ChooseHealth DELAWARE

All-workstream stakeholder meeting

March 18th, 2014

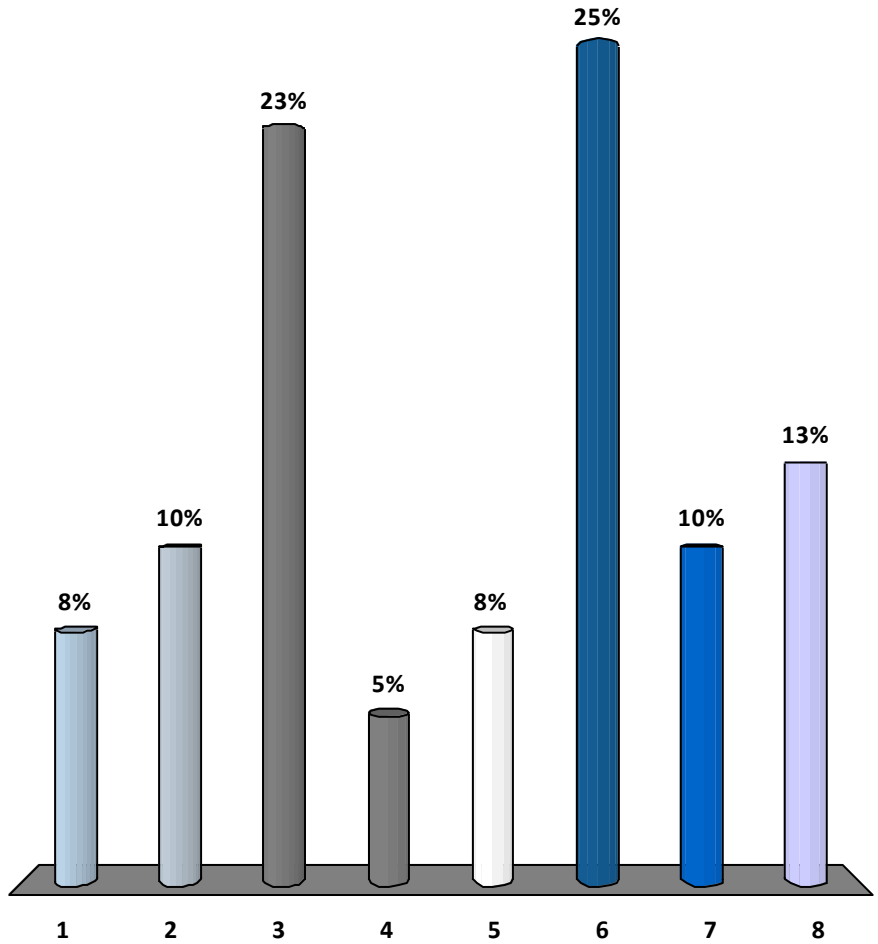
Agenda

Time	Topic
08:30-8:45	**Introduction**
08:45-9:15	Updates across workstreams
09:15-9:30	Q&A
09:30-9:45	*Break*
09:45-11:15	Clinical discussion
11:15-12:00	Data discussion

Welcome back: Who is in the room?

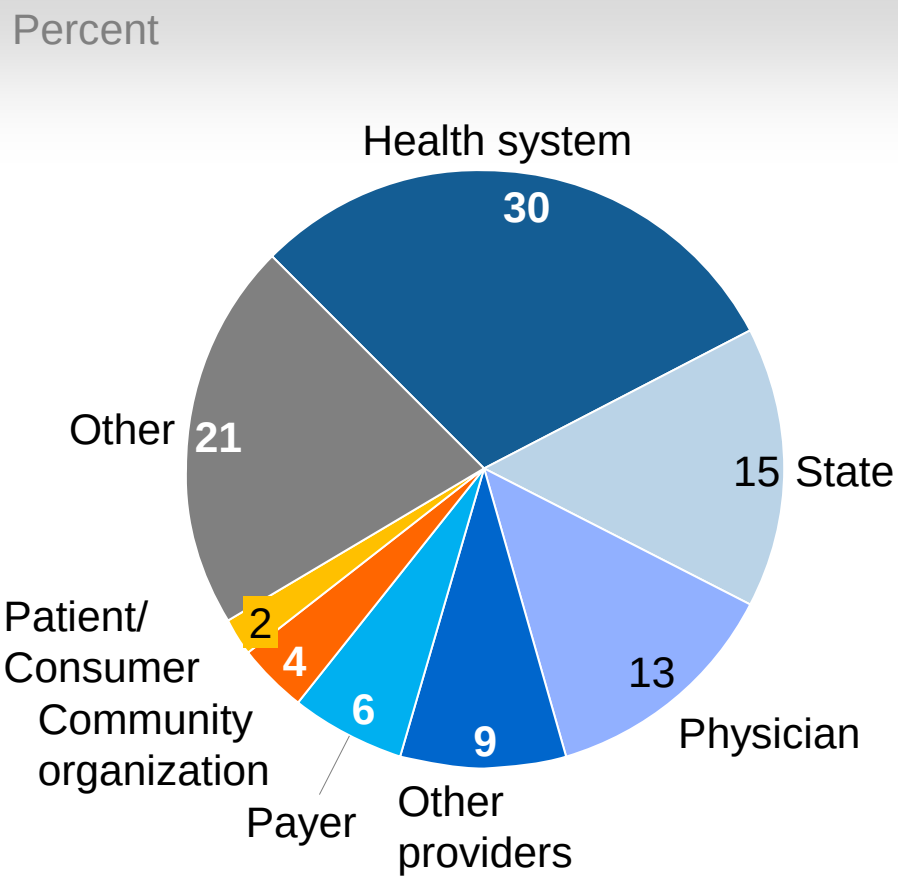
Which stakeholder group do you represent?

1. Patient/consumer
2. Physician
3. Health system
4. Nurses, behavioral health specialists and other providers
5. Community organization
6. State
7. Payer
8. Other



Our last cross-workstream meeting

Who was here



What we discussed

- Overall approach and timeline
- Feedback on the Innovation Center
- Workforce: ongoing innovation and needs, announcing the symposium
- Scorecard: types of measures, link to payment, and transparency

What has been happening

	Chair	Example current progress	Recent meetings
 **Overall**	▪ Rita Landgraf ▪ Jill Rogers	✓ Refined approach to Innovation Center	2/11 Cross-workstream 3/6 Health Care Commission
 **Delivery system**	▪ Alan Greenglass ▪ Rita Landgraf	✓ Drafted provider scorecards ✓ Launched and codified care coordination survey	3/4 Clinical working session
 **Population health**	▪ Lolita Lopez ▪ Matt Swanson	✓ Drafted Healthy Neighborhoods approach	3/11 Population health working session
 **Payment**	▪ Rita Landgraf, Steve Groff, (for Medicaid)	✓ Framed approaches to supporting coordinated care	3/17 Payment working session
 **Data and Analytics**	▪ Jan Lee ▪ Jill Rogers	✓ Identified data and analytics workflow options	To be scheduled
 **Workforce**	▪ Kathy Matt ▪ Jill Rogers	✓ Set up workforce symposium on Apr 8	Symposium April 8

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Delaware's Population Health Approach

Address statewide health challenges with local solutions, moving the needle on state health outcomes but recognizing that health needs and barriers differ by community

Build from ongoing successes of existing community organizations and focus interventions on priority needs

Create a supportive environment for individuals to make healthier choices and change behavior upstream of care delivery

Improve the ability of individuals to navigate resources and **increase coordination** between health systems and community initiatives

Healthy Neighborhoods Program – DRAFT

Healthy Neighborhoods program definition: A statewide program that will offer funding and resources for individual communities to build from successful existing initiatives and target priority health needs. Healthy Neighborhoods will:

1. **Convene forums** for community leaders to discuss local health needs
2. **Align on statewide priorities**, complemented with **local priorities and solutions**
3. **Assess existing resources**
4. **Facilitate targeted interventions** tailored to neighborhood demographics and needs
5. **Track performance**, annually publish outcomes, and communicate best practices

Resources offered to Healthy Neighborhoods will include:

- Dedicated **funding pool** for local population health interventions
- One dedicated **staff member** to administer and facilitate each neighborhood
- **Data/analytics support** to 1) help quantify and assess local health needs and 2) track health outcomes over time
- Support in building an **inventory** of Delaware's existing community health resources
- **Materials to guide** health programs, including needs prioritization frameworks and handbooks of potential interventions (evidence-based where available)

Draft roles for Healthy Neighborhoods

Statewide level

Healthy Neighborhoods Committee
(DE Center for Health Innovation)

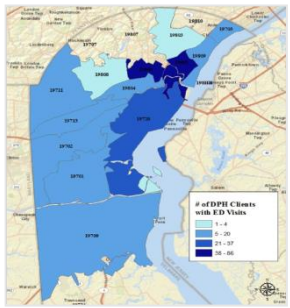
- Create program funding pool
- Oversee Neighborhood designation and grant renewals
- Set statewide priority health goals and scorecard

Division of Public Health

- Assist with data and infrastructure needs
- Share tools/resources to help prioritize goals/interventions
- Initiate inventory of existing community health resources

Healthy Neighborhoods Program Director

- Provide leadership and coordination across all neighborhoods
- Meet regularly with Healthy Neighborhood Coordinators



Healthy Neighborhood level

Healthy Neighborhood Council (~15 leaders)

- Identify 2-3 priority local health goals and interventions
- Populate and maintain database for existing resources
- Allocate funding among initiatives

Healthy Neighborhood Champion

- Chair Council meetings and promote the Neighborhood mission

Healthy Neighborhood Coordinator

- Set up Council and quarterly general forum meetings
- Apply for grants and manage distribution of funds
- Track progress against agreed scorecards and report outcomes

Some of our challenges going forward

- **Identifying existing organizations** with similar health goals and helping them to coordinate efforts
- **Addressing regions** in Delaware with limited community health and medical resources
- **Securing sustainable funding** to launch Healthy Neighborhoods
- **Setting up data and infrastructure** to identify priority health goals and track success
- **Refining how to fully leverage DPH resources** to support Healthy Neighborhoods

Workforce status update

Last time, we heard from the breakout session

The most important outcomes and programs you hope will result from the learning and development program. Including:

- Care coordinator definition, core competencies, best practices
- Recruitment and retention strategy for existing roles (e.g., RN, PCP)
- Community outreach and engagement

Brief update

- Workforce symposium RSVP link available on the CMMI website (space is limited): *http://dhss.delaware.gov/dhcc/*
- Currently working on defining roles for care coordinators, health coaches, community health workers for discussion at symposium and on initial strategy for workforce planning capacity

Agenda for workforce symposium – DRAFT

Welcome and overview of the day

How others have approached workforce transformation – what worked, what didn't

- Speakers from innovative programs outside of Delaware
- Roundtable discussions, Q&A: takeaways/learnings for Delaware

Break

Overview of the future workforce requirements in Delaware

- What delivery in 2018 needs to look like and what this means for today's workforce
- Healthcare Theatre simulations to illustrate scenarios where care coordination is beneficial
- The current workforce landscape in Delaware, and the journey to 2018

Lunch

Building the learning and development journey for select roles

- Breakout discussions
- Plenary report back and discussion
- Next steps and close

Stay tuned for announcement of the speakers!

Reception

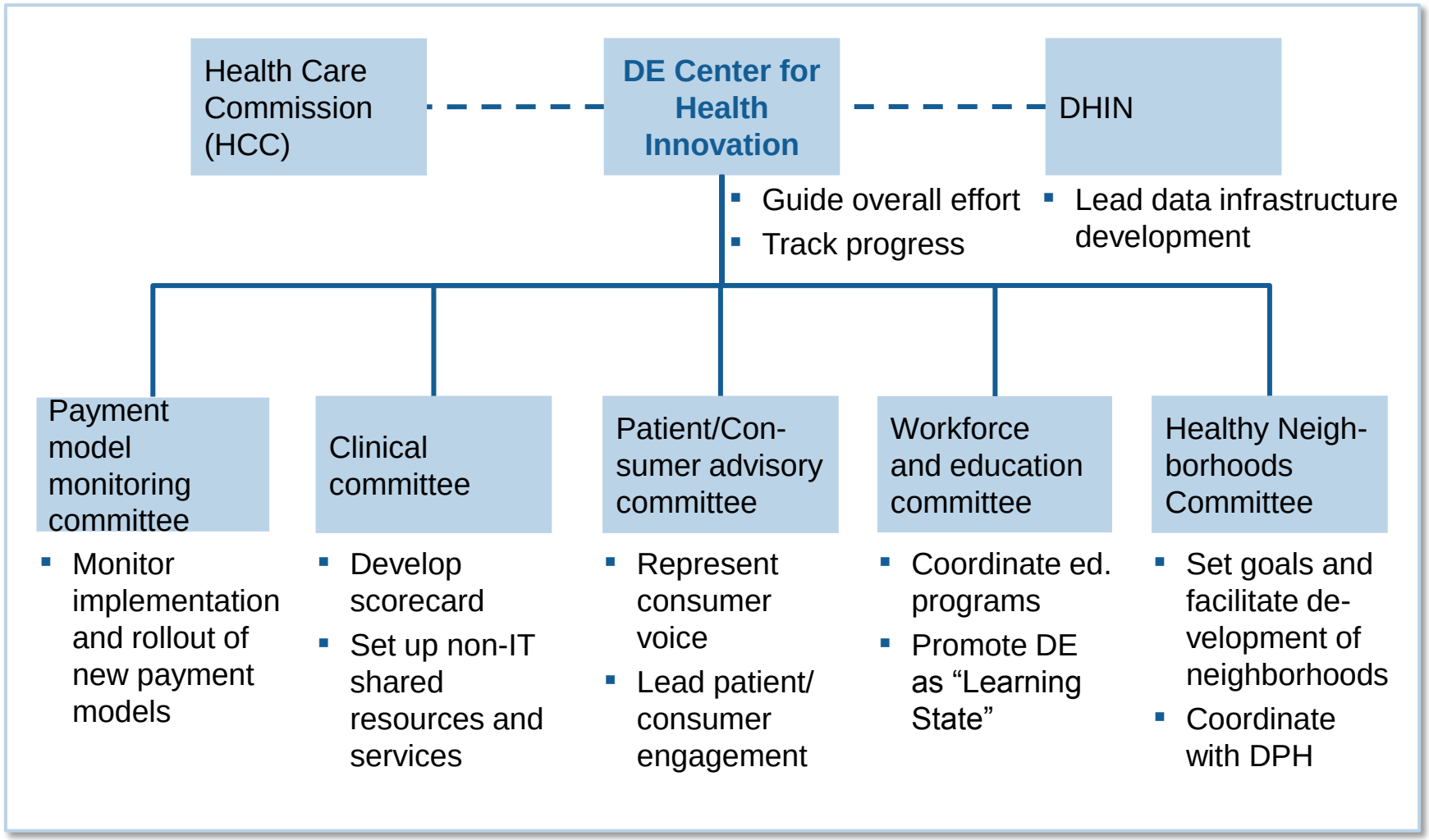
ILLUSTRATIVE

Payment update: Potential models of transforming care delivery

		"Upfront investment"	"Back-end rewards"
P4V[1]	A PMPM only	▪ PMPM care coordination fee	
	B PMPM + bonus payments	▪ PMPM care coordination fee	▪ Potential to earn bonus payments tied to quality and utilization
Total cost of care	C PMPM + shared savings	▪ PMPM care coordination fee	▪ Sharing in upside for savings on total cost of care
	D CPT payments + shared savings[2]	▪ CPT code for FFS payments for post-discharge care coordination	▪ Sharing in upside for savings on total cost of care
	E Shared savings only		▪ Sharing in upside for savings on total cost of care

1 Assumes that continuation of PMPMs will be contingent on performance as well as capabilities
2 Currently available through Medicare

Reminder: Innovation Center structure



Committee and Board roles/responsibilities

Payment model monitoring committee	▪ Define vision and core principles for payment model design ▪ Identify options for payment design consistent with these principles ▪ Identify approaches to funding delivery system transformation ▪ Monitor and report on the implementation and rollout of new payment models
Clinical committee	▪ Convene stakeholders to define priorities for delivery system transformation ▪ Recommend measures for common provider scorecard ▪ Define and launch shared resources and services, including clinical guidelines/protocols (e.g., for care coordination)
Patient/Consumer advisory committee	▪ Develop recommendations for patient/consumer engagement tools and campaigns ▪ Represent patient/consumer voice in stakeholder sessions
Workforce and education committee	▪ Coordinate education programs and workforce symposia ▪ Continue to identify education and training priorities for Delaware workforce ▪ Promote Delaware as a “Learning State”
Healthy Neighborhoods Committee	▪ Identify goals for Healthy Neighborhoods and select Neighborhoods for funding ▪ Monitor progress of Healthy Neighborhoods and provide technical assistance ▪ Coordinate with Division of Public Health
Board	▪ Review committee recommendations and recommend them to stakeholders ▪ Set measures to track and monitor implementation ▪ Recommend policy support from HCC if needed ▪ Ensure continued open, transparent, participatory process

Innovation Center: feedback you have shared

Composition of Board	▪ Ensure not government led ▪ Consider additional perspectives (e.g., on community health)
Authority	▪ Should engage in more than just monitoring (i.e., to ensure reach 80% in new models) ▪ Should not have authority to replace existing initiatives ▪ Ensure clinical components led by clinical experts
Appointments	▪ Consider nominating committee

Current perspective on Innovation Center role in transformation process

- Expectation is for participation on a multi-payer, multi-stakeholder basis
- Current belief that there is not widespread support for mandatory participation while we design and implement models that are still new
- Innovation Center role is to:
  - Put forward a consensus approach after broad input and consistent with core principles (i.e., builds from ongoing innovation)
  - Develop measures to monitor implementation across Delaware
  - Invite state to implement across its levers (e.g., Medicaid, state employees, public health)
  - Policy support from Health Care Commission
- Health Care Commission role is to continue to be the main policy and convening body for the state

Specific updates

- Innovation Center to be formed by DHIN
- Added additional members to Board
- Members recommended by Health Care Commission for first year
- Nominating committee to recommend members after first year

Innovation Center Board overview – DRAFT

Overview

- Board of 9-15 Directors, 2 non-voting Directors
- Board members must be knowledgeable about delivery, reimbursement, and/or regulation of health care services, community health, patient engagement, health education, or as a health consumer

Expertise required

- Board should include at least the following members
  - One member of patient or consumer groups
  - One practicing physician
  - One practicing non-physician clinician
  - Chair of the Health Care Commission
  - One member with expertise in hospital/health system administration
  - Secretary of the Department of Health and Social Services
  - One member with expertise in payor administration
  - One member with experience in administration of a community health provider
  - One member involved in purchasing health care coverage for employers
  - Director of the Office of Management and Budget
  - One representative of an institution of higher education
- Non-voting Directors
  - The Executive Director of the Board
  - The CEO of the DHIN

Timeline for Innovation Center (draft)

- Developed working approach
- Identified need for organizational approach and idea for Innovation Center

- Refining concept and structure
- Integrating feedback

- Staffing Innovation Center Board
- Developing website
- Establishing charters (meeting frequency, etc.)

"Go live" phase will depend on grant status

- With funding: hiring of Innovation Center staff
- Without funding: interim staffing through participating orgs
- Begin convening meetings

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Questions

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Approach for today

Goals by early April

- Complete round one drafts for non-technology shared services
  - Clinical guidelines
  - Care coordination support
  - Transformation support
  - Learning collaboratives
- Complete round one versions of common provider and overall system scorecards

Goals for today's discussion

- Refine approach to care coordination shared services
- Refine second draft of common provider scorecard

Care coordination shared service

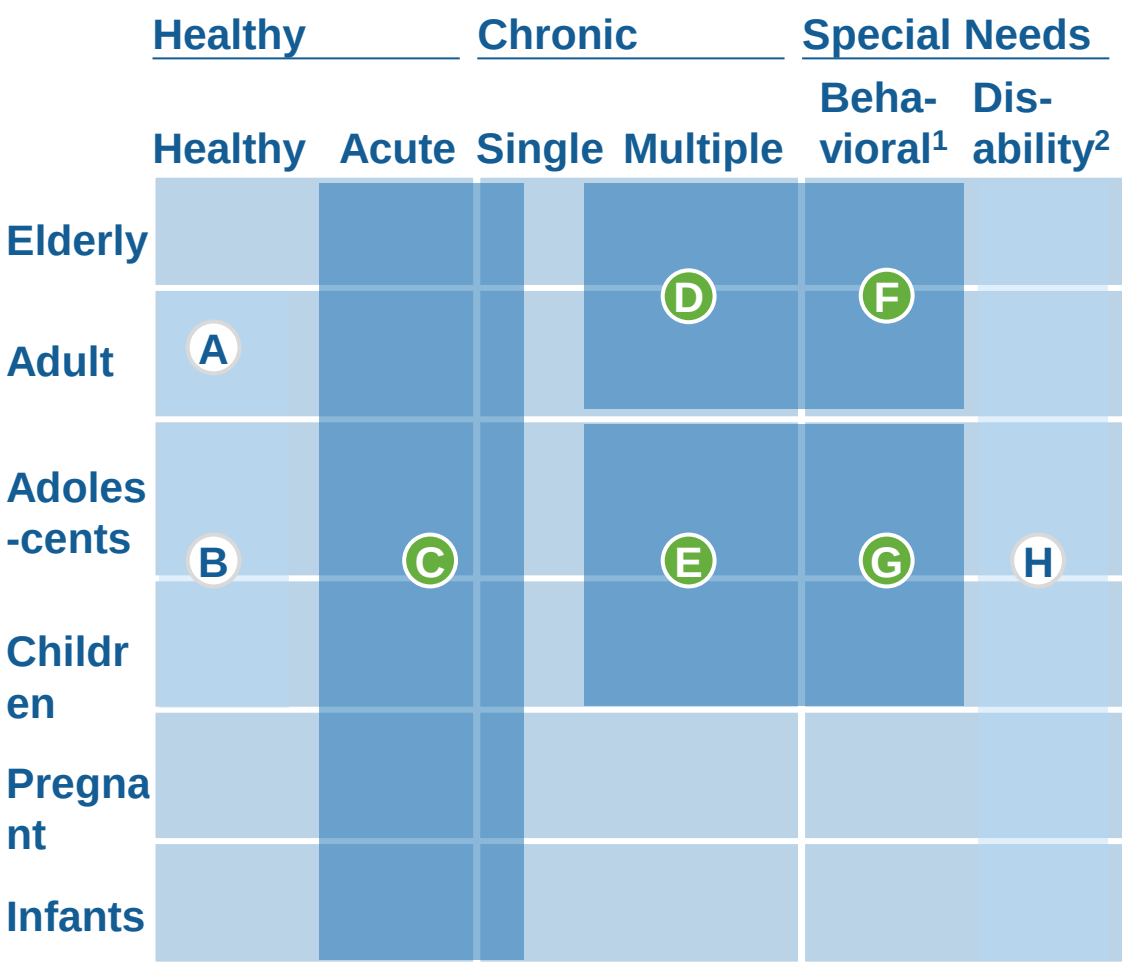
Feedback received so far

- Need for additional clarity about what **type of care coordination** we expect to develop in DE
- Preference for **building permanent skills, capabilities**, and care coordinator pipeline
- Desire for **integrated care that is more coordinated** (not just coordinated care)
- Optimize for **giving different provider types choice** in support they receive

Approach for building a CC shared service

1. What is the scope of care coordination?
2. What is the definition of integrated, coordinated care?
3. Who is accountable for delivering care?
4. Where does the care coordinator sit?
5. What do we mean by “sharing” care coordinators across practices?
6. What does this operating model mean in terms of capabilities providers will need?
7. What does that mean for supporting providers to get those capabilities within the current market structure?
8. What are the options for care coordination shared service?
9. How is it going to be funded?
10. How do we get the right information to all providers?

Reminder: scope for care coordination



Our focus

Example areas of focus

- A Prevention – adults
- B Prevention – youth
- C Effective diagnosis and treatment
- D Care coordination – adults/elderly
- E Care coordination - youth
- F Care coordination / health homes – adults/elderly
- G Care coordination / health homes – youth
- H Care coordination / health homes – special needs

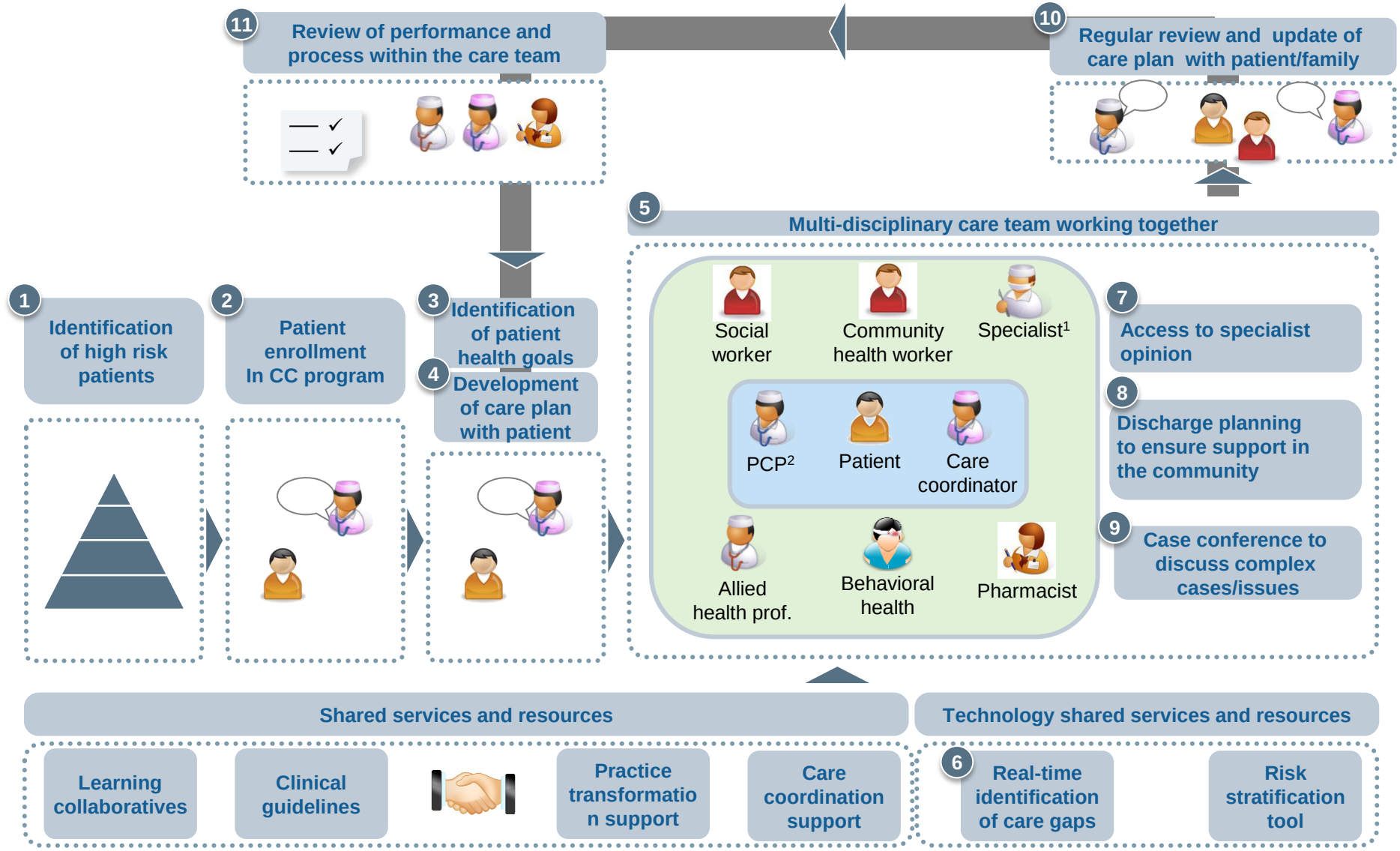
1 Includes mental health, addiction, substance abuse
2 Includes physical, mental and developmental disabilities

Care coordination activity landscape

Primary focus for delivery system

Type of coordination	Care focus	Population focus
High-intensity care coordination	▪ Patients with multiple complex medical and psychosocial needs	▪ Top 1% most complex, high risk
Longitudinal chronic care coordination	▪ Long-term coordination for chronic disease patients	▪ Top 5-15% high risk
Community coordination	▪ Getting patients access to primary care	▪ All
Episodic care coordination	▪ Acute episodes of care	▪ Generally healthy
Transition coordination	▪ Ensuring safe transitions (e.g., inpatient to outpatient, long-term care)	▪ All

Approach to integrated, coordinated care



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

Accountability for delivery transformation

- **Patients will have an attributed PCP to** promote **patients identifying with that practice/**provider and to enable outcomes-based payment
- PCP may be part of an independent practice, health system network, or ACO
- PCPs (and health system/ACO with whom they affiliate) will have **primary accountability for delivering integrated, coordinated care for their patients,** with expectation that this will occur **with support from dedicated care coordinators**
- **Value-based payment** will reward providers for better managing care and improving outcomes
- **Providers will have information and other shared services/tools** to support coordinated care

Other models we are examining

A	**North Carolina Community Care Networks**	▪ 14 nonprofit networks provide coordination ▪ Care managers monitor active case load of 150-200 patients each across practices and develop relationships with care team
B	**CareSupport of CareOregon**	▪ Multidisciplinary care mgmt. teams operate from central location to support highest risk patients across state ▪ Social workers act as BH case managers
C	**Vermont Community Health Teams**	▪ Teams include nurse coordinators, social workers, CHWs ▪ CHTs work closely with and in providers' practices across a specific region to provide coordinated care to patients
D	**SouthCentral Foundation**	▪ Primary care teams in each practice provide coordination for medical/ behavioral health patient needs ▪ Patient-selected PCP, BH consultant, dedicated nurse CC
E	**Bangor Beacon Community**	▪ Network of tech. supported nurse coordinators helping high-risk/cost patients with long-term chronic diseases ▪ Combination of EMR and home health monitoring systems
F	**Col. Children's Healthcare Access Program**	▪ Centrally located team provides support services, including care coordination, a resource hotline, and Medicaid billing assistance to practices for Medicaid pediatric patients
G	**Torbay & Southern Devon Health & Care NHS Trust**	▪ Multi-disciplinary care teams (spanning health and social care) ▪ Care coordinator role and individual care plans introduced ▪ Rapid response team and investment in intermediate care
H	**Tower Hamlets Primary Care Networks**	▪ GP practices organized into networks with a hub providing diagnostics, outpatient appointments, urgent, out-of-hours care ▪ Patients cared for by nurses working with GPs/others in MDTs

SOURCE: Commonwealth Fund case studies, CareOregon, SouthCentral Foundation, CCHAP

Straw poll on location of care coordinator

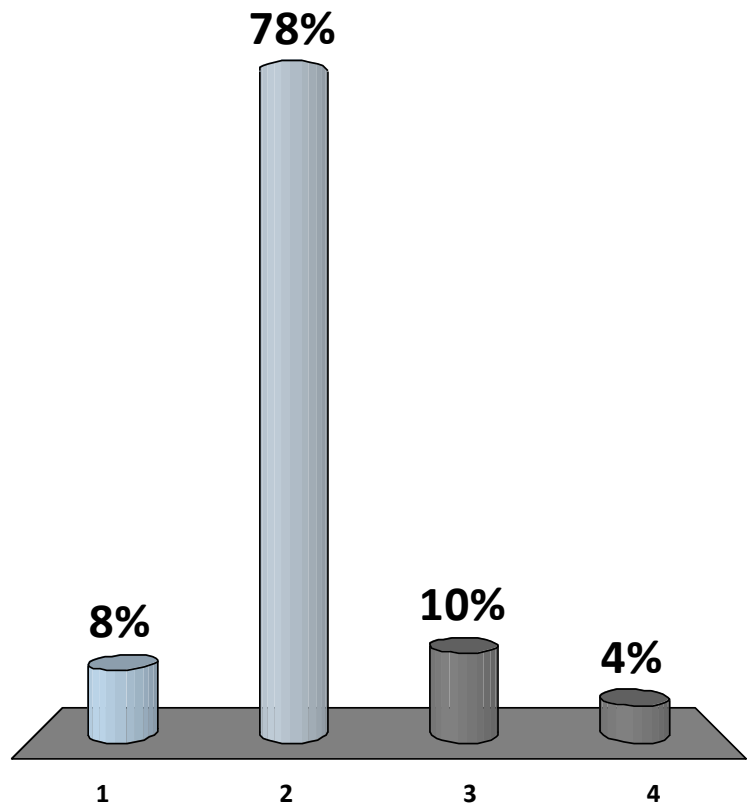
	Description	Votes (percent)
CCs[1] in all practices	▪ Coordinators are embedded and in-person for all types of provider organizations/ practices	▪ 24%
CCs shared across multiple practices	▪ Coordinators in-person and over phone but shared across panels of multiple provider organizations/ practices	▪ 56%
CCs in large practices, by phone for smaller	▪ Coordinators are in-person for larger practices (e.g.,>10 providers) and by phone for small (e.g., <10 providers)	▪ 20%
CCs only by phone for all	▪ Care coordinators are by phone for all practices	▪ 0%

1 Care coordinators(CCs)

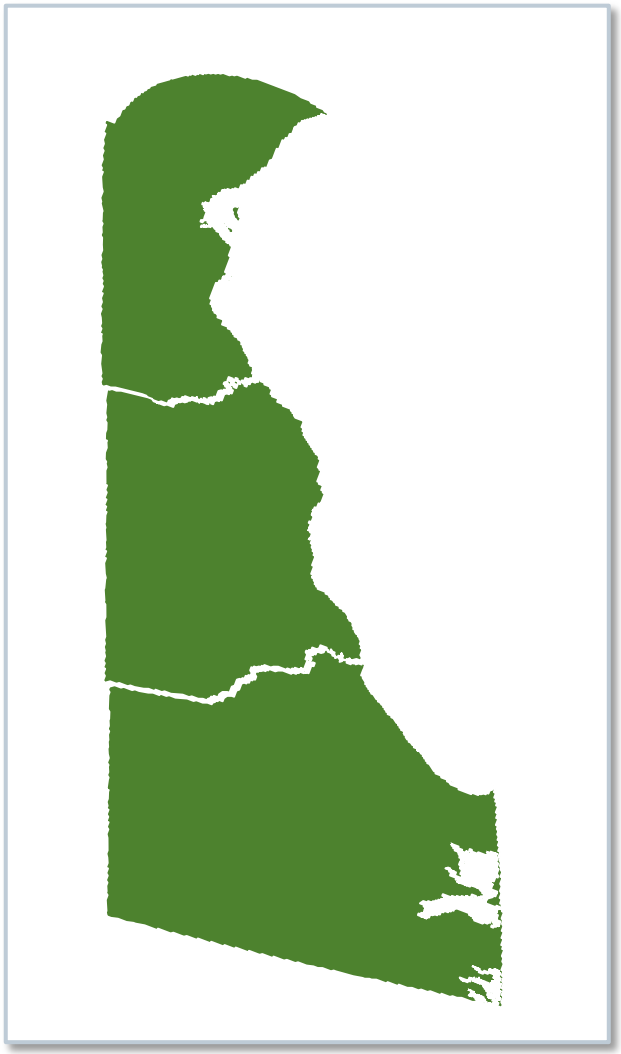
Care coordination operating model

Which model do you think is best for DE?

1. Care coordinators in all practices
2. Care coordinators shared across multiple practices
3. Care coordinators in large practices, by phone for smaller
4. Care coordinators only by phone for all



Reminder: A closer look at Delaware's market structure



- Provider landscape is **both concentrated and fragmented**
  - **~80% of DE physicians[1]** work in small practices (i.e., <5 physicians)
  - **~75% of DE primary care physicians[1]** are in small, independent practices
  - **Six private health systems** state wide (including a children's hospital), VA hospital, and three community health centers
- **Landscape varies significantly across geographies** (e.g., PCP density by county)
- Lots of **ongoing activity** (not exhaustive)
  - PCMH pilots (e.g., MSD/Highmark PCMH)
  - Clinically integrated hospital networks
  - ACOs

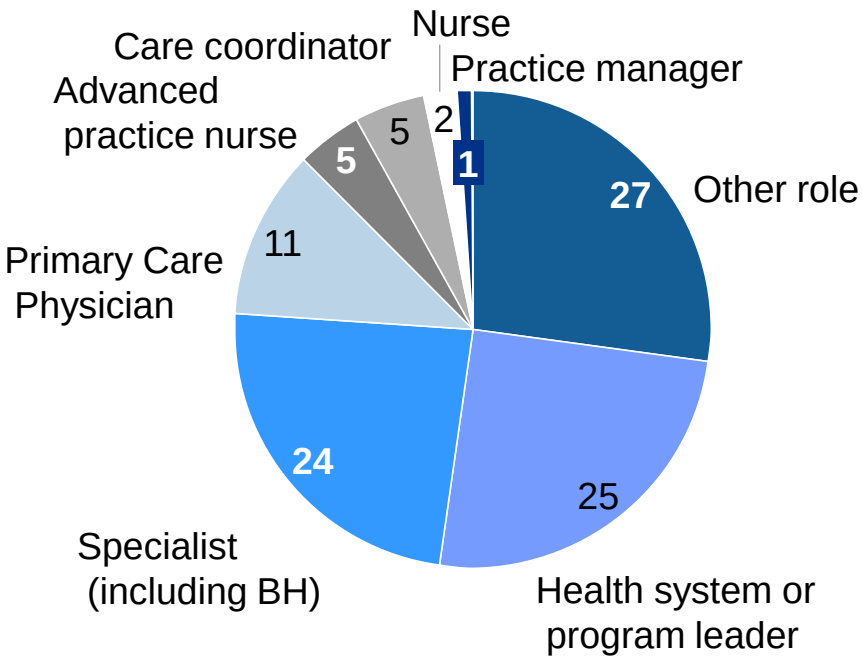
1 SK&A physician database, May 2013

Care coordination survey overview

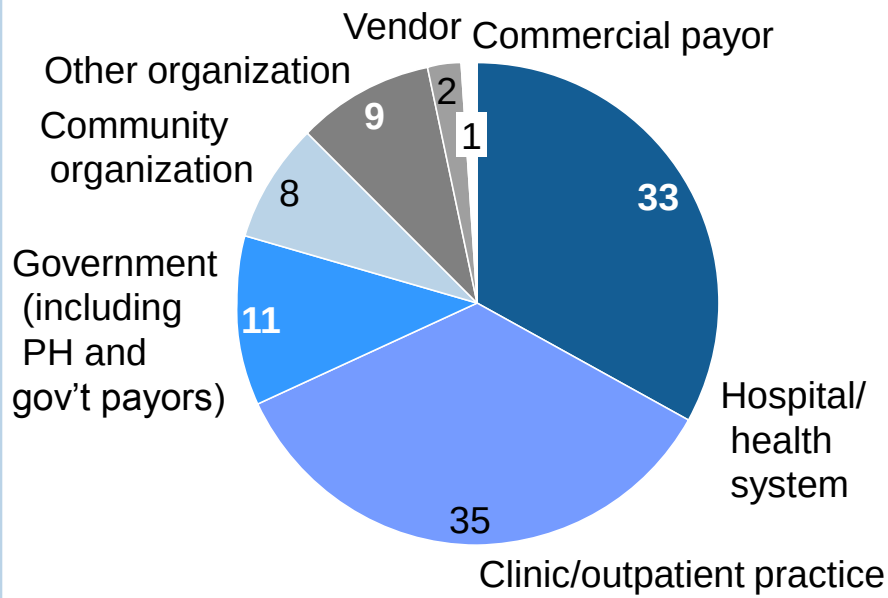
Initial numbers

- 88 completed responses
- Respondents came from 63 unique organizations (including 23 anonymous ones)

What is your role?



What type of org. do you work for?



1 Includes 23 anonymous organizations

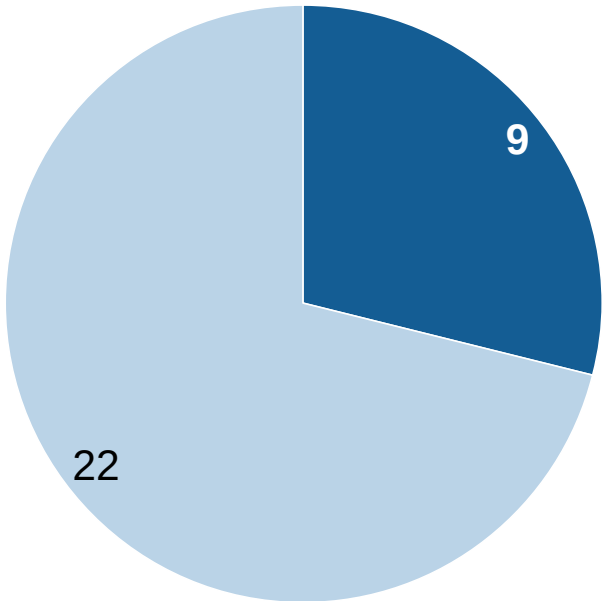
SOURCE: CC survey

Initial results: formal coordination programs

Have a formal CC program | Do not have a formal CC program

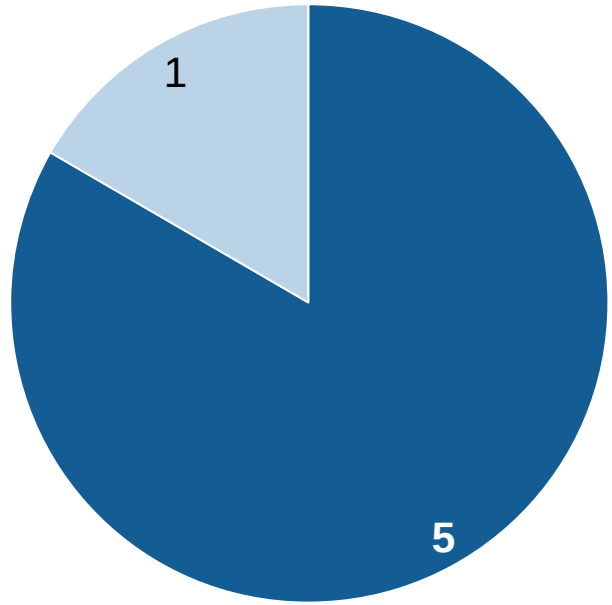
Clinics/outpatient practices

Number of unique respondents



Hospitals/health systems

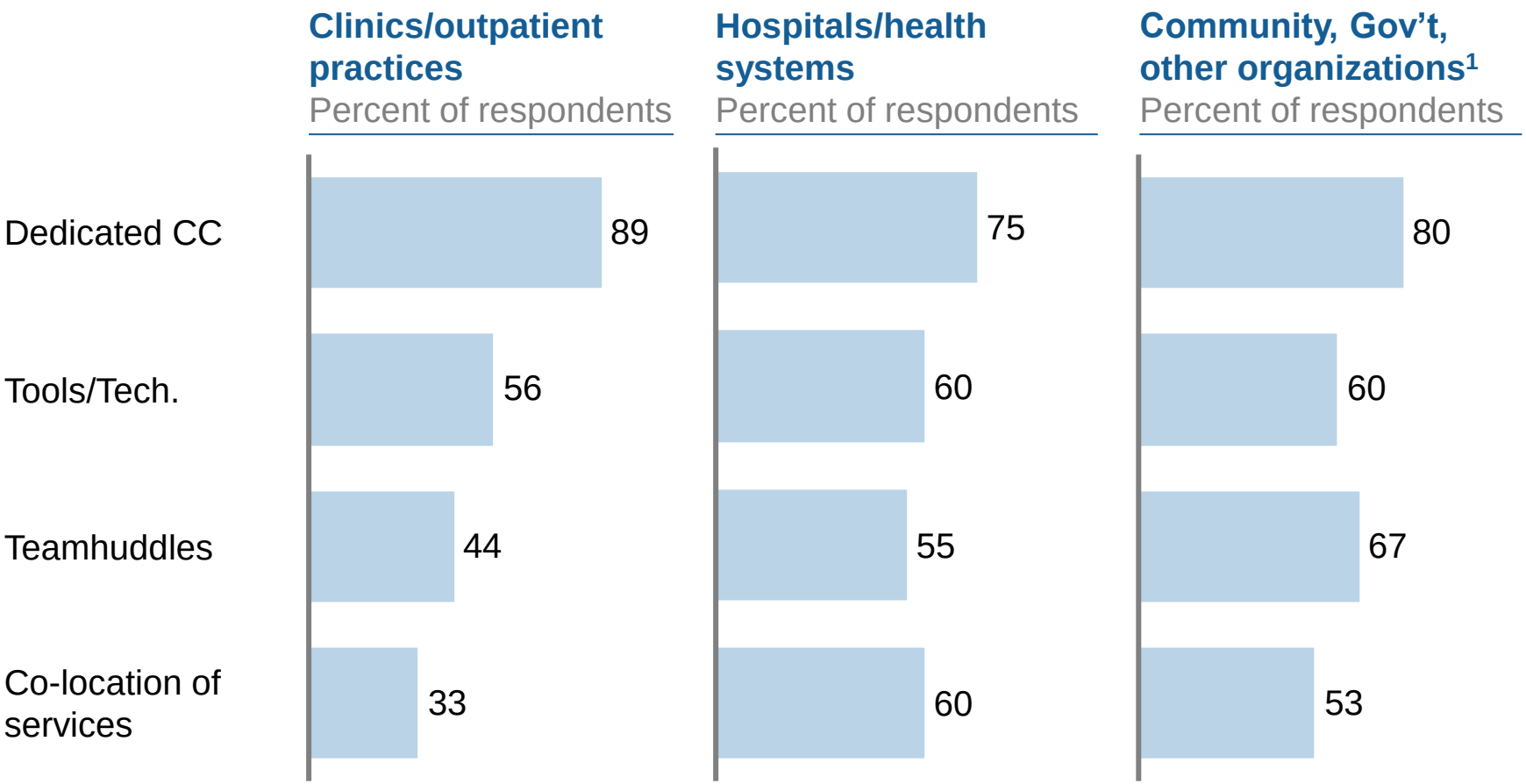
Number of unique respondents



SOURCE: CC survey

Initial results: approach to coordination

For respondents saying "yes" to having a formal program

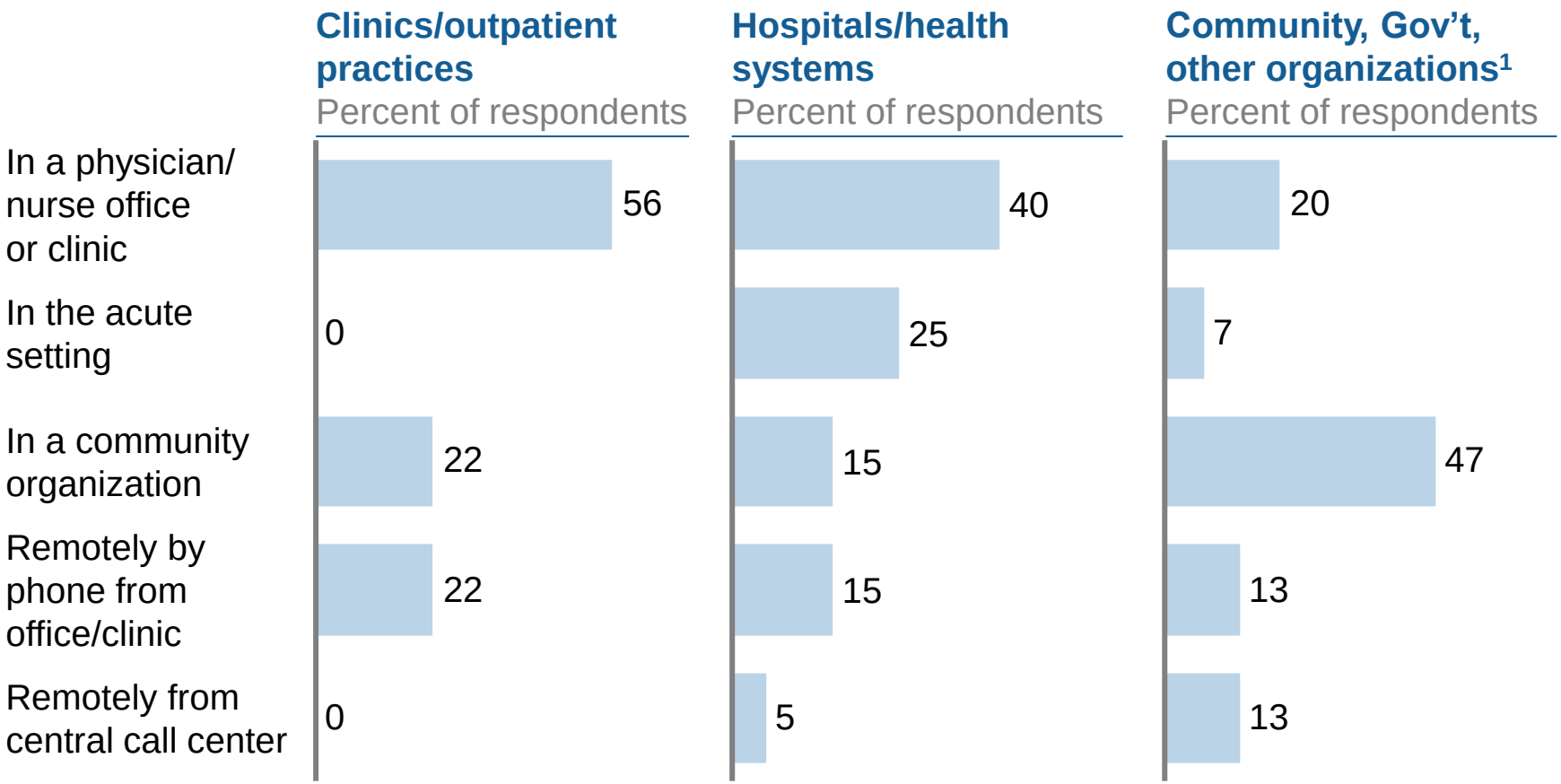


1 Includes community organizations, government organizations, public/private payers, vendors, and anyone who responded with 'other organization' in the survey

SOURCE: CC survey

Initial results: location of engagement with patients

For respondents saying "yes" to having a formal program

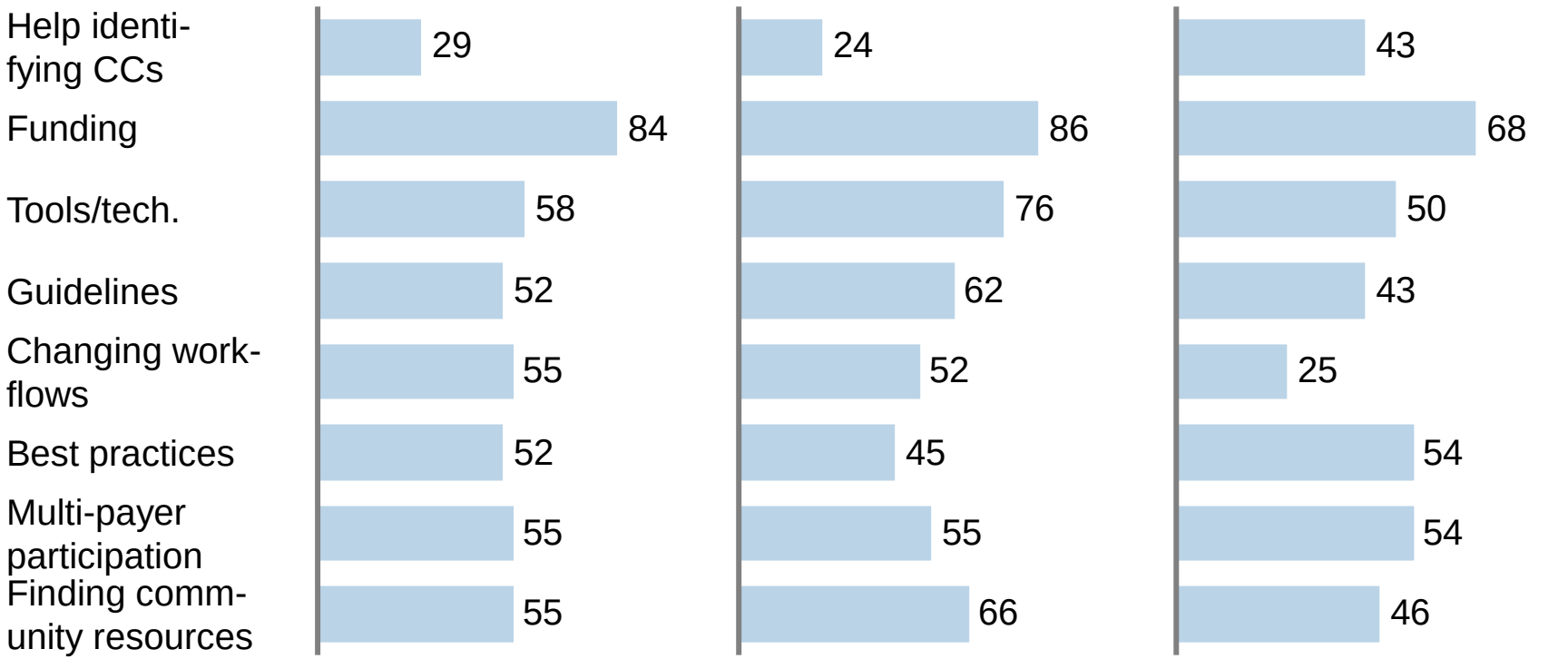


1 Includes community organizations, government organizations, public/private payers, vendors, and anyone who responded with 'other organization' in the survey

SOURCE: CC survey

Initial results: services to support CC

For respondents saying "yes" to having a formal program

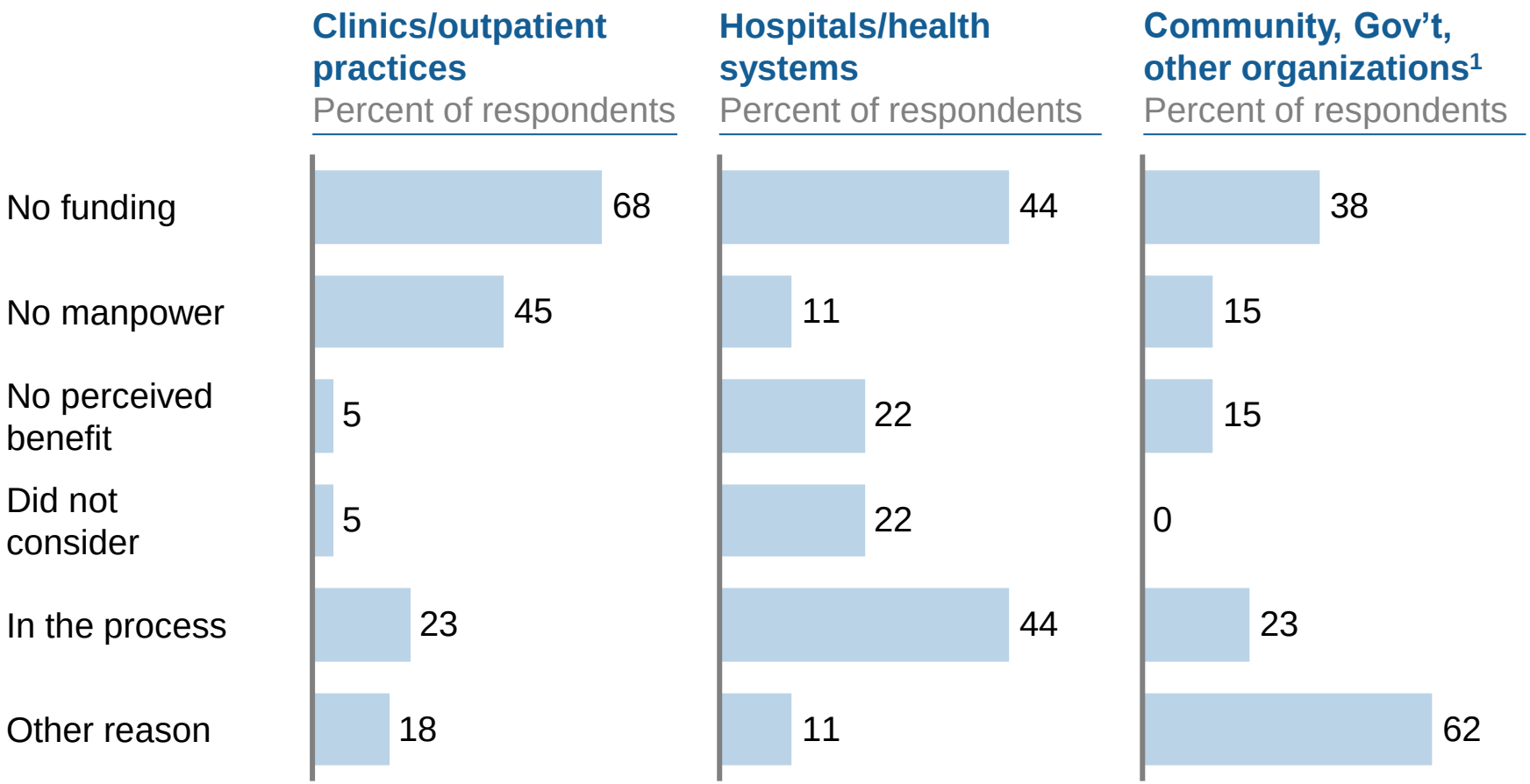


1 Includes community organizations, government organizations, public/private payers, vendors, and anyone who responded with 'other organization' in the survey

SOURCE: CC survey

Initial results: reasons for not doing CC

For respondents saying "no" to having a formal program



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SOURCE: CC survey

Care coordination shared service (first draft)

Given DE provider needs

- **Access** to care coordinators
- **Expertise**/coaching to implement care coordination elements
- Help with **sharing** care coordinators and finding practices to share with
- **Specialized services** for top 1% complex patients
- Support for **working in multidisciplinary teams**

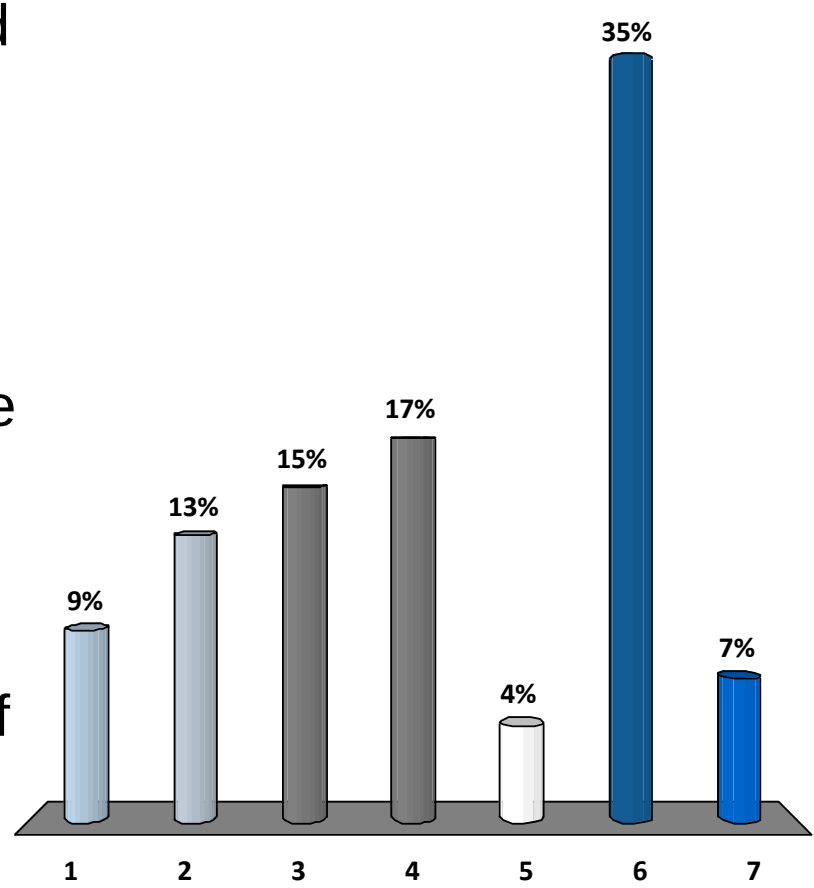
Menu of shared services

1. Certification of care coordinators
2. Training to integrate coordination and coordinator into practice flows
3. Support for sharing a care coordinator across practices (e.g., match-making service)
4. Central care coordinator team/service to provide specialized services
5. Facilitating team huddles across not co-located providers

CC shared service options

What is the highest priority shared service for DE providers

1. Certification of care coordinators
2. Training to integrate coordination and coordinator into practice flows
3. Support for sharing a care coordinator across practices (e.g., match-making service)
4. Central care coordinator team/service to provide specialized services
5. Facilitating team huddles across not co-located providers
6. Market place to choose any and all of these
7. None of them



Three scorecards for Delaware

Focus for today

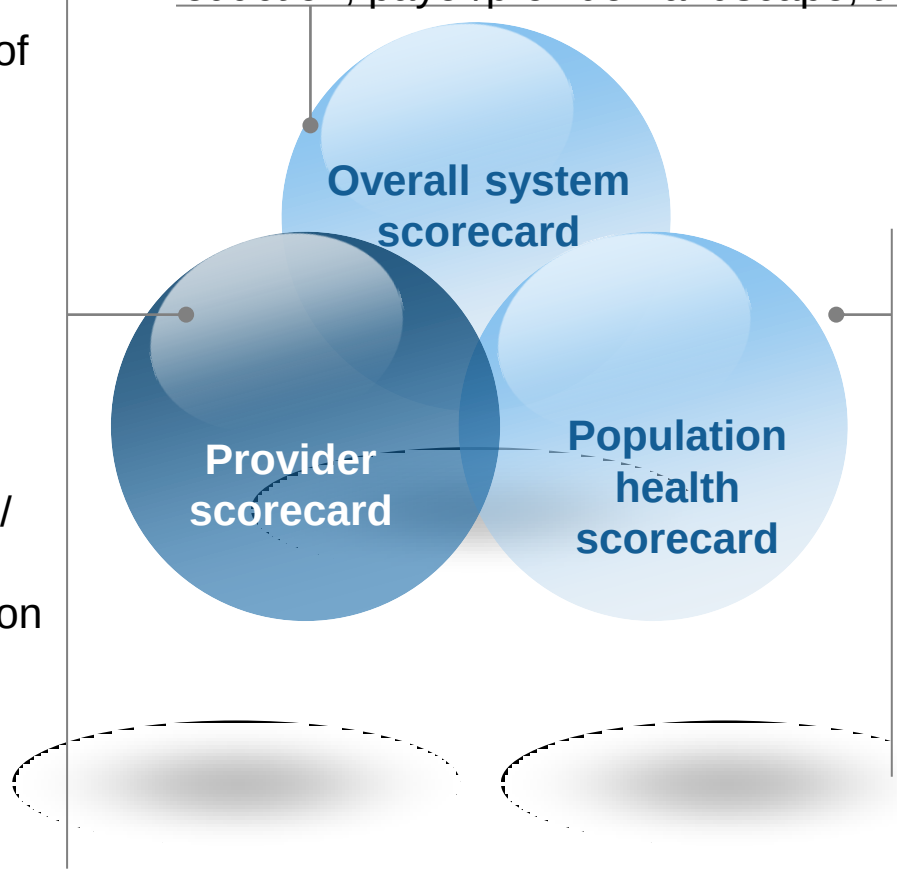
Purpose: Ensure statewide progress toward Triple Aim and transformation goals

Content: Health improvement, quality/effectiveness, cost reduction, payer/provider landscape, transformation

Purpose: Provide a simple, common set of measures to

- Measure practice progress vs. Triple Aim and transformation
- Enable outcomes-based payment models

Contents: Measures/ milestones on Triple Aim and transformation



Purpose: Measure rollout of healthy neighborhoods and local progress on priority population health indicators

Content: Priority health improvement/ quality of care/patient access to care measures for each neighborhood

Common provider scorecard approach

Approach

- **Common to all providers participating in new population-based payment models**, but not to every provider specialty
- Small set of measures **focused on Triple Aim and transformation**, with initial focus on primary care
- Robust enough **for payers to use in outcomes-based payment model**
- Include **measures that are risk-adjusted** to further incent better care for high-risk patients
- Allow users to see their performance and **compare to that of peers**
- Include follow-on drill-down pages that **help providers understand drivers of performance** on each measure

Feedback received so far

- Lay out scorecard principles/ approach
- Consider moving overall population/state-level metrics
- Initial emphasis on transformation/process quality measures
- Consider having 2-3 areas the whole state is trying prioritize
- Think about having measures that are population specific (e.g., pediatrics)
- Set targets that are ambitious, but realistic

Draft provider scorecard (second draft)

Domain	Category	Metrics
Care improvement	Quality/ effectiveness of care – outcomes	▪ Diabetes Care: HbA1c control (< 8.0%) ▪ Ischemic Vascular Disease: Lipid Profile and LDL control <100 ▪ Controlling High Blood Pressure (i.e., BP was adequately controlled <140/90 during the measurement year)
	Quality/effective-ness of care – process	▪ Use of appropriate medications for people with asthma ▪ Screening for Clinical Depression and Follow-Up Plan ▪ Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention ▪ Weight screening and follow-up ▪ Pneumonia vacc. status for Older adults ▪ Colorectal Cancer Screening ▪ Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
	Quality– structure/ transformation	▪ Transformation milestones over the initial years of the program
	Patient experience	▪ CAHPS survey (or survey with equivalent measures)
Cost reduction	Total cost of care	▪ Risk adjusted, total cost of care
	Utilization	▪ Inpatient admissions per 1000 patients ▪ ED visits per 1000 patients ▪ Hospital All-Cause Unplanned Readmissions, Risk Adjusted ▪ Hospital ED Visit Rate that did not Result in hospital admission

Since the last draft

- **Added 5 metrics** to quality/ effectiveness of care and to cost/ utilization
- **Added transformation metrics/ milestones** section which small group is working on
- **Removed health outcomes section** because feeling that it is beyond control of providers and may belong on overall system scorecard

Scorecard prioritization activity

Goal

- Refine second draft of scorecard

Approach

- **Poster activity (15 min):**
  - You have 6 green dots and 6 red dots to allocated across all areas which means you will have to prioritize
  - Place a green dot in “yes” if measure is one of the top that should be on the score card
  - Place a red dot in “no” if measure is lower priority or should be removed
  - For now, please do not vote based on technical feasibility or specifications (e.g., HbA1C < X%, adult vs. children weight screening)
- **Report back and reflect (10 min)**

Discussion: Outcomes quality measures

	Metrics	Yes	No
What's on this draft	Diabetes Care: HbA1c control (< 8.0%)	17	0
	Ischemic Vascular Disease: Lipid Profile and LDL control <100	10	0
	Controlling High Blood Pressure (i.e., BP was adequately controlled <140/90 during the measurement year)	17	1
What's commonly used but not on this draft	Diabetes Composite: Tobacco Non-Use (i.e. percent of patients identified as non-users)	1	4
	Daily Aspirin or Antiplatelet Medication Use for Patients with Diabetes and IVD	1	5
	Cesarean Rate for Low-Risk First Birth Women	0	5
What's not commonly used, but interesting	Elective Delivery Prior to 39 Completed Weeks Gestation	4	6
	Healthy Term Newborn	4	6

Discussion: Process quality measures

	Metrics	Yes	No
What's on this draft	Use of appropriate medications for people with asthma	3	0
	Screening for Clinical Depression and Follow-Up Plan	17	5
	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	11	3
	Weight screening and follow-up	14	
	Pneumonia vacc. status for Older adults	0	3
	Colorectal Cancer Screening	1	1
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	0	0
What's commonly used but not on this draft	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	0	2
	Childhood Immunization Status	4	1
What's not commonly used, but interesting	Low Back Pain: Appropriate use of Imaging Studies	5	11
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	1	0
	Screening for SPMI	2	2

Discussion: Cost/utilization measures

	Metrics	Yes	No
What's on this draft	Inpatient admissions per 1000 patients	6	4
	ED visits per 1000 patients	15	3
	Hospital All-Cause Unplanned Readmissions, Risk Adjusted	6	3
	Hospital ED Visit Rate that did not Result in hospital admission	10	2
	Risk adjusted, total cost of care	3	0
What's commonly used but not on this draft	Admissions for ambulatory care sensitive conditions	1	0
	Generics dispensing rate/ratio	3	14
What's not commonly used, but interesting	Diabetes Long-Term Complications Admission Rate	2	0
	Chronic Obstructive Pulmonary Disease Admissions	3	1
	Bacterial Pneumonia Admission Rate	0	1
	Adult Asthma Admission Rate	1	1

Agenda

Time	Topic
08:30-8:45	Introduction
08:45-9:15	Updates across workstreams
09:15-9:30	Q&A
09:30-9:45	*Break*
09:45-11:15	Clinical discussion
11:15-12:00	**Data discussion**

Agenda for data discussion

- Review approach to data workstream
- Discuss provider reporting
- Discuss provider reporting timeline

Reminder: Near-term data goals

Category	Questions to answer
Approach to data infrastructure	How will we organize ourselves as stakeholders to deliver the necessary data infrastructure for healthcare innovation in Delaware?
Payer analytics and report design	What is the required functionality of payer analytics and reporting in order to launch new payment models in Delaware?
Provider performance reporting tool	What connectivity is required between payers and providers to deliver provider reports covering quality and cost?

Data inputs from other workstreams

NOT EXHAUSTIVE

	Example input into data workstream	Data workstream responsibility
Payment workstream	Develop payment algorithm guidelines	Develop infrastructure to enable delivery of scorecards with quality, metrics, total cost of care, and payment calculations
Clinical workstream	Develop provider scorecard metrics	
Pop. health workstream	Develop Healthy Neighborhoods scorecard	Identify potential sources of data and infrastructure needed to support launch and monitoring of Healthy Neighborhoods program
Innovation Center	Define statewide scorecard metrics	Develop infrastructure to enable aggregation and reporting of program-level metrics

Working approach for data infrastructure

Stages of development	Business requirements	Technical requirements	Technical design
"Host" workstream (e.g., payment)	▪ Develop business requirements and use cases	▪ Clarify and refine requirements ▪ Assist with platform selection	▪ Provide necessary technical contacts to validate design
Data workstream	▪ Iteratively refine business requirements with host workstream in working group sessions	▪ Develop technical requirements ▪ Evaluate and select potential solutions	▪ Develop technical design ▪ Validate design with stakeholders

Full implementation and launch will require funding sources, owner, and project management

Data "lives" in many different places in Delaware

NOT EXHAUSTIVE

Provider clinical data

- Various EHR systems
- 40% of providers still use paper records for some clinical results

DHIN connectivity for ADT, radiology, pathology, and more

DHIN
Delaware Health Information Network

- Health care provided to Delawareans
- Delawarean health outcomes

Payer claims data

- Medicaid (separate reporting by fee-for-service and managed care)
- Medicare
- Commercial (with payer-specific systems)

Working to understand how data flows among these stores in Delaware

Public health data

- Data stores
  - Division of Public Health (vitals, vaccination registry, numerous other stores in DE Health Statistics Center)
  - Federal/national databases

Guiding principles for design

Principle	Description
Cost	▪ DE will seek to implement a cost-effective solution
Speed to implement	▪ DE will implement a solution with: – Critical functionality for payment launch by Q3 2015 – Desired or enhancing provider and payer functionality rolled out in phases after initial launch
Provider empowerment	▪ Providers will have clear and timely information to report on and understand their own activities and performance
Long-term HIE integration	▪ DE will make technical decisions that will facilitate integration with the existing HIE in the long term where appropriate
Seamless user experience	▪ Providers should have a seamless, Delaware-branded experience (e.g., single sign-on, despite potentially varying back ends)

Stages for provider reporting

PRELIMINARY

Focus for today's discussion

	Launch	Scale-up	Sustain
Patient need	▪ Accountability for quality of care in new payment model	*Advanced understanding of and transparency into summary data across a patient panel to support and focus quality and cost improvements across the health system*	*Advanced ability to support quality and cost improvements through analytics at a level deeper than aggregate performance*
Provider need	▪ Quality reporting data and total cost across providers for patients ▪ Data to enable participation in new payment model		
Payer need	▪ Ability to evaluate provider performance in new payment model		
Potential tools	▪ **Provider reporting by payer**	▪ **Scorecard aggrega-ted across payers**	▪ **Capability to analyze clinical and financial data across payers**

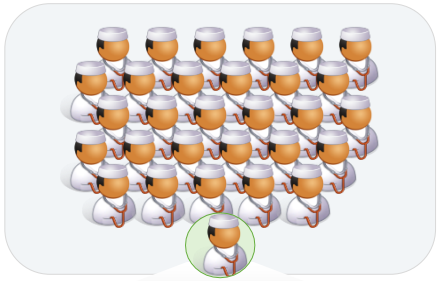
Provider reporting: Summary

PRELIMINARY

- Focus for payer-provider connectivity has been on **reporting infrastructure necessary to launch the new payment model in 2015**
- Intended connectivity is **between all commercial and government payers and providers** in Delaware
- Reporting infrastructure will seek as much as possible to **leverage existing tools and infrastructure**
- To execute on the common scorecard from the clinical workstream, providers will need to **supply aggregate data on key metrics on a quarterly basis** (e.g., % of diabetic patients with Hemoglobin A1c level below X%)
- Reporting infrastructure will allow payers to **deliver static reports to providers on a quarterly basis**

Provider reporting: Detail

PRELIMINARY



Provider A

1. Record key quality and practice transformation metrics (as defined in clinical workstream)

2. Supply aggregate quality and practice transformation metrics

5. Quality and cost reports

Payer X

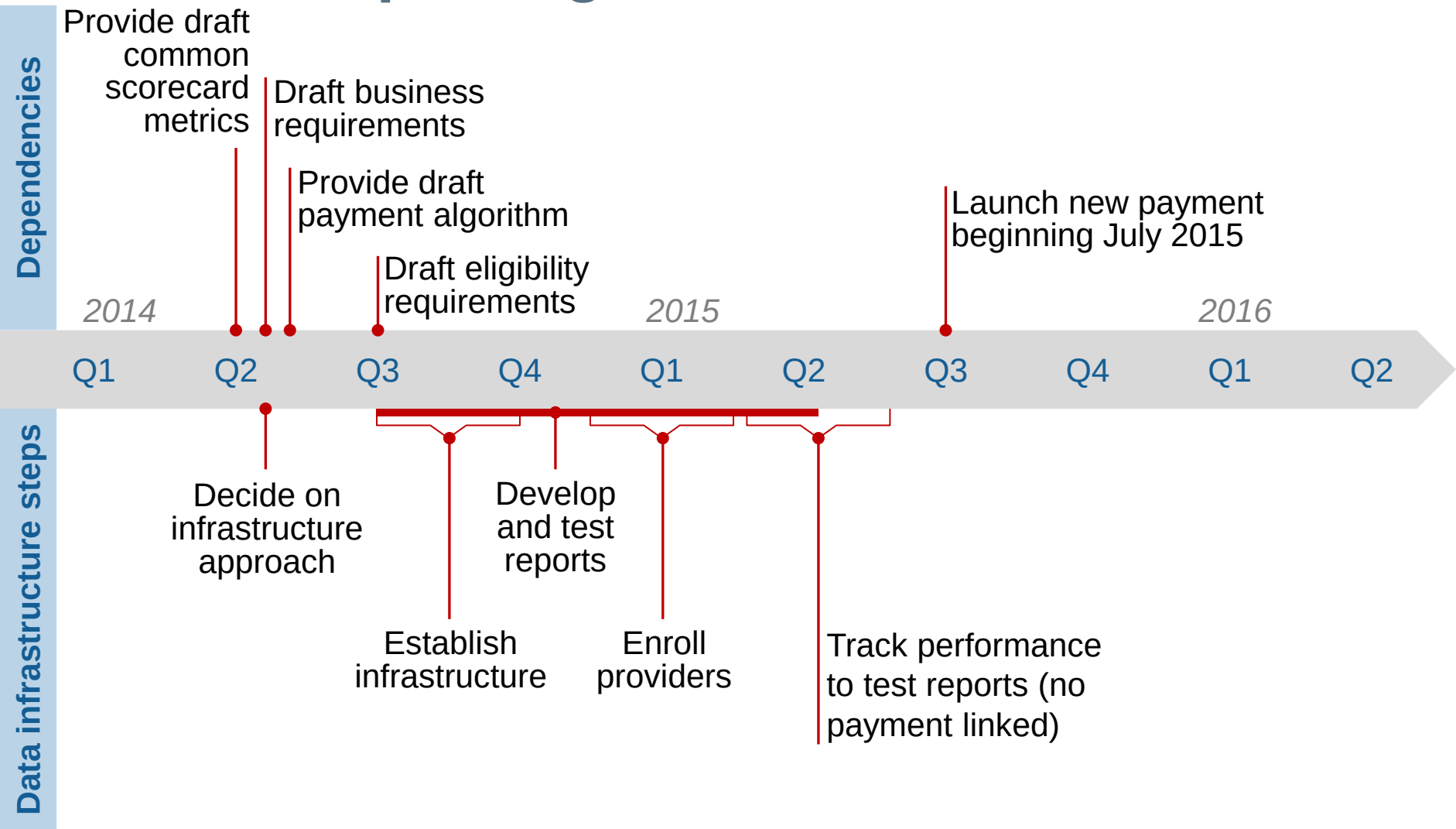
3. Aggregate quality metrics from provider and cost/quality metrics from claims
4. Calculate total cost of care minus exclusions

Payer Y

Payer Z

Data infrastructure timeline: Provider reporting

PRELIMINARY



Example quality metric for reporting

PRELIMINARY

Hemoglobin A1c (HbA1c) Control (<X%)

Description

- The percentage of members 18 - 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <X% during the measurement year

Calculation

HbA1c Control (X%) = Members whose HbA1c level is <X% during the measurement year / Members 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year

How does your organization currently record this or similar metrics?

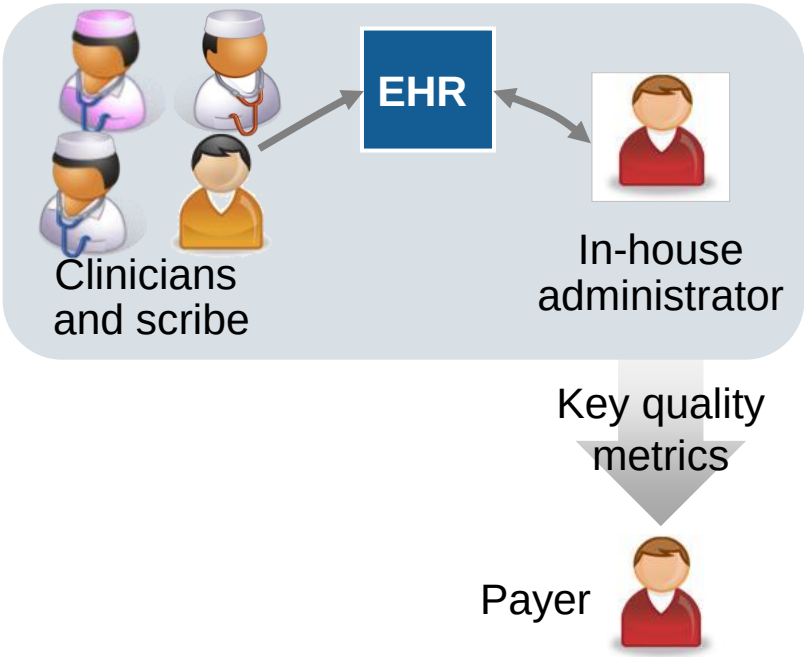
SOURCE: National Quality Foundation Quality Forum

Potential approaches to provider data submission

FOR DISCUSSION

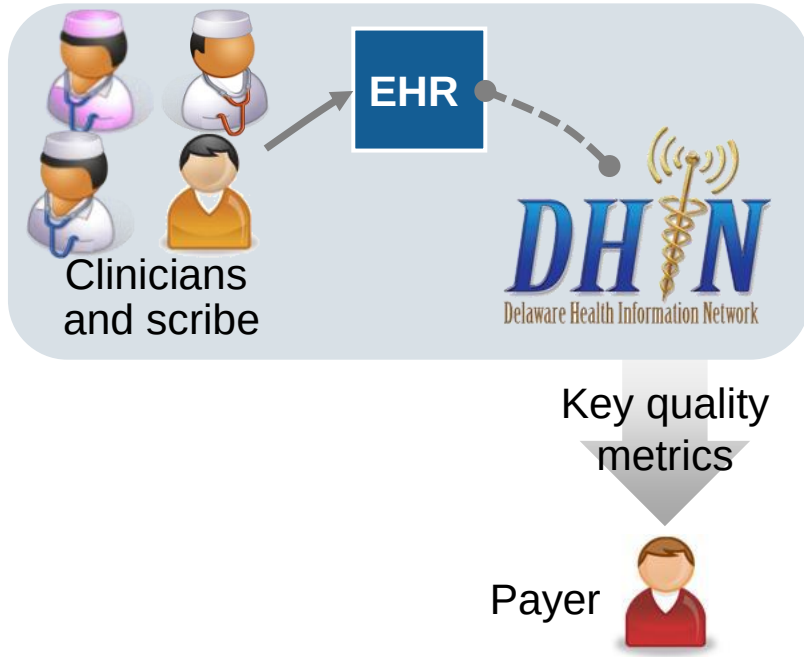
Option A

- Provider aggregates metrics to report numerators and denominators to payer



Option B

- Provider engages DHIN to aggregate data from EHR and send to payer



- Delaware providers could use both approaches at launch
- Delaware stakeholders could start with provider aggregation and move to aggregation through DHIN

Wrap up and next steps

- Please continue to share feedback across all workstreams and about the Innovation Center

- Upcoming meetings
  - April 8: Workforce symposium
  - April 10: Health Care Commission
  - *Additional meetings to be scheduled*

Thank you!