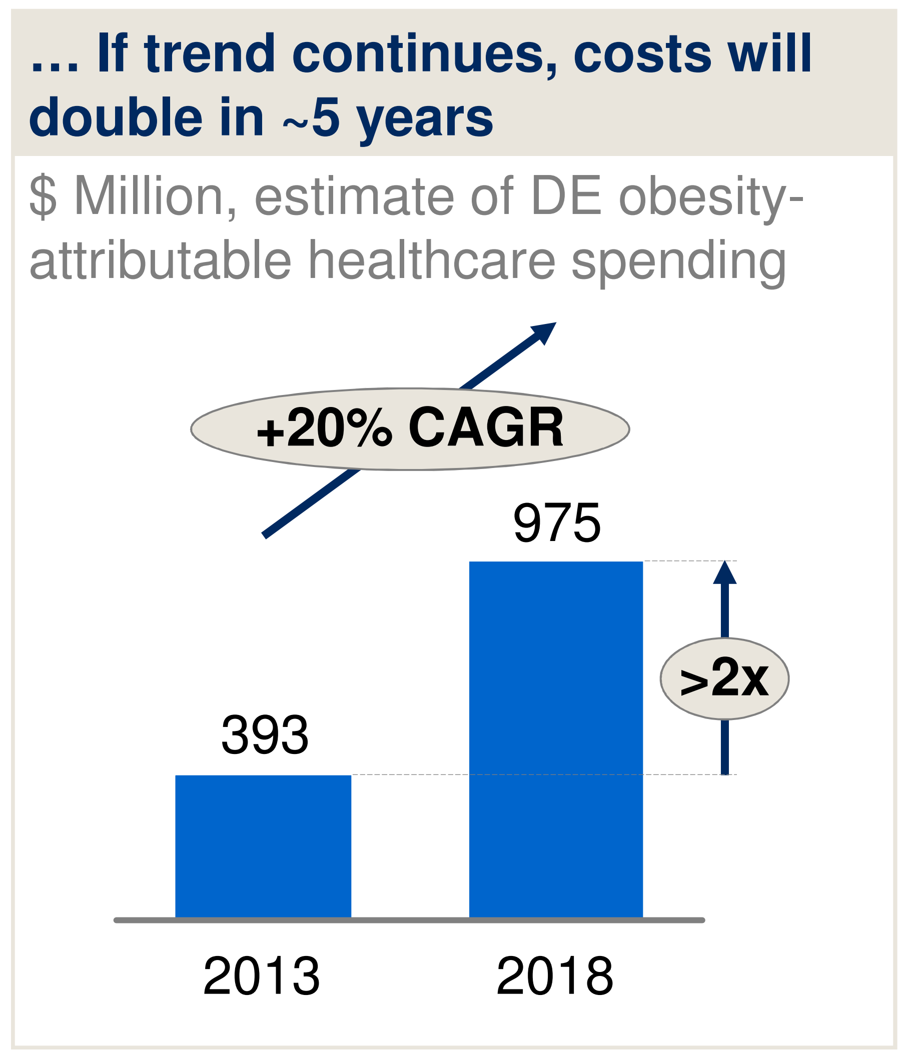
Adult obesity prevalence doubled in past two decades…

%, of DE adults that are obese

+4% CAGR

1992	2011
13	29

>2x



SOURCE: CDC BRFSS; Report Reducing the impact of Chronic Diseases in DE (2012)

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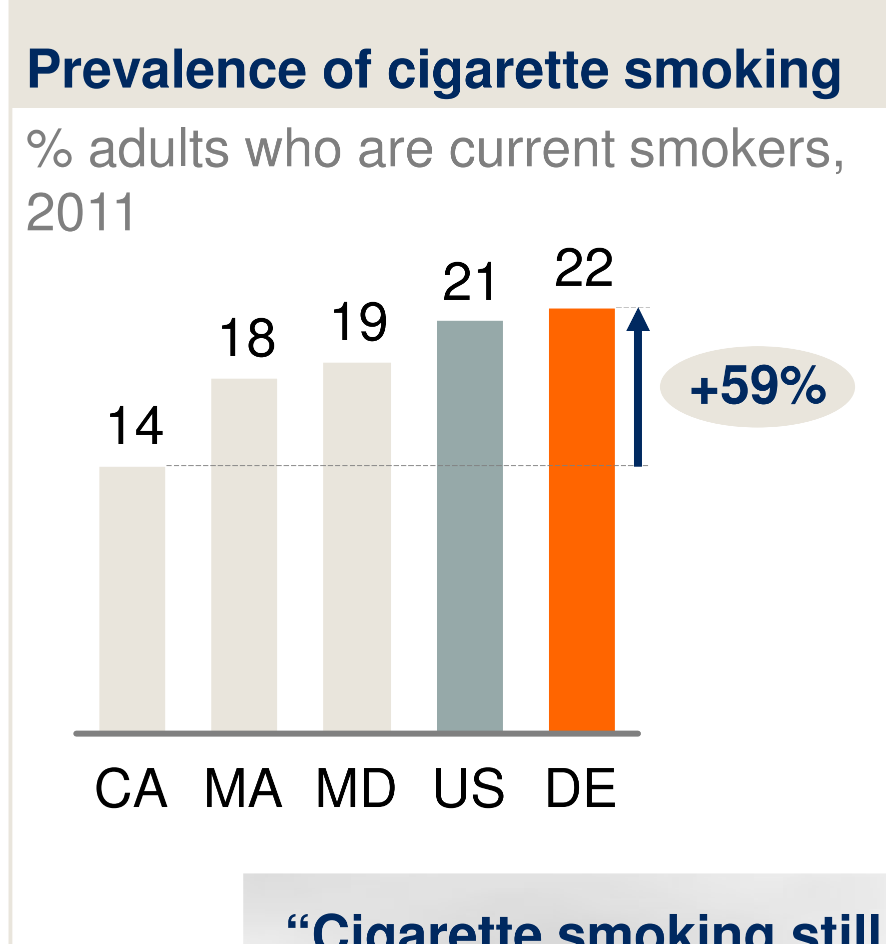
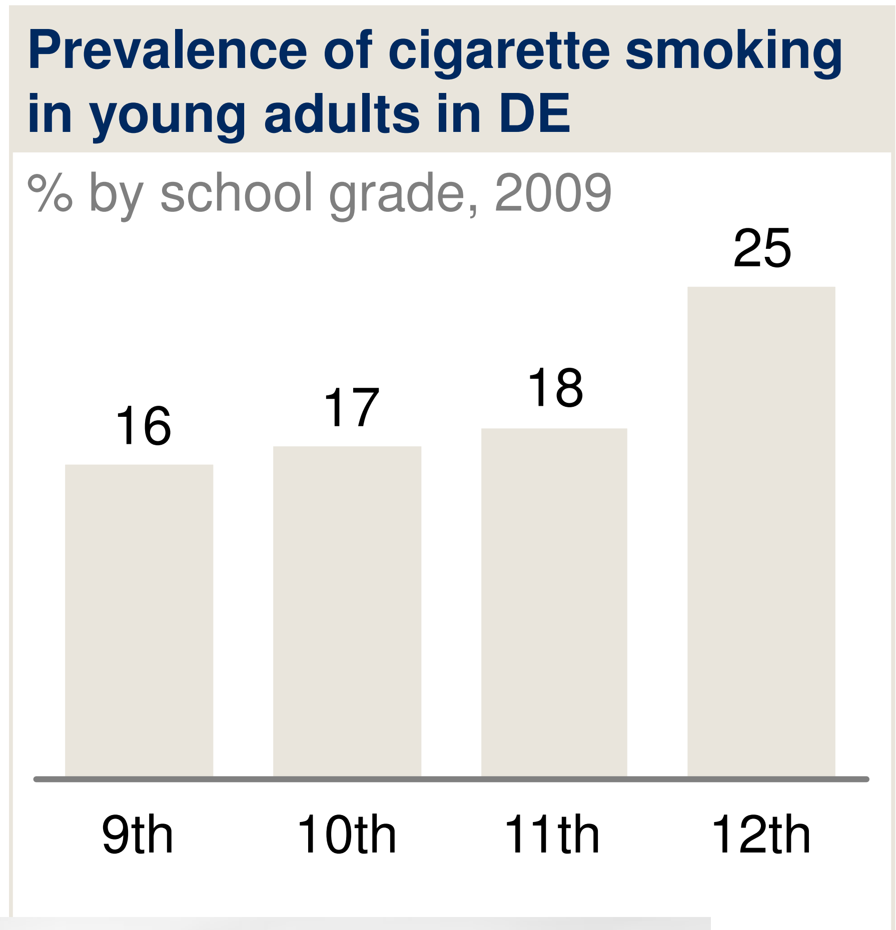
5 And unhealthy activities persist



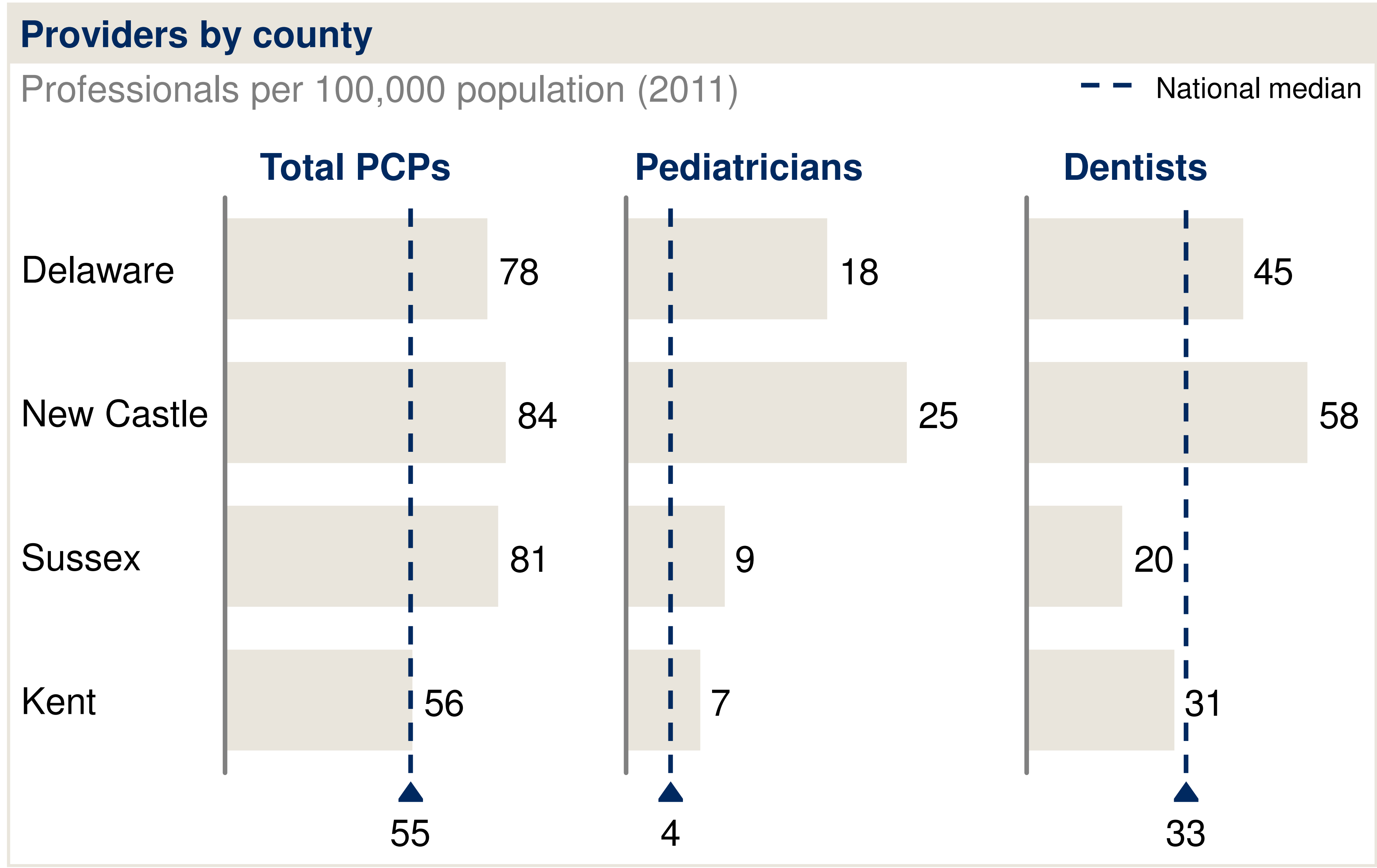


"Cigarette smoking still Delaware's tragic threat"

– The News Journal, May 1st, 2013

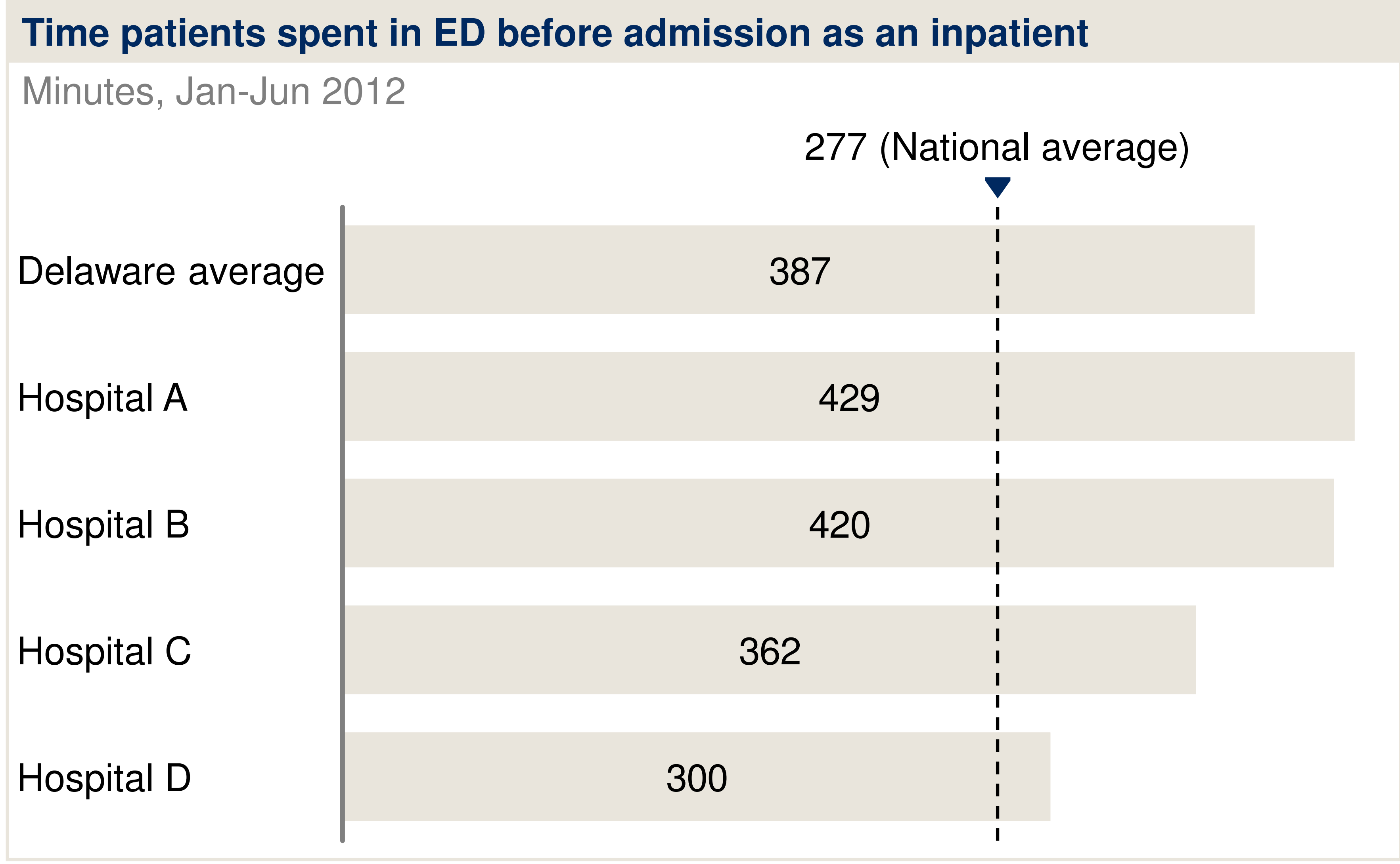
SOURCE: CDC BRFSS; Report Reducing the impact of Chronic Diseases in DE, 2012

6 Experience limited by access variations



SOURCE: DE Health Care Commission Health Care Workforce Report (citing Primary Care Physicians in Delaware, 2011, University of Delaware, Delaware Population Consortium)

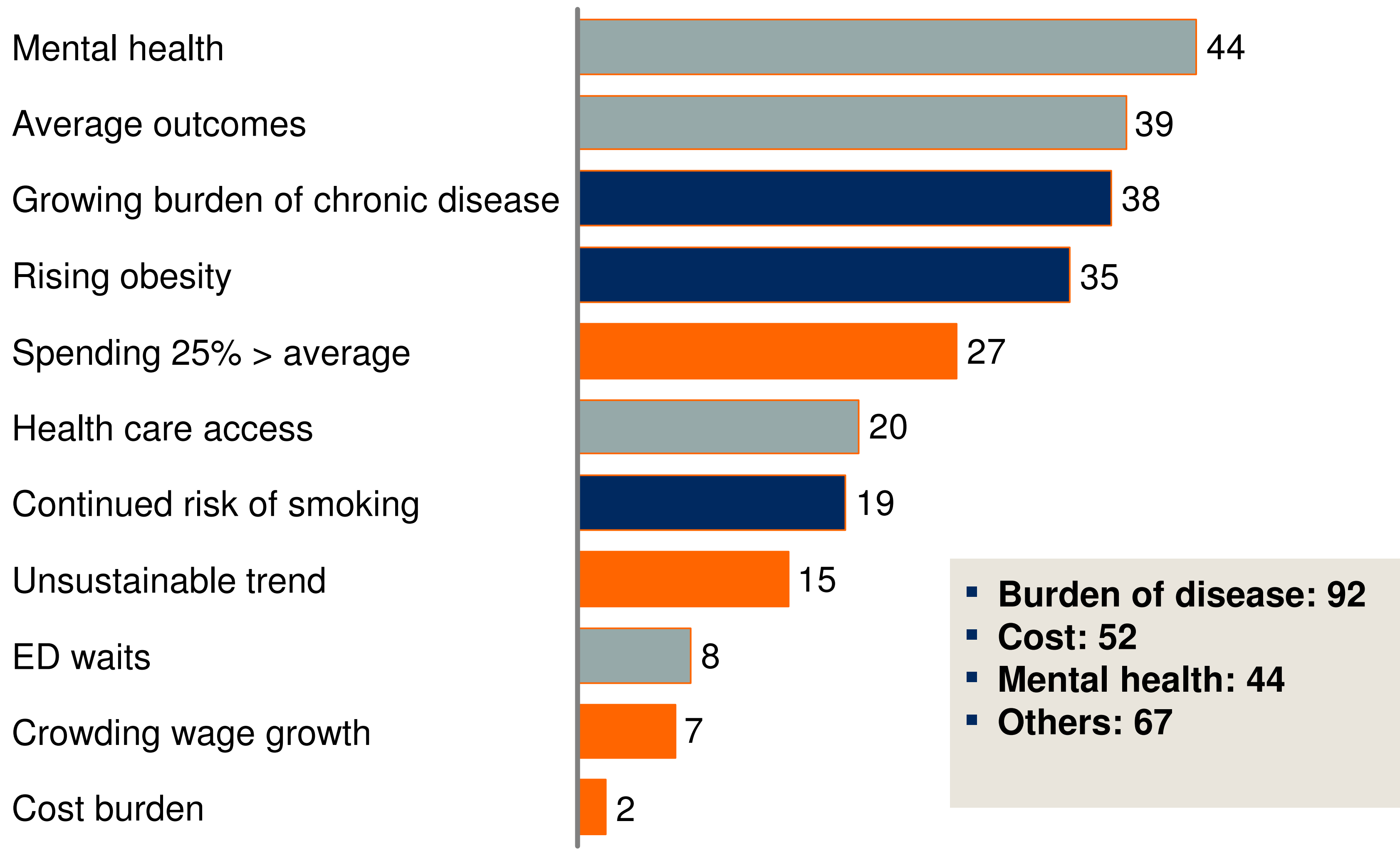
7 And significant emergency wait times



1 System-level figures are reported as an average of the performance measures from all hospitals within the system

SOURCE: CMS: Hospital Compare

Results: issues the audience identified



EXAMPLE

Example: seeing change through patient experience

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

In addition to baseline vs. Triple Aim, we must consider DE's unique characteristics

- 2nd smallest state by size and 6th smallest by population
- Represents a microcosm of America demographically (within 5% of national distribution for poverty status, education level, age, urban/rural population)
- Growing elderly population – projected to be 9th highest population over 65 by 2030
- Concentrated commercial health insurance landscape – two payers account for three quarters of commercial lives
- Transitioned to Medicaid Managed Care with two payers covering ~80 percent of Medicaid enrollees
- Concentrated provider landscape – three hospitals account for ~80 percent of discharges

SOURCE: U.S. Census Bureau, Kaiser State Health Facts, HealthLeaders InterStudy data, American Hospital Directory; Financial Compass 2010

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Ten lessons learned

1. Transformation is possible
2. Vision should address the heart before the head
3. Know what motivates change
4. Understand stakeholder perspectives
5. Across delivery models, there is a need for both more and less
6. Population health requires focus
7. Across payment models, common principles have emerged
8. Data and analytics capabilities need rapid iteration and refinement
9. Workforce is not just about new or more people
10. Policy tools can be important enablers for change

It is happening in Arkansas…

What's in scope

- **Ambitious:** Building a health care system for the 21st Century
- **Multi-payor:** Medicaid, Blue Cross Blue Shield, QualChoice, Medicare
- **State-wide:** Covering 3 million population

Components of model

- **Comprehensive:** Payment, Information, Engagement, Workforce
- **Innovative payment approach:** Combination of episode-based payment (for 50-60% of spend) and population-based (for 100%)
- **Groundbreaking:** July 2012 launch of episode payment (e.g., pregnancy, hip/knee) – 5-10% of spend for payors

How it has evolved

- **Adapt to landscape:** Moved from prospective bundles to retrospective risk sharing by Principal Accountable Provider (based on average cost and quality performance)
- **Pragmatic:** Focus on "July 2012:, "Version 1.0"
- **Industrial strength:** "Not a pilot", "Across all spend"

Impact to date

- **Broad reaching:** To date 3,000+ providers, 100K patients, 5% medical spend
- **Home grown:** State-wide clinical portal designed / launched and analytic engine for payments launched in 6 months

SOURCE: Arkansas Payment Improvement Initiative

…in Sacramento…

What's in scope

- **Focused:** 42,000 CalPERS (Public Employees' Retirement System) members managed by a single system
- **Ambitious:** Sought and achieved savings from year one of operation
- **Collaborative:** Payors and providers came together to share risk

Components of model

- **Innovative risk-sharing mechanism:** Each health provider bears risk for their own performance and pooled sharing of margin
- **Shared clinical information and protocols:** Parties share clinical data and protocols, following standardized best practice treatment pathways
- **Focus on settings of care:** Alternative care sites, e.g., IP surgery to ASC, ED to urgent primary care clinics

How it has evolved

- **Home grown methodology:** Program evolved from concept to detailed with input from all stakeholders over the period of 2 years
- **IT system support built in parallel:** The program relies on shared data and initially this was clunky but they're now building a bespoke HIE[1]

Impact to date

- **Better patient care:** 17% reduction in inpatient readmissions
- **Efficiency:** Half day reduction in average length of stay (14% fall in total bed days) and 50% reduction in patients with an LOS of >20 days
- **Savings:** $20 million in year one – $15.5 million recouped by Blue Shield, $5 million shared among partners

1 Health Information Exchange

SOURCE: Sacramento ACO; Los Angeles Times; Healthcare Informatics

…and in Oregon

What's in scope	▪ **Ambitious:** A Transformation Center will push the implementation of the most effective delivery models state-wide ▪ **Interventionist:** Seeks to re-focus care delivery towards proactive primary care, population health and prevention and to reduce health disparities ▪ **Multi-payor:** Initially OHA (care purchaser for 1 in 4 insured Oregonians), Medicaid, DEs and state employees - with plans to expand from this base
Components of model	▪ **Based around PCPCH[1] delivery model** ▪ **Community-driven:** 15 Community Advisory Councils have been created to set priorities and goals that reflect local population health needs ▪ **Coordinated care:** Risk-bearing CCOs (Coordinate Care Organizations) can experiment with different delivery models but are accountable for the same set of performance and outcomes measures ▪ **Aligned incentives** reward outcomes not volume
How it has evolved	▪ **Extensive planning:** 3 year planning process involving all major stakeholders ▪ Builds on long history of state-driven coordinated care initiatives
Impact to date	▪ **Savings:** Expected to save $372 million over the 3-year SIM demonstration period

1 Primary care patient-centered home

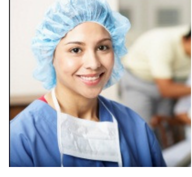
SOURCE: Oregon Health Authority; New York Times; Oregon SIM Testing Grant Application

Lesson #4: understand different perspectives

Example perspectives about health transformation

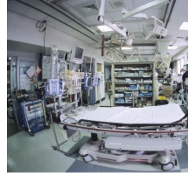
Patients / clients

- How will this change my experience?
- How will I really know if my care is better?



Clinicians

- How can I reduce administrative burden?
- Will I be able to maintain my income level?



Hospitals / facilities

- How will any changes affect my revenue and cost position relative to alternatives?

Payers

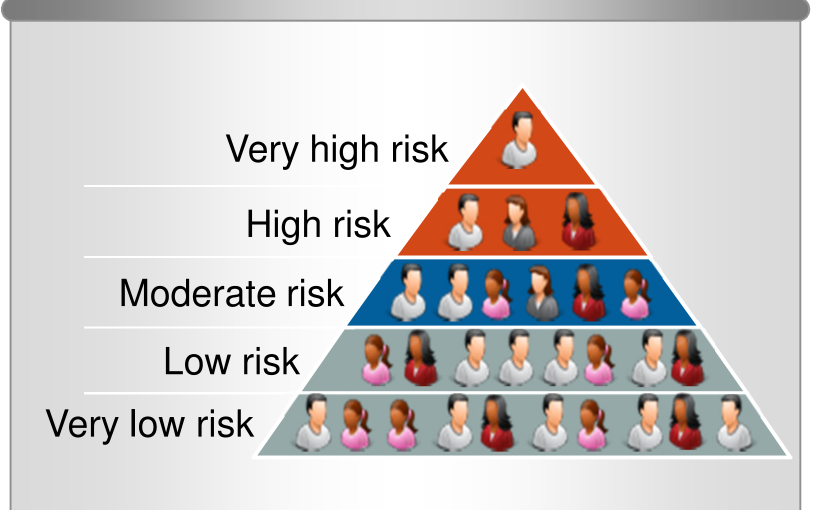
- How can we manage medical expenditures and focus more on value?

Taxpayers

- How can we make public support for health care more sustainable?

Lesson #5: as care is more integrated…

Success in integrated care



1. Patient registry
2. Risk stratification
3. Care packages
4. Care plans
5. Care delivery
6. Case conference
7. Performance review

… supported by key enablers

Reimbursement

Governance

Information

Clinical leadership

Patient engagement

SOURCE: Carter, Chalouhi, McKenna, Richardson, "What it takes to make Integrated Care work", Health International, 2011

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…there is a need for both "more" and "less"

More of…

Limiting procedures to ones you perform at reasonable high volume

Dedicating more cognitive time to educate patients, reinforce treatment adherence, and manage/refine therapy

Accessing economies of scale through consolidation or shared services

Championing and adhering to standardized, evidence-based clinical pathways

Accepting responsibility for cost and quality of care that occurs outside the office

Leading regular practice meetings and working as part of a multidisciplinary team

Less of…

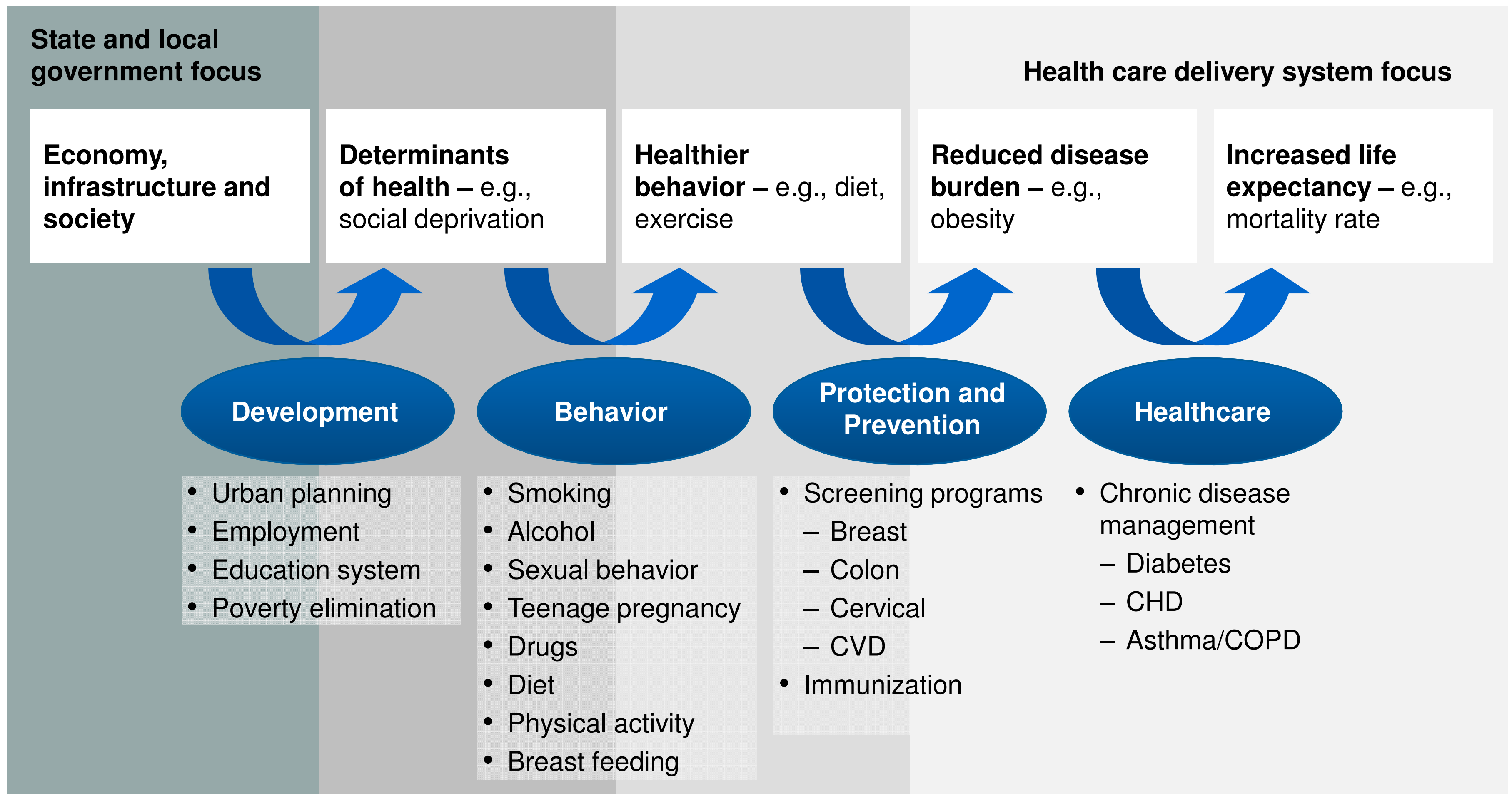
Making unnecessary referrals

Ordering expensive, low-value interventions, diagnostics, and supplies

Relying on medicines rather than behavior change as the most powerful treatment for chronic disease

SOURCE: Latkovic, "Using payments to drive cost-reducing innovations", Health International, January 2013

Lesson #6: population health requires focus



Lesson #7: across payment models…

Full alignment of payment to outcomes

	Payment model	Most applicable
↑	**Population-based payment** ▪ Capitation	▪ Primary prevention for healthy ▪ Care for chronically ill (e.g., managing obesity, CHF)
	Episode-based payment ▪ Retrospective Episode Based Payment (REBP) ▪ Bundled payment	▪ Acute procedures (e.g., CABG, hips, perinatal) ▪ Most inpatient stays that include post-acute care, readmissions ▪ Acute outpatient care (e.g., broken arm, some behavioral health)
	Pay for performance ▪ Incentive-based rate increases ▪ Bonus payments tied to quality ▪ Bonus payment tied to value	▪ Discrete services provided by entity with limited influence on upstream or downstream costs (e.g., MRI, prescription, medical device, Health Risk Assessment)

SOURCE: Latkovic, "Using payments to drive cost-reducing innovations", Health International, January 2013

…there is a set of common principles

Principle	Description
Setting expectations	Expand use of population-based and episode-based payment
Significant	Maximize provider revenue and earnings subject to outcomes-based reimbursement
at Scale	Ensure a critical mass of providers within a local market transition to outcomes-based reimbursement
Stable	Clarify long-term vision and commit to providers
Striving, but practical	Design approach to be effective in current regulatory, legal, industry structure
Sustainable	Ensure providers that adapt thrive financially
Supportive	Payment innovation necessary but not sufficient—needs support for transformation
Supply-demand integration	Align reimbursement with patient engagement, benefits, network design, etc.

SOURCE: Latkovic, “Using payments to drive cost-reducing innovations”, Health International, January 2013

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Lesson #8: can build data tools quickly

- **Technology is a critical enabler** to any payment innovation program
- Successful programs are **iterative, focusing initially on quick-wins** then rigorously prioritize implementation roadmaps based on capabilities and value potential
- Program and underlying technology design should take a **provider-centric view** to maximize adoption
- Technology solutions can achieve **meaningful impact in under one year**
- Payers can significantly leverage and extend **existing capabilities** (e.g., analytics) to accelerate impact
- **Robust vendor solutions** are beginning to emerge and are a critical medium-term program component; plan to **partner for the long-term** to enable the deep integration required

Lesson #9: workforce strategy is more than new people

	Fact	*Implication for workforce strategy development*
1	▪ In the developed world 60% of health care expenditure is on workforce	▪ Credible efforts to bend the cost curve must have a **significant workforce element**
2	▪ New models of care have failed elsewhere because the required workforce did not exist	▪ A **fact-based forecast** of future work-force supply/demand by role is needed to identify and address pinch points
3	▪ Future models of care will require new skills and behaviors	▪ Understanding the **skills and behaviors** needed to deliver new models of care is vital if they are to be implemented
4	▪ 70% of a health care workforce today will be the same workforce 10 years from now	▪ Investing in building new skills in the **existing workforce** underpins delivery
5	▪ Monetary incentives alone are not enough to deliver change	▪ A strategy for change builds on under-standing the **need to change, role modeling the change,** as well as **skills and aligned incentives**

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NOT POLICY RECOMMENDATIONS

Lesson #10: policy can enable transformation

	Examples
Data	▪ Creating data governance rules that respect the rights of individuals and enable information sharing between the right people at the right time, within a consented environment
Patient	▪ Enabling incentives that account for behavioral economics research (e.g., opt-in vs. opt-out)
Workforce	▪ Permitting professionals (e.g., NPs) to practice at the top of their license

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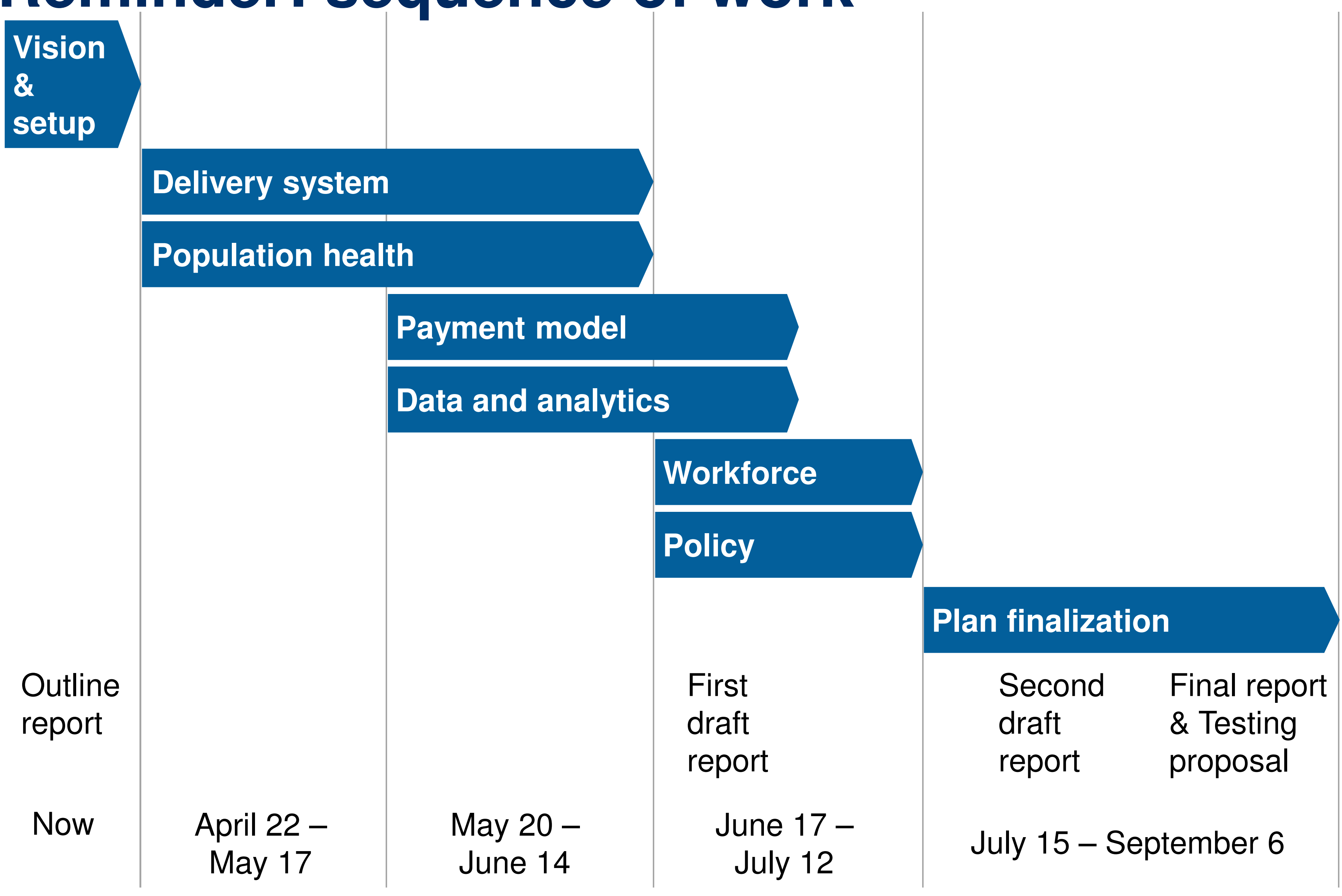
Our approach follows key areas of transformation

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

Reminder: sequence of work



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Delivery system

Goals

- Describe how better care should be delivered and population health improved, including targeted analysis of utilization and case studies about different models and input from consumers (e.g., PCMHs)

Areas of focus

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

Chair: Bettina Riveros

Sponsor: Rita Landgraf

Approach to developing care delivery model

1. Understand population segments and their needs
2. Evaluate potential care delivery interventions (sources of value)
3. Prioritize sources of value for each patient segment to build portfolio of care delivery interventions
4. Identify required changes in behavior, capabilities, capacity, and structure from the current care delivery system for each priority segment and source of value
5. Determine specific levers (e.g., incentives, transparency) to drive change
6. Evaluate organizing structure(s) that enable desired changes
7. Identify and develop the plan to build the required provider tools and capabilities to support delivery system transformation

1 Understanding segment needs

PRELIMINARY AND ILLUSTRATIVE

	Sub-segment	Examples of sub-segment needs
Elderly	▪ Top 1% of need ▪ Top 5% of need ▪ All the rest	▪ Continuous, comprehensive care, support and monitoring (home and site of care) ▪ Rapid support and response system with triaging ▪ Access to care when needed
Adults	▪ Complex chronic ▪ Chronic/ at risk ▪ Healthy adults	▪ Comprehensive, coordinated disease management ▪ Multiple access channels for self-management ▪ Preventive measures, and active management of major risk factors
Maternity and Peds	▪ Pregnancy ▪ Neonatal ▪ Pediatrics	▪ Access to OB/GYNs, and prenatal care/regiments ▪ Access to high quality NICU facilities/capacity ▪ Age-appropriate immunization coverage
Special Needs	▪ Behavioral health ▪ Developmental disabilities ▪ Addiction and substance abuse ▪ Dual eligibles	▪ Screening, diagnosis and comprehensive treatment ▪ Community support systems ▪ Access to specialty care and services tailored for addiction and substance abuse ▪ Continuous, comprehensive care, support and monitoring (home and site of care)

2 Potential interventions

	Description	Examples
Primary prevention	▪ Prevention of disease by removing root causes	▪ Diet, physical activity, smoking cessation
Secondary prevention	▪ Early detection of disease while asymptomatic to prevent disease progression	▪ Routine check-ups, breast cancer screening
Provider choice and setting	▪ Utilizing highest value care settings; higher value downstream providers	▪ Enhanced function of PCPs, rapid response to triage / direct patients into appropriate treatment channel
Effective diagnosis and treatment	▪ Evidence-informed choice of treatment method/intensity	▪ Reducing unnecessary testing, ensuring appropriate choice of medications
Care coordination/ chronic disease management	▪ Ensuring patients effectively navigate the health system and adhere to treatment protocols	▪ Care coordination, across specialties and care channels for chronic conditions like CHF and Diabetes

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For discussion

1. What are the most pressing patient / client needs in DE today?
2. Which source of value is the greatest opportunity for DE?
3. What examples from of delivery change within the state and globally are most applicable to DE?
4. What are the most exciting changes that we can leverage?

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Population Health: overview

Goals

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

Areas of focus

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

Chair: Lolita Lopez

Sponsor: Karyl Rattay

Questions to address

Assessment of requirements for change	▪ What are the biggest health needs in DE (e.g., where is DE an outlier)? ▪ Out of priority initiatives identified already (e.g., from the Governor's Council) which address the highest priority needs? ▪ From prioritized set of initiatives, which could materially benefit from delivery system and payment model transformation?
Analysis of reform options	▪ What case examples have addressed priority areas? ▪ From these examples, what are lessons learned, and range of options? ▪ What are the criteria to assess options?
Mapping of population health & delivery model	▪ How can proposed changes to delivery and payment support prioritized areas?
Implementa-tion plan	▪ What are the goals for each priority area and how are they linked to delivery and population health goals? ▪ What costs/incentives are needed to align providers? ▪ What information/technology and other enabling actions are needed? ▪ What payment model changes are required? ▪ What is the implementation plan (who is accountable for what by when)?

We have a strong base to build from

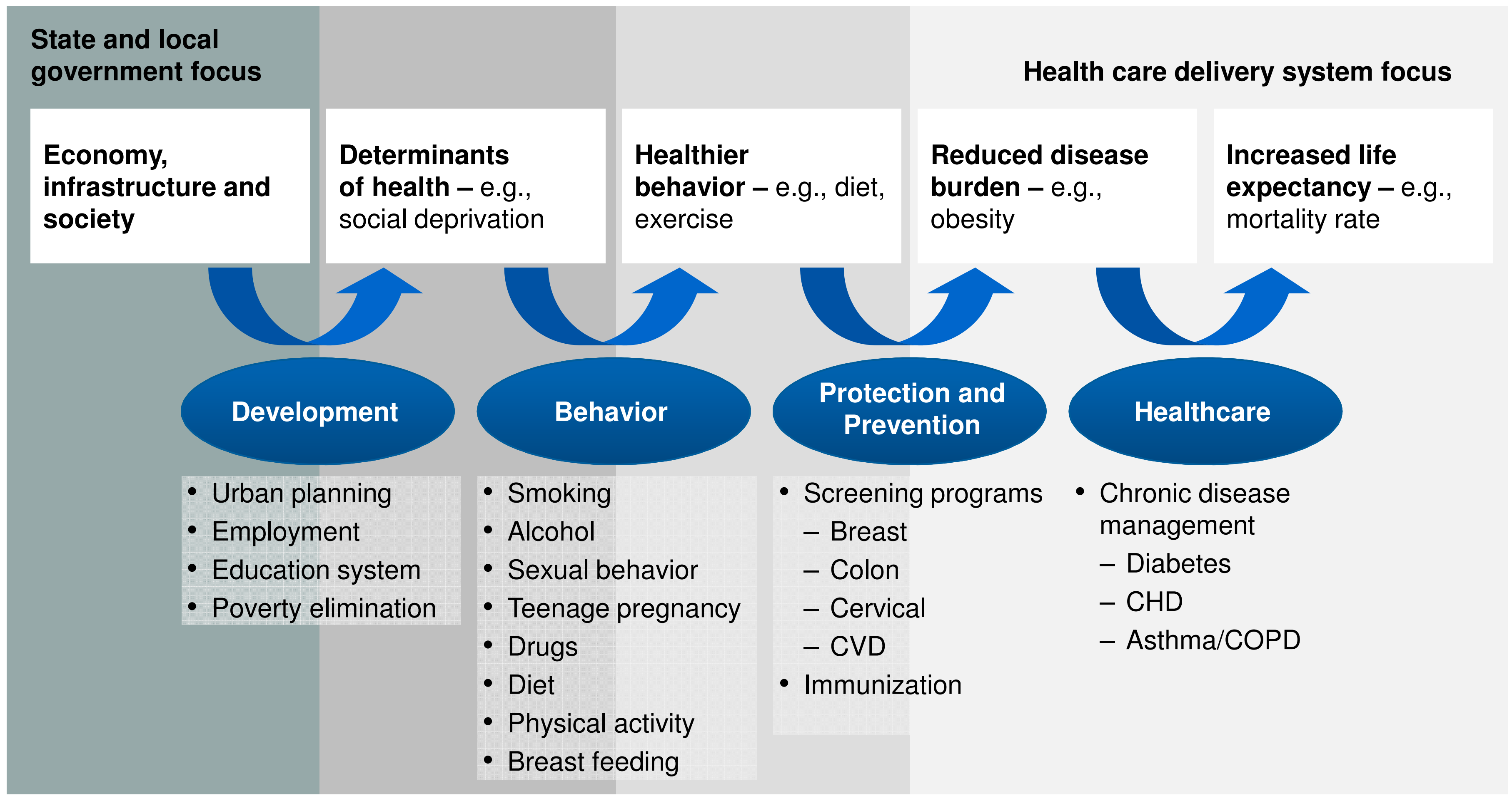
NOT EXHAUSTIVE

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

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

PROPRIETARY AND CONFIDENTIAL

Population health focus



For discussion

1. What are the **major Population Health needs** in Delaware?

2. What examples of innovation have you seen in Delaware that address **integration and coordination of Delivery System** with the broader community?

3. How can **preventive and primary care** access and coverage be **integrated** with other system resources?

4. What are the **obstacles for understanding and navigating** the healthcare and public systems in Delaware?

Agenda

- Introduction *10:00*
- Context for transformation *10:15*
- Break *12:00*
- Lessons learned *12:45*
- **Workstreams** *1:15*
  - Delivery system *1:30*
  - Population health *2:15*
  - Break *3:00*
  - **Payment model** ***3:15***
  - Data & analytics / workforce / policy *4:00*
- Wrap-up *4:45*

Payment Model

Goals

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

Areas of focus

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

Chair: Matt Swanson

Sponsor: Bettina Riveros, Steve Groff

Questions to address

Documented analysis of peer state programs	▪ How have others approached payment design? ▪ What lessons can we learn from their experiences?
Data analysis to inform evaluation of payment models	▪ What does the current data tell us about variation in delivery, quality, and cost in DE?
Synthesis of analyses and implications for payment model	▪ What are the priorities and lessons learned that will shaped DE's approach to payment?
Analysis of reform options, including impact and trade-offs	▪ What is the set of options and how should they be prioritized and evaluated?
Development of preferred payment option and impact	▪ What design parameters are required to support DE's payment model? ▪ What quality measures should be used?
Financial forecast of impact of new payment models	▪ What financial impact will the new model have?
Plan for payment model and implementation plan	▪ What will it take to put the new model(s) in place?

Payment models across the US

Full alignment of payment to outcomes

	Most applicable
Population-based payment ▪ Capitation	▪ Primary prevention for healthy ▪ Care for chronically ill (e.g., managing obesity, CHF)
Episode-based payment ▪ Retrospective Episode Based Payment (REBP) ▪ Bundled payment	▪ Acute procedures (e.g., CABG, hips, perinatal) ▪ Most inpatient stays that include post-acute care, readmissions ▪ Acute outpatient care (e.g., broken arm, some behavioral health)
Pay for performance ▪ Incentive-based rate increases ▪ Bonus payments tied to quality ▪ Bonus payment tied to value	▪ Discrete services provided by entity with limited influence on upstream or downstream costs (e.g., MRI, prescription, medical device, Health Risk Assessment)

SOURCE: Latkovic, “Using payments to drive cost-reducing innovations”, Health International, January 2013

For discussion

- What are our aspirations for Payment Model reform?
- What does the new Payment Model need to accomplish – for patients, providers and payers?
- Which Payment Model changes would you like to see here in Delaware?
- What programs in other states can we learn from?

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▪ Wrap-up	*4:45*

Data & analytics

Goals

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

Areas of focus

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

Chair: Jan Lee

Sponsor: Gary Heckert

Questions to address

Topic	Questions
Inventory of health data sources and systems	▪ What are the key health data sources and systems in Delaware?
Assessment of health data capacity and infrastructure	▪ What are the current HIT capabilities of payers and providers within the statewide infrastructure that are relevant to the new delivery and payment model?
Assessment of health data flow and reporting needs for State Innovation Plan	▪ What capabilities are required across key stakeholders to implement the target care delivery and payment model?
Identification of linkages among data systems	▪ What is the optimal level of payer infrastructure standardization across each component (e.g., analytics, pooling, reporting, visualization, portal)?
Analysis of options to close analytic gaps and build future-state analytic capabilities	▪ What is the best strategy to develop the required HIT capabilities?
Development of plan for building data analytic capacity for State Innovation Plan	▪ What will be the pace of roll-out of the required capabilities throughout the state? ▪ What is the required budget? ▪ What is the best funding model?

Understanding data requirements

What data is needed to …

Patients	… enable patients to be active partners and managers of their own health
Clinicians	… have right information to make diagnosis and treatment decisions, and connect with care team in a coordinated manner
Hospitals	… measure costs, outcomes and performance of previous and newly implemented care delivery models
Payers	… seamlessly adjust to new payment mechanisms
System	…tell that programs are on track to deliver change

For discussion

- How is information being used today to support care delivery?
- What information gaps exist today across providers and geographies?
- What information will be needed to enable outcomes-based payment models?

Workforce

Goals

- Define and identify path forward to achieve required changes in workforce numbers, composition and effectiveness

Areas of focus

- Assess changes required in workforce, including current state assessment, quantified gap and financial analysis
- Analyze options for workforce changes
- Develop plan for workforce development and implementation

Chair: Kathy Matt

Sponsor: Jill Rogers

Questions to address

	Key questions
Assessment of workforce requirements	▪ What workforce is required for future delivery model? ▪ What are some 'no regrets' workforce needs that will be required regardless of delivery model design?
Analysis of options for workforce changes	▪ What is the gap between today and future? ▪ Which enablers drive transformation?
Workforce development implementation plan	▪ What is the timeframe to deliver change?

DE's health care workforce today

Current workforce

- Above national average for PCPs, 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
  - 92 Psychiatrists per 100,000
- 49 schools, universities and colleges in the area (DE, NJ, PA and MD) offering 100 health care related programs

Known challenges

- Growing overall demand for health care leads to increased need for providers of all types
- New models of care delivery potentially require workforce changes
  - New roles (e.g., care coordinators)
  - New levels of practice (e.g., NPs practicing at the top of licensing level)
  - New skills (e.g., team based working, data analytics, new information tools)

Current workforce proposals (examples)

- Build infrastructure to collect and analyze workforce data
- Support state-of-the-art workforce education and training programs
- Ensure a supportive regulatory/policy environment (e.g., review licensure)
- Ensure integrated and supportive practice environments
- Create and implement a comprehensive workforce recruitment strategy

SOURCE: Delaware Health Care Commission Health Care Workforce Report; Health Care Workforce Recommendations, December 2012

PRELIMINARY

Flow of workforce requirements

Attraction and Retention	Training and Professional Development	Attrition and Retirement
▪ How many additional health care professionals does Delaware need to attract to meet growing demand? ▪ What are non-traditional sources for Delaware's health care workforce?	▪ What training will health care professionals require to implement new models of care? ▪ What capacity exists to provide training and development for active health care professionals?	▪ What proportion of health care professionals are retiring in the next five years? ▪ What are the key causes of attrition in Delaware?

For discussion

- What do you see as the most pressing health care workforce challenges for DE today?
- What training would be required to adjust to potential changes to the health care delivery model (e.g., coordination of care)?
- What is your vision for DE's health care workforce ten years from now?

Policy

Goals

- Identify opportunities to align state agencies, policies and purchasing to support care delivery and payment model changes

Areas of focus

- Assess requirements for policy, regulatory, and/or legislative changes
- Analyze options for policy changes
- Develop plan for policy change implementation, including technical advice into changes needed to achieve the State's vision

Chair: TBD

Sponsor: Brenda Lakeman

State health organizations

Organization	Mission	Divisions and Programs
Department of Health and Social Services	"To improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations"	▪ Child Support ▪ Developmental Disabilities ▪ Long Term Care ▪ Management Services ▪ Medicaid & Medical ▪ Public Health ▪ Services for Aging and Physical Disabilities ▪ Social Services ▪ Substance Abuse and Mental Health ▪ Visually Impaired
Health Care Commission	"[…] to develop a pathway to basic, affordable health care for all Delawareans"	▪ Delaware Health information network ▪ Community Healthcare Access Program ▪ Health workforce development ▪ Research and Policy development ▪ Specific issues
Health Resources Board	"To promote cost effective and efficient use of health care resources"	▪ N/A

SOURCE: Organization websites

State health organizations (cont'd)

	Mission	Divisions and Programs
State Employee Benefits Committee	▪ "Control and management of employee health care insurance, blood bank, life insurance; and all other benefit coverage"	▪ Active State employees and dependents ▪ Retired State employees and dependents ▪ Participating non-State groups
Governor's Council on Health Promotion and Disease Prevention	▪ "to advise state agencies on development and coordination of strategies, policies, programs and other actions statewide to promote healthy lifestyles and prevent chronic and lifestyle-related disease"	▪ Work Group 1 – *Support integrated consistent care* ▪ WG 2 – *Develop policy and funding* ▪ WG 3 – *Create an environment that supports health choice* ▪ WG 4 – *Educate for health*
Delaware Rural Health Initiative	▪ "Single voice for issues affecting rural Delawareans, and […] present approach to improving the health of Sussex County residents"	▪ N/A
Other DE organizations?	▪ TBD	▪ TBD

SOURCE: Organization websites

For discussion

- How are state agencies enabling or limiting delivery system innovation today?
- What are the priority policy needs for health system transformation?

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What we heard today

Next steps

- You will hear information about dates for the rest of the effort later this week
- Later this week we will also have information posted to the website

PRELIMINARY

Reminder: timing of key meetings