

# Overview: Clinical Committee

## 1 Common Scorecard

- **What it is:** Quality, cost, experience measures across all payers, eventual goal is for a single scorecard for all payers
- **Where we are today:** Version 1.0 drafted and being tested
- **Next steps:** Gather feedback and create version for payment

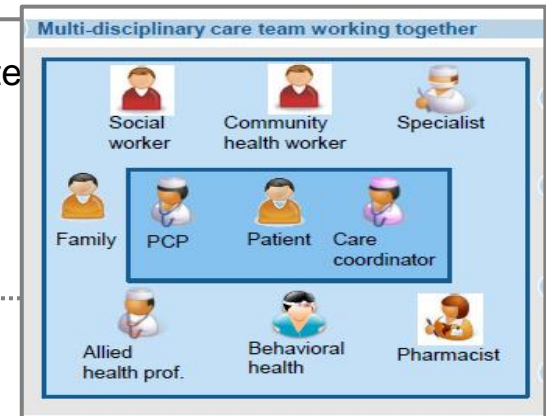
Home		About the program		Reports	Submit milestones	Contact us
Practice:	Dover Family Health	Period:	2016 Q1	Report:	Global scorecard	
<b>Overview</b> <span style="float: right;">           Overall - Commercial            Overall - Medicaid            Payer 1 - Commercial            Payer 2 - Medicaid         </span>						
Current period (Apr 2014-Mar 2015)		Previous pe (Apr 2013-Mar 2014)				
Quality measures	Congratulations! 12/14 measures meet goals	Some areas need improvement 9/14 measures meet goals				
Patient experience	Congratulations! Average satisfaction score is 85	Significant improvement needed Average satisfaction score is -20				
Utilization	Congratulations! 3/3 measures meet goals	Congratulations! 3/3 measures meet goals				
Total cost of care	Congratulations! Cost of care decreased .3%	Congratulations! Cost of care decreased .2%				
Milestones	Congratulations! You currently meet milestones	Some areas need improvement Not all milestones met				
Providers	4	3				
Patients	4500	3400				

## 2 Practice Transformation

- **What it is:** Common approach to help providers adopt changes in clinical, operational workflows and build the capabilities to coordinate care
- **Where we are today:** Consensus paper on capabilities, milestones, and support model published, RFP released by HCC for expert vendors
- **Next steps:** Support engagement of providers with expert vendors

## 3 Care Coordination

- **What it is:** Supporting practices to work with their patients to navigate the health system
- **Where we are today:** Developing detailed definitions and support model
- **Next steps:** Get to consensus by mid-August



## 4 Behavioral Health Integration

- **What it is:** Strategy to integrate primary care and behavioral health
- **Where we are today:** Identifying current barriers and best practices
- **Next steps:** Develop strategy by end of year

# Common Scorecard: Version 1.0 for testing

Category	Measures	Measure type	Data source
Quality of care – outcomes	1 Diabetes care: HbA1c control	HEDIS (CDC) <sup>1</sup>	CPT-II or clinical
	2 Controlling high blood pressure	HEDIS (CBP) <sup>1</sup>	CPT-II or clinical
Quality of care – process	3 Use of appropriate medications for people with asthma	HEDIS (ASM)	Claims
	4 Avoidance of antibiotic treatment in adults with acute bronchitis	HEDIS (AAB)	Claims
	5 Appropriate treatment for children with URI	HEDIS (URI)	Claims
	6 Adherence to statin therapy for individuals with coronary artery disease	NQF #543	Claims
	7 Screening for clinical depression	NQF #418	CPT-II or clinical
	8 Tobacco use: screening and cessation intervention	NQF #28	CPT-II or clinical
	9 Colorectal cancer screening	HEDIS (COL)	Claims
	10 BMI assessment	HEDIS (ABA)	Claims
	11 Adolescent well-care visits	HEDIS (AWC)	Claims
	12 Influenza immunization	NQF #41	CPT-II or clinical
	13 Childhood immunization status	HEDIS (CIS)	Claims
	14 Developmental screening in the first three years of life	NQF #1448	Claims
	15 Fluoride varnish application for pediatric patients	NQF #1419	CPT-II or clinical
Total cost of care	16 Total cost of care per patient <sup>2</sup>	n/a	Claims
Utilization	17 Inpatient admissions per 1000 patients <sup>2</sup>	n/a	Claims
	18 ED visits per 1000 patients <sup>2</sup>	n/a	Claims
	19 Plan All-Cause Readmissions <sup>2</sup>	HEDIS (PCR)	Claims

1 Modified definition

2 Can be risk-adjusted; exact definitions are being refined

# Transformation Milestones – measuring progress on population health management



# Your input: integration of Behavioral Health with Primary Care

## Instructions:

- What are the key challenges in integrating Behavioral Health with Primary Care in Delaware?
- Place **1 dot** on the challenge you feel is the **most important** in **each** of the top 2 boxes
- Use post-it notes to identify any other challenges not on this list

## Clinical and operational challenges (1 dot)

- Cultural misalignment between behavioral and primary care providers
- Information sharing mechanism
- Divided leadership and low staff engagement

## Financial challenges (1 dot)

- Fee-for-service environment
- Separate funding streams & non-aligned incentives
- Initial up-front costs
- Savings accrue to health system

## Other challenges (not listed above, could be clinical, operational, financial, etc.)

# Overview: Healthy Neighborhoods

## 1 Population Health Scorecard

- **What it is:** Statewide view of progress at improving health
  - **Where we are today:** Finalized first version, using America's Health Rankings
  - **Next steps:** Develop plan for hosting (e.g., on website) and refining over time
- 

## 2 Healthy Neighborhoods priorities

- **What it is:** Common priority health needs across Delaware – each Healthy Neighborhood can choose one or more as their initial focus
  - **Where we are today:** Defined four priority areas based on Delaware needs and potential impact
  - **Next steps:** Work with potential Neighborhoods to select their initial priority
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## 3 Operating model design

- **What it is:** Define approach to how Healthy Neighborhoods will be formed and organizations will work together to address statewide health needs in their communities
  - **Where we are today:** Developed draft approach
  - **Next steps:** Gather further feedback and finalize first draft approach
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








## 4 Initial neighborhoods

- **What it is:** Refining Healthy Neighborhoods approach with initial neighborhoods
- **Where we are today:** Identifying what should be tested and how to run in initial neighborhoods
- **Next steps:** Finalize approach, identify initial neighborhoods

 DE ranked 1-17  
 DE ranked 18-34  
 DE ranked 35+

# Population health scorecard

## Delaware 2014 America's Health Rankings, Overall: 35

	2014		No 1 state		2014		No 1 state
	Value	Rank			Value	Rank	
<b>Behaviours</b>				<b>Clinical care</b>			
 Smoking (Percent of adult population)	19.6	29	10.3	 Low Birthweight (Percent of live births)	8.3	32	5.7
 Binge Drinking (Percent of adult population)	17.0	28	9.6	 Primary Care Physicians (Number per 100,000 population)	112.8	30	324.6
 Drug Death (Death per 100,000 population)	16.6	39	3.0	 Dentists (Number per 100,000 population)	47.7	43	107.6
 Obesity (Percent of adult population)	31.0	37	21.3	 Preventable Hospitalizations (Number per 1,000 Medicare beneficiaries)	53.9	19	28.2
 Physical Inactivity (Percent of adult population)	26.2	37	162	 <b>All determinants</b>	-0.13	33	0.71
 High School Graduation (Percent of incoming ninth graders)	77.0	39	93.0	<b>Outcomes</b>			
<b>Community &amp; Environment</b>				 Diabetes (Percent of Adult population)	11.1	41	6.5
 Violent Crime (Offenses per 100,000 population)	547	45	123	 Poor Mental Health Days (Days in previous 30 days)	3.6	22	2.5
 Occupational Fatalities (Deaths per 100,000 workers)	4.5	29	2.2	 Poor Physical Health Days (Days in previous 30 days)	3.9	25	2.8
 Infectious Disease (Combined score Chlamydia, Pertussis, Salmonella)	-0.06	26	-0.9	 Disparity in Health Status (Percent difference by education level)	28.8	25	15.5
 Chlamydia (Cases per 100,000 population)	489.2	37	233.0	 Infant Mortality (Deaths 1,000 live births)	8.2	47	4.2
 Pertussis (Cases per 100,000 population)	6.3	14	1.6	 Cardiovascular Deaths (Deaths per 100,000 population)	246.9	29	184.7
 Salmonella (Cases per 100,000 population)	16.3	31	6.8	 Cancer Deaths (Deaths per 100,000 population)	201.9	37	145.7
 Children in Poverty (Percent of children)	22.7	36	9.2	 Premature Deaths (Years let per 100,000 population)	7,729	37	5,345
 Air Pollution (Micrograms of fine particles per cubic meter)	10.2	40	4.9	 <b>All outcomes</b>	-0.10	37	0.34
<b>Policy</b>				 <b>Overall</b>	-0.23	35	0.91
 Lack of Health Insurance (Percent of population)	9.0	6	3.8				
 Public Health Funding (Dollars per person)	\$105	11	\$219				
 Immunization-Children (Percent aged 19 to 35 months)	71.8	21	82.1				
 Immunization-Adolescents (Percent aged 13 to 17 years)	72.6	9	81.3				

**Goal: Delaware will be one of the five healthiest states in the nation**

# Your input: Healthy Neighborhood priorities

**Instructions:** For this exercise, please place a dot next to the priority that you feel is the most important for your neighborhood to address

Priority areas	Description	Which is most important for your neighborhood?
<b>1</b> Healthy Lifestyles	Activities that promote balance between physical/emotional well-being and the demands of daily life (e.g., exercise, diet)	
<b>2</b> Maternal & Child Health	Health considerations that affect mothers, infants and children (e.g., prenatal care, nutrition)	
<b>3</b> Mental Health & Addiction	Prevention, treatment and management of behavioral health conditions (e.g., depression screening, alcohol cessation)	
<b>4</b> Chronic Disease Prevention & Management	Activities that prevent chronic disease or minimize impact on daily life (e.g., polypharmacy management, care coordination)	

# Overview: Workforce and Education

## 1 Credentialing

- **What it is:** Streamline credentialing process
- **Where we are today:** Identifying current processes across State and private organizations and barriers to simplifying
- **Next steps:** Develop draft approach



## 2 Learning and development

- **What it is:** Develop curriculum for care coordination; build health professionals consortium to expand graduate training positions
- **Where we are today:** Consensus paper drafted
- **Next steps:** Finalize curriculum consensus paper; HCC to release RFP for both curriculum and the consortium

## 3 Workforce capacity planning

- **What it is:** Build sustainable capabilities that give regular view to future needs
- **Where we are today:** Reviewed current data and its limitations, as well as future options
- **Next steps:** Develop full needs assessment



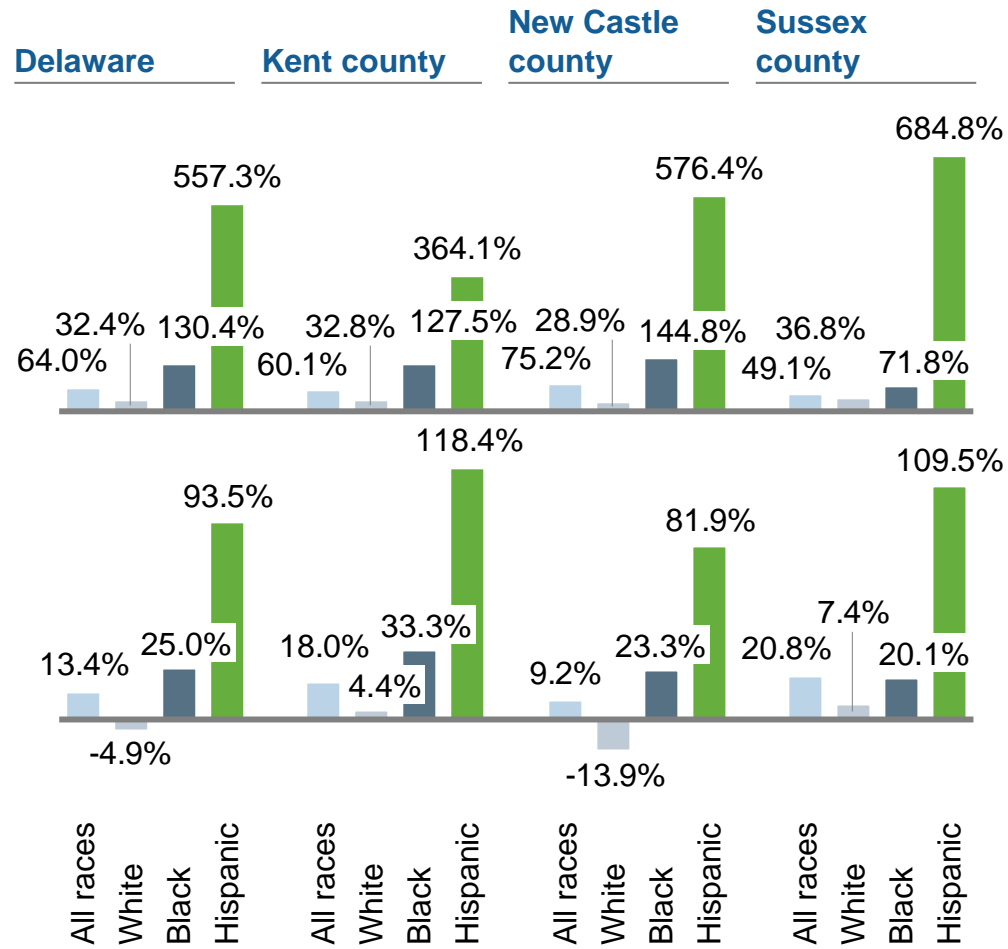


# Demographic trends affecting Delaware's health care workforce

1. Delaware's total population will increase through 2040
2. Delaware's 65+ population is expected to grow at a faster rate than the total population
3. Among Delawareans 65+, projected population increases are directly correlated with age
4. Projected increases in total population are higher among Black and Hispanic Delawareans
5. The comparatively high projected population increases among Black and Hispanic Delawareans are even more pronounced among the 65+ population
6. Overall, Delaware's youth (0-19 years) is expected to grow at a slower rate than the total population

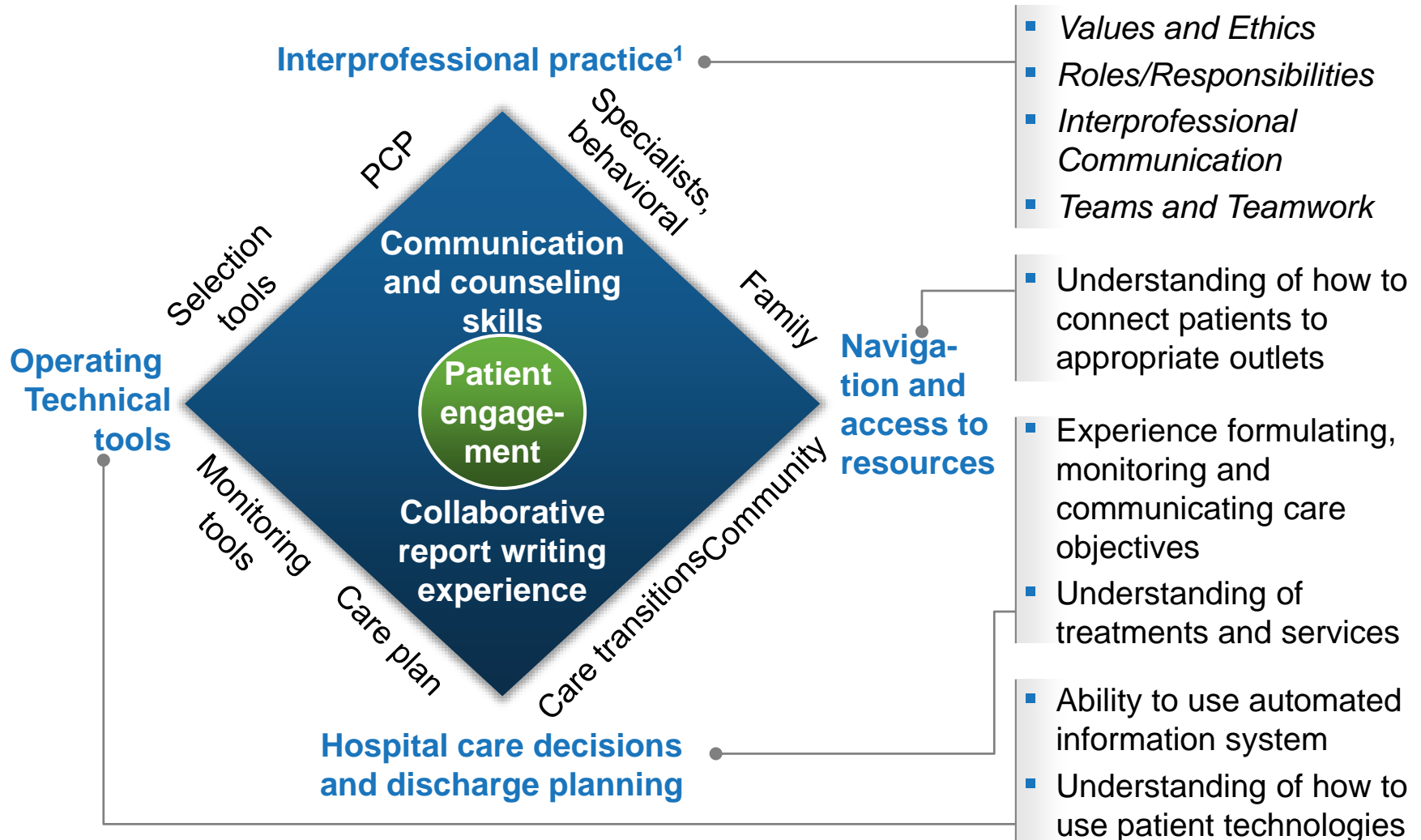
**2015-2040 projected population increases (PPI), 65+ only, by race**

**2015-2040 projected population increases (PPI), total population (All ages), by race**



**Note: some county-level projections are based on a small 2015 baseline**

# Competencies for care coordination



<sup>1</sup> American Association of Colleges of Nursing, "Core Competencies for Interprofessional Collaborative Practice"

# Your feedback: learning and re-learning curriculum

**Instructions:** For this exercise, please use post-it notes to provide feedback on the different elements of Delaware's learning and re-learning curriculum for care coordination

## Current perspective

## Your feedback

### Audience

- Any member of the primary care team with primary responsibility for coordinating clinical care
- Expanded over time

### Topics

- (1) Standards of Practice, (2) Care Planning, (3) Care Team Leadership, (4) Communication Skills (e.g., patient engagement) (5) Use of HIT (e.g., risk prediction software), (6) cross-system integration (e.g., social service)

### Format / channels

- Individual and group settings
- Format: (1) actual and simulated patient interactions, (2) didactic and clinical experiences, (3) fully incorporate technology including telemedicine

# Overview: Patient and Consumer Advisory

## 1 Messaging and awareness

- **What it is:** Promoting outreach and education to Delawareans about how Delaware's health transformation supports and empowers patients and consumers
- **Where we are today:** Gave feedback about consumer and patient messaging, outreach channels, videos, and opportunities to increase cultural awareness in communications
- **Next steps:** Communications to gather further feedback on refined website (e.g., through focus group); Committee to offer input on messaging for "How will SIM affect me?"

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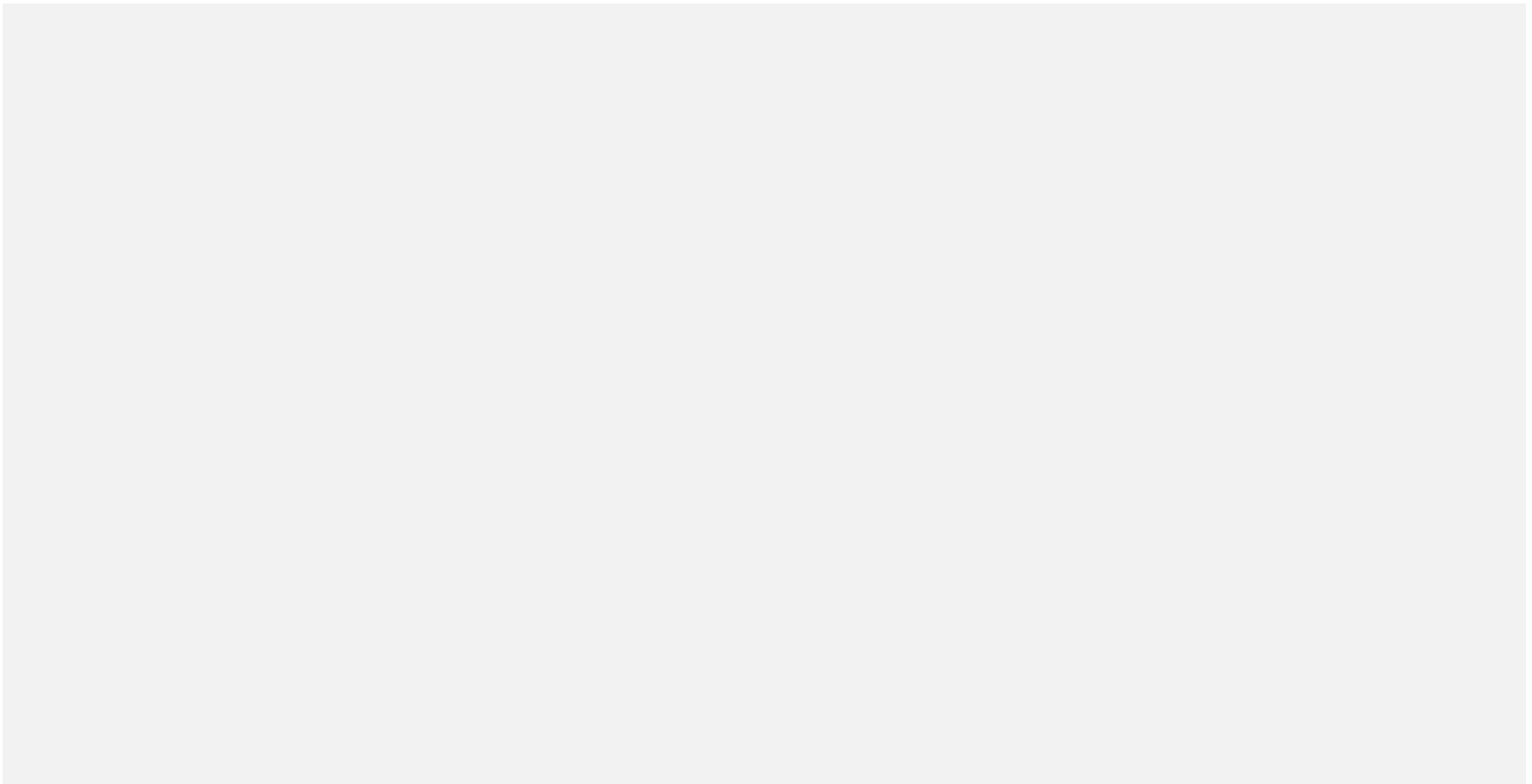
## 2 Consumer input to design choices

- **What it is:** Providing consumer perspective input to other committee initiatives
- **Where we are today:** Met with representatives from Health IT, Healthy Neighborhoods to give feedback
- **Next steps:** Define needs for patient engagement tools



# Your input: DCHI website content

**Instructions:** What questions would you like to see the DCHI website answer? Examples include “what is the impact on me as a consumer?”, “what will be major milestones for this strategy?” Please place post-its with your ideas below.



# Overview: Payment Model Monitoring

## 1 Provider support for transition to value-based payment models

- **What it is:** Defining practice support funding eligibility and method of payment, defining eligibility and funding structure for care coordination
- **Where we are today:** Built consensus on the eligibility and funding requirements for practice transformation and care coordination
- **Next steps:** Work with Clinical Committee to further determine the care coordination requirements and capture in a white paper

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## 2 Model for value-based payment and relation to shared savings

- **What it is:** Designing the elements of value-based payment models (e.g., total cost of care, pay-for-value)
- **Where we are today:** Building consensus around methodology for calculations
- **Next steps:** Finalizing consensus around design elements and producing a white paper

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## 3 Linking payment models to Common Scorecard

- **What it is:** Designing a system to tie payment to performance using the measures in the Common Scorecard
- **Where we are today:** Gathering feedback on the types of models that could be adopted
- **Next steps:** First wave of practice enrollment in late 2016 to use the Common Scorecard for all or part of payment

# Approach to payment transformation

■ January-June  
■ July - on

## Design decision

- 1 Panel definitions** What is the method by which patients are attributed to a provider for purposes of measuring provider performance?  
.....
- 2 Practice transformation** How are providers supported in practice transformation, financially or otherwise?  
.....
- 3 Care coordination** How are providers paid for coordinating care outside of traditional office visits?  
.....
- 4 TCC risk sharing** What are the rules by which risk sharing payouts are calculated, based on performance for total cost of care?  
.....
- 5 P4V bonus payments** What are the rules by which bonus payments are calculated, based on performance for resource utilization?  
.....
- 6 Quality requirements** What are the rules by which performance on quality and experience measures are factored into TCC and/or P4P payments?

# Two types of value-based payment models for primary care

## Description

### Pay for Value

- Pay-for-value enables providers to earn bonuses for meeting both a set of quality measures and managing resource utilization
- As a common goal, pay-for-value models look for a decrease in the growth of overall costs

### Total cost of care

- Total cost of care models look at the overall spending as a key metric and look to reduce wasted healthcare spend (with the savings shared between payer and provider)
- Similarly to pay-for-value, these models also have a requirement to meet quality and patient experience goals

**Delaware is targeting to have 80% of payments and 90% of primary care providers going through these models in the of next 4 years**



# Your input: value-based payment

## Instructions

- Place post-its on the left with what you think the biggest **challenges for adoption of value-based payment** models will be
- Place post-its on the right with your **ideas for facilitating the transition to value-based payment** (as led by DCHI, payers, providers, or others)
- If you include a challenge on the left, please make sure to include an idea to address it on the right!

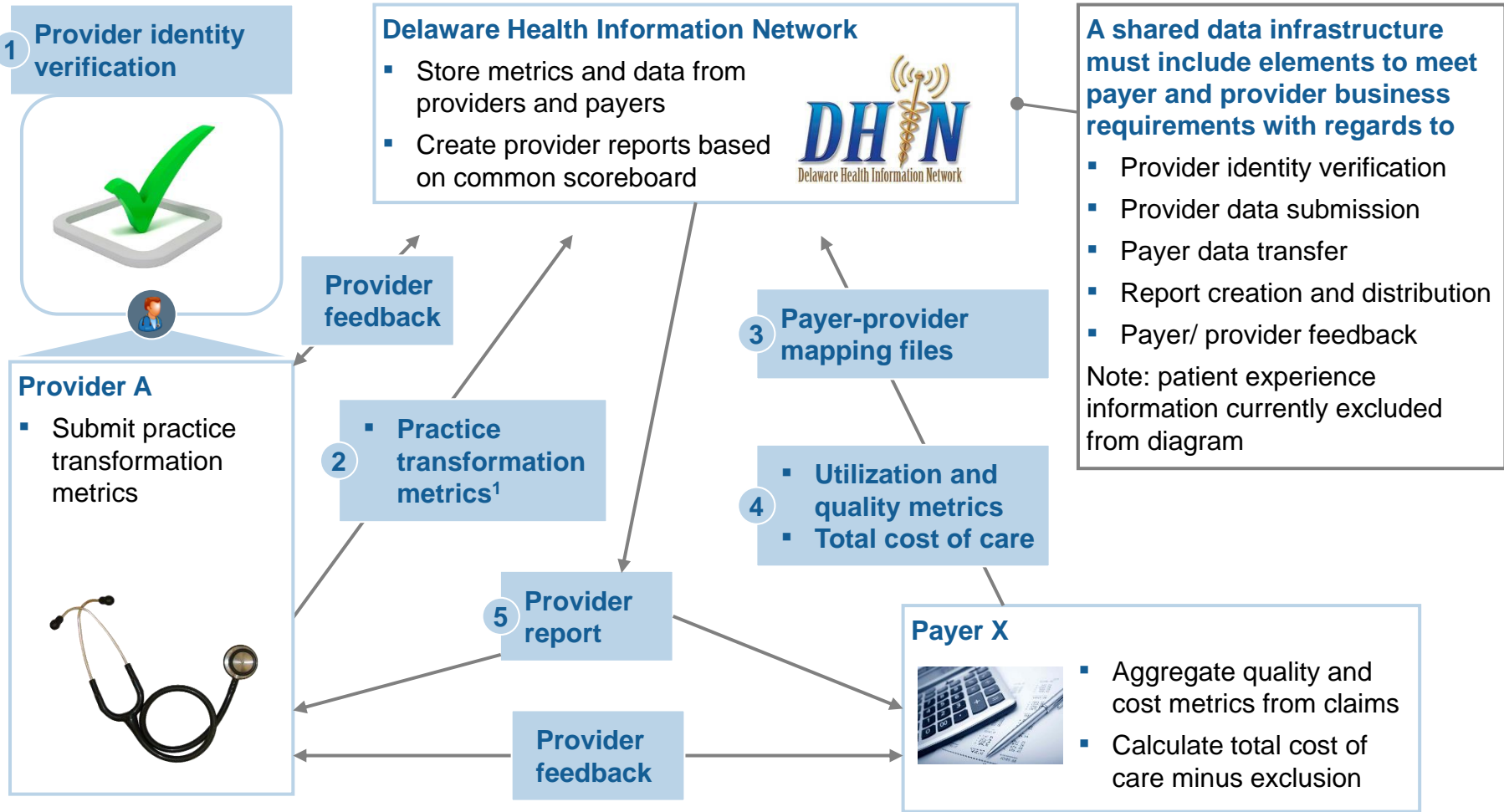
## Biggest challenges

**SAMPLE ANSWER:** I think that providers will say they don't understand how total cost of care is calculated (such as who is included for measurement)

## Ideas to facilitate the transition

**SAMPLE ANSWER:** DCHI could circulate fact sheets on different emerging models and an FAQ on where payers are approaching differently

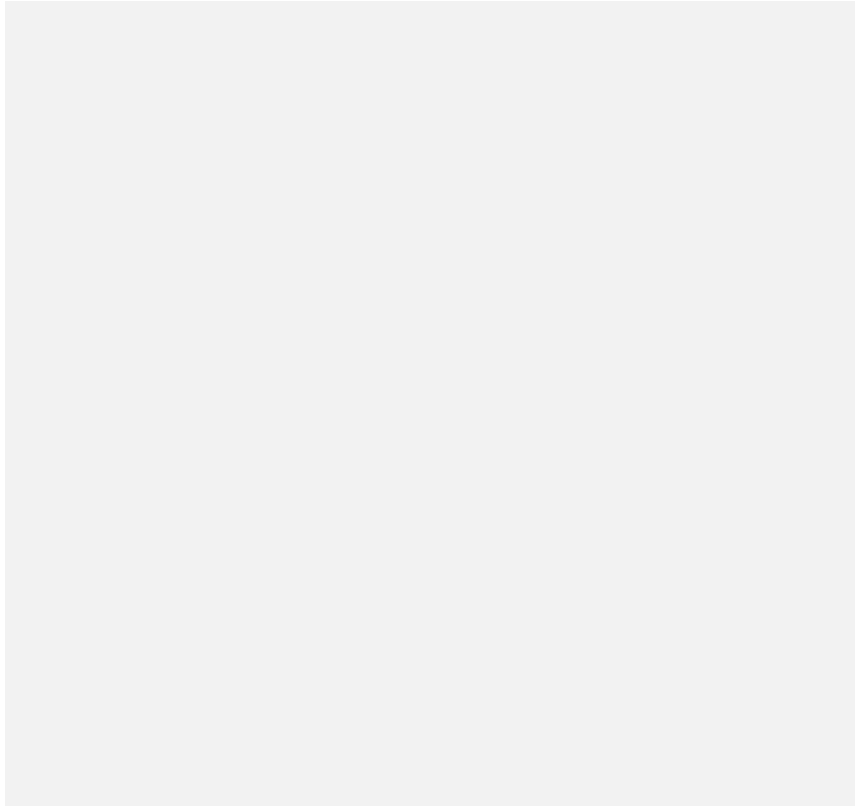
# Process to produce the Common Scorecard



<sup>1</sup> Step 2 will be in place in 2016

# Your input: data needs for consumers

What would you want to see in a patient portal (e.g., information or tools that may be useful to manage your health and the health of others)? Please place post-it notes below:



What other tools would you like to have for Delaware patients and consumers? Please place post-it notes below:

