ChooseHealth DELAWARE

All-workstream stakeholder meeting

May 20th, 2014


WELCOME

Agenda

Time	Topic
08:30-8:40	**Status update**
08:40-9:00	Recap from Workforce Symposium
09:00-9:15	Transition to Innovation Center
09:15-9:45	Overall scorecard
09:45-10:15	Common provider scorecard
10:15-10:30	*Break*
10:30-12:00	Integration across delivery and Healthy Neighborhoods

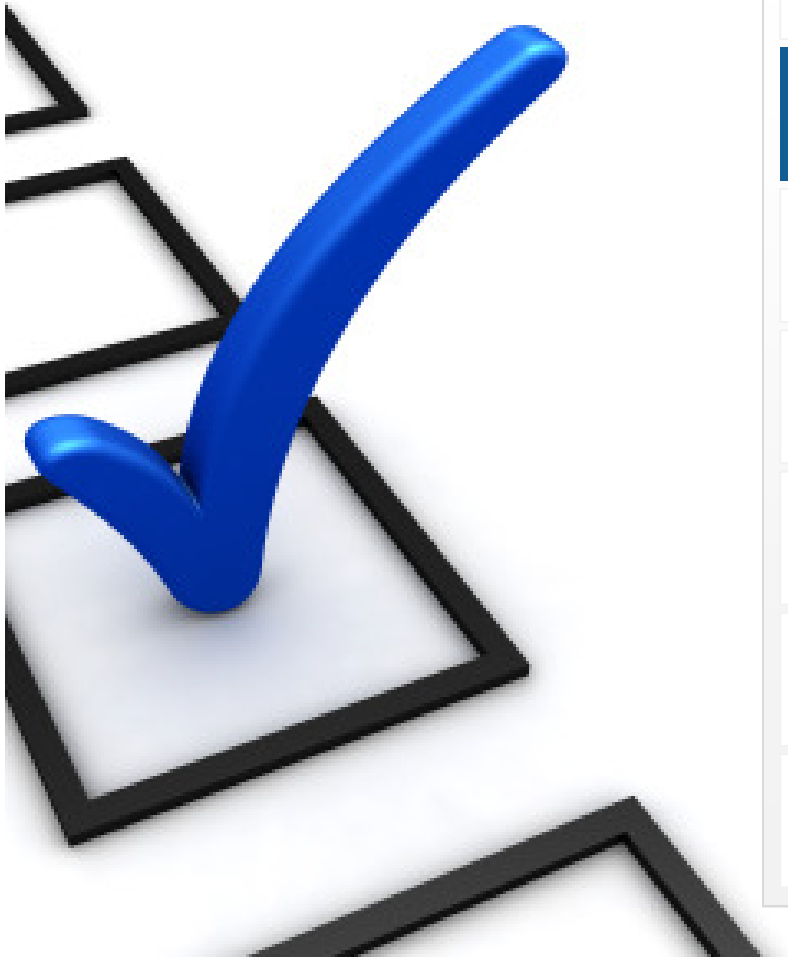
What has been happening

	Update
 **Overall**	▪ Innovation Center incorporating documents filed with Secretary of State on April 22nd ▪ Innovation Center Board nominees approved by HCC and DHIN on May 1st ▪ Draft of overall scorecard for discussion today
 **Work-streams**	▪ Updated common provider scorecard draft for review today ▪ Developing draft of system requirements to generate provider reports ▪ Held workforce symposium with 125 attendees on April 8 (more on this soon)
 **Grant**	▪ No further update ▪ Current areas of agreement posted to HCC website and reviewed at May 1st HCC meeting

Current focus

- Preparing for Innovation Center launch in July
- Syndicating and refining drafts of materials across workstreams
- Developing communications plan
- Continuing to refine shared service and workforce requirements
- Addressing critical path data requirements

Agenda



Time	Topic
08:30-8:40	Status update
08:40-9:00	**Recap from Workforce Symposium**
09:00-9:15	Transition to Innovation Center
09:15-9:45	Overall scorecard
09:45-10:15	Common provider scorecard
10:15-10:30	*Break*
10:30-12:00	Integration across delivery and Healthy Neighborhoods

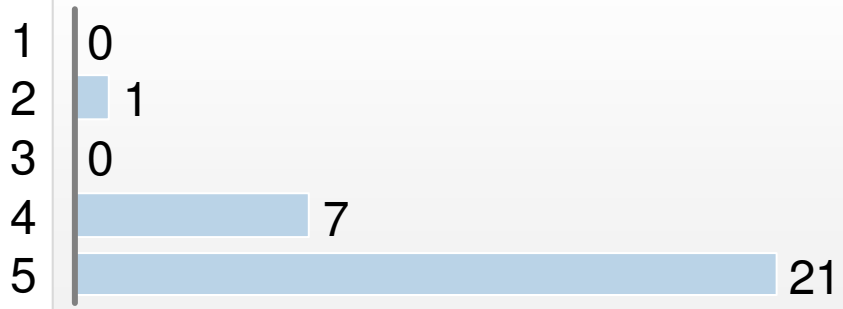
Video

96% of attendees agreed that time spent at symposium was valuable

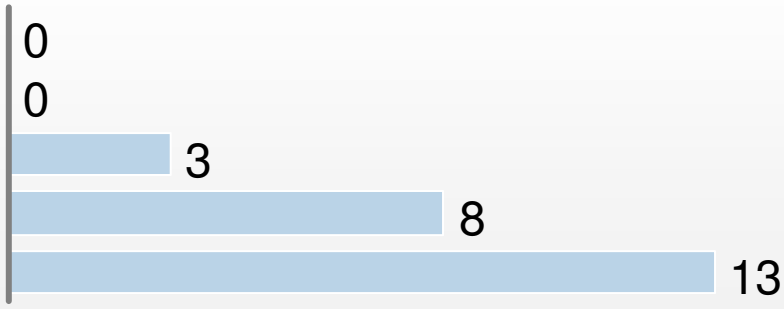
NOT EXHAUSTIVE

1 = strongly disagree, 5= strongly agree

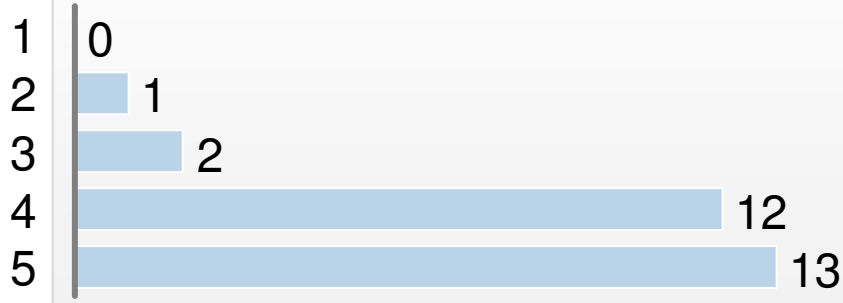
Time spent at workforce symposium overall was valuable



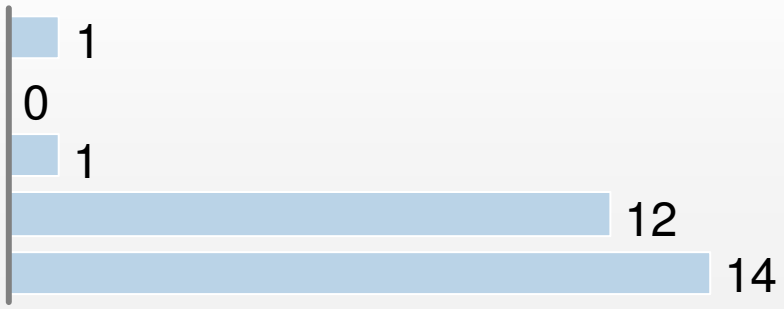
Time spent on plenary report back and discussion was valuable



Time spent on examples of ongoing innovation in Delaware was valuable



Time spent on overview of future delivery requirements in Delaware and core competencies was valuable



SOURCE: 29 feedback forms from the April 8th, 2014 Delaware Healthcare Workforce Symposium

Feedback from symposium

NOT EXHAUSTIVE

"Keep"

- Healthcare Theatre Simulation
- "Everything!" (Great speakers, breakout discussions were very useful, whole day was well-planned and executed)
- We liked learning about both the innovative healthcare delivery models around the country similar to Delaware and the innovation in Delaware
- Excellent diversity of participants

"Change"

- More examples of ongoing innovation in Delaware
- Provide more information (e.g., specific input into development of care coordinator position, how everything will be paid for, more detail on start-ups and innovation)
- Improve logistics (e.g., reduce to half-day, more breaks)

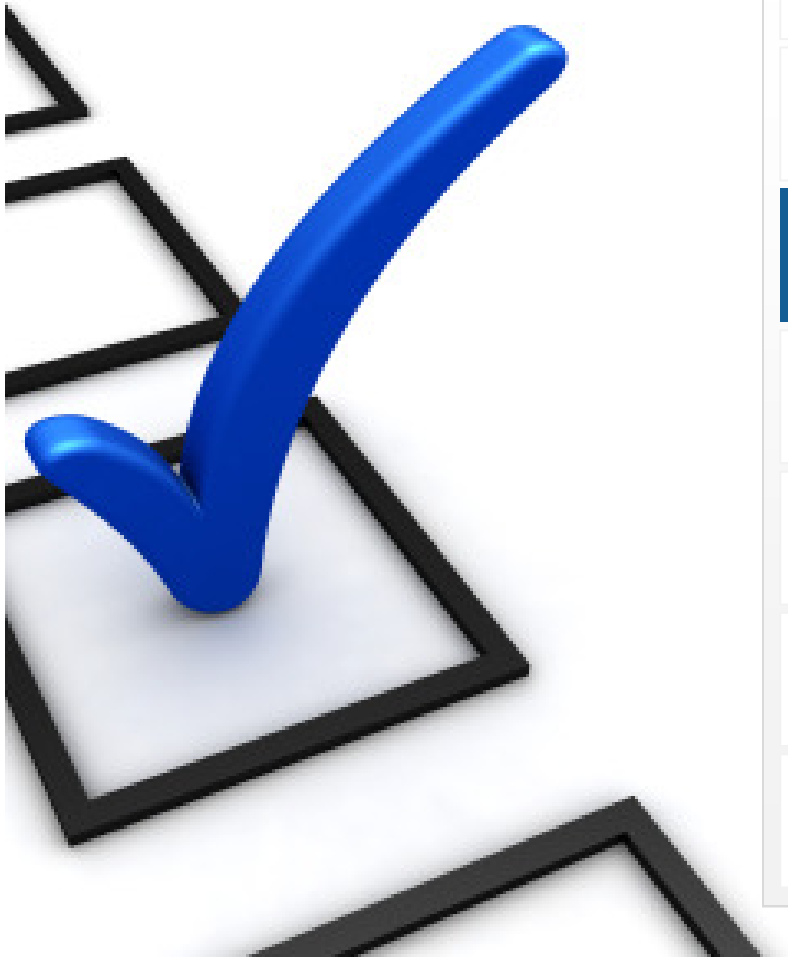
SOURCE: 29 feedback forms from the April 8th, 2014 Delaware Healthcare Workforce Symposium

Symposium: ideas about care coordination from breakout sessions

Key skills to coordinate care	▪ Interpersonal skills to be able to communicate effectively, show empathy, and foster interdisciplinary collaboration ▪ Technology/IT knowledge ▪ Time management ▪ Ability to operate as a team player
Most significant gaps	▪ Interpersonal skills required for cultural transformation ▪ Technical skills (e.g., to use EMRs, patient self-management tools, etc.) ▪ Understanding of payment system ▪ Continuous learning of what resources are available
Best way to learn skills	▪ Standardized formal program with minimum competencies required ▪ Experiential learning (internships for real-life patient experience, simulations) ▪ Learning program in spurts to keep people engaged over time ▪ Certification or accreditation for team manager and for team concept

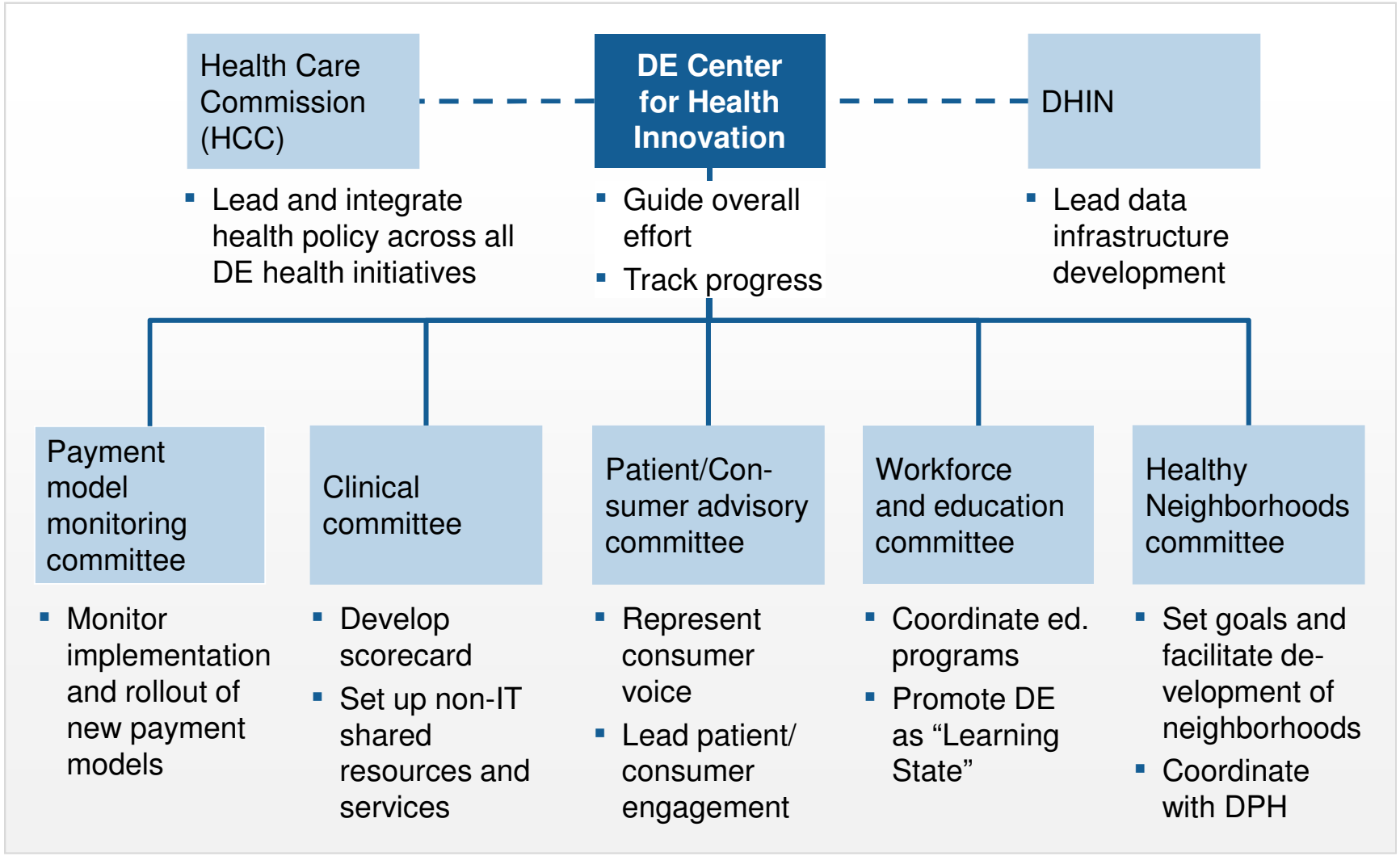
SOURCE: Plenary session responses

Agenda

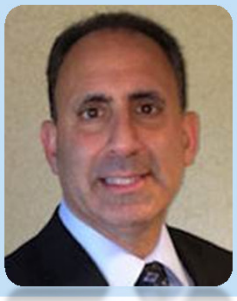


Time	Topic
08:30-8:40	Status update
08:40-9:00	Recap from Workforce Symposium
09:00-9:15	**Transition to Innovation Center**
09:15-9:45	Overall scorecard
09:45-10:15	Common provider scorecard
10:15-10:30	*Break*
10:30-12:00	Integration across delivery and Healthy Neighborhoods

Reminder – Innovation Center structure



Introducing the first Board members (1/2)



Gregory Bahtiarian, DO
Mid-Atlantic Family Practice

Traci Bolander, Psy.D.
Mid-Atlantic Behavioral Health

Thomas Brown
Nanticoke Health Services, Nanticoke Physician Network

Nancy Fan, MD
Women to Women OB/GYN; Saint Francis Hospital

Alan Greenglass, MD
The Medical Group of Christiana Care; Christiana Care Quality Partners

Kathy Janvier, Ph.D., RN
Delaware Technical Community College

Paul Kaplan, MD
Highmark Blue Cross Blue Shield Delaware

Introducing the first Board members (2/2)

Rita Landgraf
Department of Health and Social Services

Jan Lee, MD
Delaware Health Information Network

Lolita Lopez, FACHE
Westside Family Healthcare

Bettina Riveros, Esq.
Delaware Health Care Commission

Gary Siegelman, MD
Bayhealth Medical Center

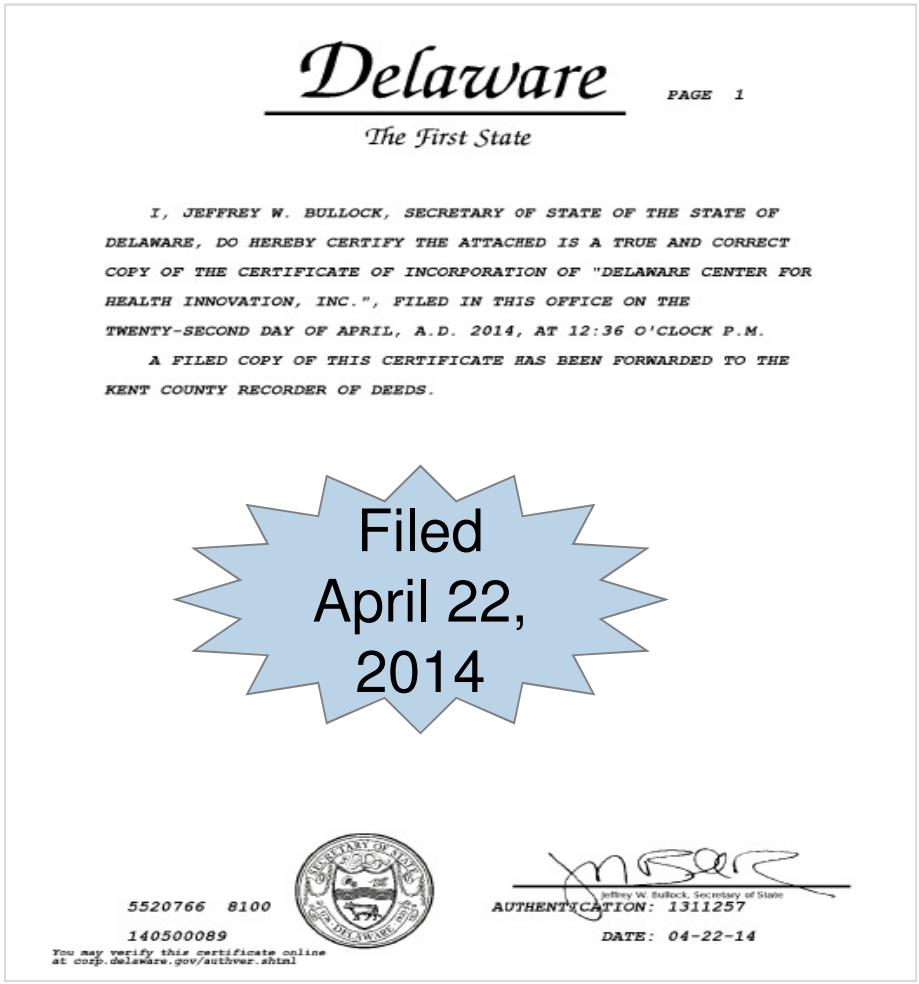
Matt Swanson
Innovative Schools; FineStationary.com

Ann Visalli
Office of Management and Budget

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

Current status and next steps



Delaware

PAGE 1

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF INCORPORATION OF "DELAWARE CENTER FOR HEALTH INNOVATION, INC.", FILED IN THIS OFFICE ON THE TWENTY-SECOND DAY OF APRIL, A.D. 2014, AT 12:36 O'CLOCK P.M.

A FILED COPY OF THIS CERTIFICATE HAS BEEN FORWARDED TO THE KENT COUNTY RECORDER OF DEEDS.

Filed April 22, 2014

5520766 8100

140500089

You may verify this certificate online at corp.delaware.gov/authver.shtml

Jeffrey W. Bullock, Secretary of State

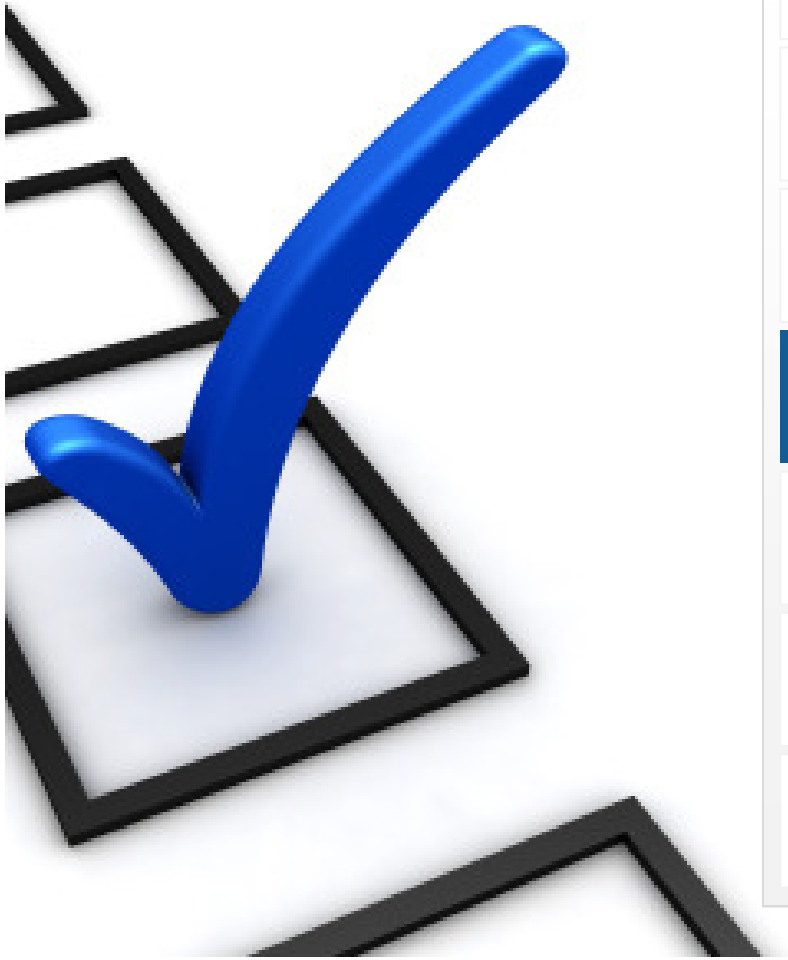
AUTHENTICATION: 1311257

DATE: 04-22-14

- Current workstreams will transition into each committee
- Data will transition to a "Technical Advisory Group" with dotted line to DHIN and Innovation Center Board

- Please send committee member nominations to HCC (Jill Rogers)

Agenda



Time	Topic
08:30-8:40	Status update
08:40-9:00	Recap from Workforce Symposium
09:00-9:15	Transition to Innovation Center
09:15-9:45	**Overall scorecard**
09:45-10:15	Common provider scorecard
10:15-10:30	*Break*
10:30-12:00	Integration across delivery and Healthy Neighborhoods

Three scorecards for Delaware

Current focus

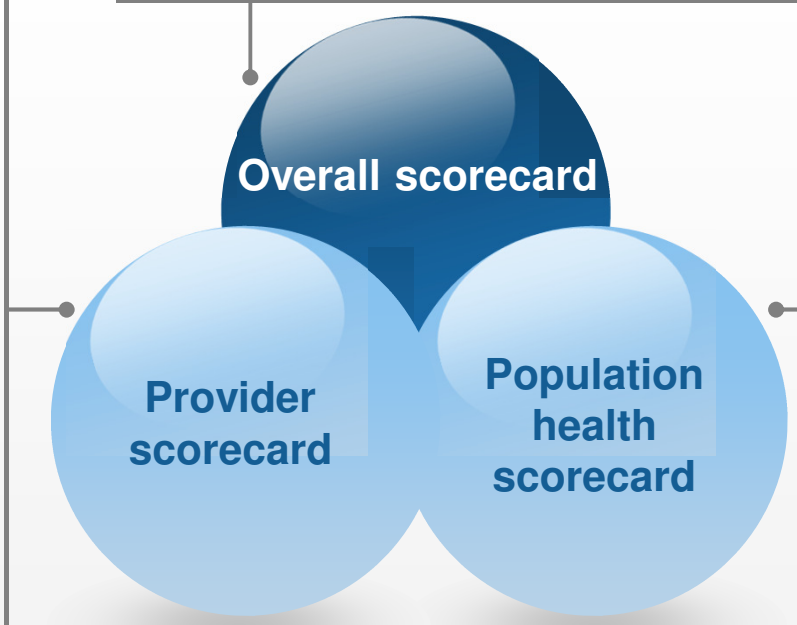
Purpose: Ensure we are making progress across the state toward our Triple Aim and delivery transformation goals

Content: State-level health improvement, quality/effectiveness, cost reduction, payer/provider landscape, transformation

Purpose: Provide a simple, common set of measures to

- Measure practice progress against the Triple Aim and transformation of care delivery
- Be used in outcomes-based payment models to promote both better, coordinated care and more effective diagnosis

Contents: Measures/milestones on the 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

Questions addressed by the overall scorecard

1	Is Delaware achieving its goals?
2	Where are there opportunities to address specific needs or share best practices?
3	What programmatic decisions/changes should the Innovation Center Board consider?

Proposed steps to develop overall scorecard

1	Agree on requirements for scorecard	
2	Align on core areas of measurement (i.e., categories)	
3	Review examples of other state scorecards and Delaware-specific state health measures	
4	Draft initial scorecard	
5	Review initial measures with stakeholders and incorporate feedback	
6	Define potential data sources and long-term approach for scorecard (e.g., updating)	

Overall scorecard requirements

- **Gives regular, actionable information to track progress** vs. the Triple Aim and transformation goals
- **Comprehensive of the overall strategy** set out in the Innovation Plan
- Capable of being **updated at least annually**
- As **automated** as possible
- As **integrated and connected with other DE scorecards** as possible (e.g., common provider scorecard, DE 2020 healthy people)
- **Includes areas of focus** for provider stakeholders (e.g., behavioral health integration)

Categories for the overall scorecard

PRELIMINARY

Domain	Category	Example metric
Health Improvement	Delaware goal	DE ranking in top 5 healthiest states
	Behavioral risk factors	Percent cigarette smoking
	Prevalence and incidence	Hypertension prevalence
	Health outcomes	Cancer death per 100,000
Care Improvement	Delaware goal	DE in top 10% of states for quality of care
	Quality of care	Use of appropriate medications for people with asthma
	Patient experience of care	Patient experience survey (e.g., CAHPS)
Cost reduction	Total cost of care	Actual total cost of care vs. expected costs
	Utilization	Inpatient admissions per 1000 patients
Implementation	Delivery	Percent of Delawareans in transforming practices
	Payment	Percent of total HC spend linked to value-based plans
	Workforce strategy	Percent of primary care providers/organizations with staff attending programs to build capabilities to support care coordination or integrated care
	Population health	% of population covered by a Healthy Neighborhood
	Data strategy	% of practices using bidirectional payer-provider portal
Provider transformation	Provider performance	Percent of participating provider organizations with expanded access
Payer transformation	Payer performance	Percent of revenue coming from value-based payment models

Example dashboards for overall measures

	Description	Number of measures
America's Health Rankings: United Health Foundation	▪ Assessment of nation's health on a state-by-state basis focusing on clinical care, health outcomes, behaviors, and environmental conditions	30
NQF's Community Tool to align measurement	▪ Collaboration between 16 national alliances to identify national priorities in Triple Aim measures	171
DE Health Tracker – Healthy people 2020 and community dashboard	▪ Dashboards to asses DE health outcomes, disease prevalence, risky behaviors, access to care, and environmental health	73
Healthy Vermonters 2020 goals	▪ Vermont's public goals for 2020 organized into 21 categories focusing on health outcomes, access to care, clinical care quality, and health behaviors/lifestyle	100+
OpenMichigan – Health & Wellness Tracker	▪ State's top-level assessment of health and wellness across the state	20

SOURCE: 2013 America's Health rankings (annual report), National Quality Forum, Healthy Communities Institute, Vermont Department of Health, Mighican.gov

Primary data sources for overall scorecard

	Metrics categories addressed
Centers of Medicare and Medicaid	▪ Healthcare outcomes ▪ Disease prevalence ▪ Quality of care – outcomes
American Community Survey	▪ Access to care ▪ Landscape
Behavioral Risk Surveillance System	▪ Behavioral risk factors ▪ Disease prevalence ▪ Quality of care (process)
National Cancer Institute	▪ Healthcare outcomes ▪ Disease prevalence ▪ Quality of care – process
Delaware Division of Public Health	▪ Health outcomes ▪ Quality of care – outcomes and process

SOURCE: CMMI, U.S. Census Bureau, Centers of Disease Control and Prevention, National Cancer Institute, Delaware Division of Public Health

PRELIMINARY

Proposed overall scorecard (draft)

Roll-up from common provider scorecard

Health Improvement	Delaware goal	▪ DE's rank in America's Health Rankings (or some other ranking system)
	Behavioral risk factors	▪ Percent cigarette smoking ▪ Percent of Delawareans eating fruits and vegetables ▪ Percent of Delawareans who report physical inactivity
	Prevalence and incidence	▪ Hypertension prevalence ▪ Diabetes prevalence ▪ Obesity prevalence
	Health outcomes	▪ Cancer death per 100,000 ▪ Coronary heart disease deaths ▪ 30 Day Mortality Rate, all-cause, risk-adjusted post PCI intervention/cardiogenic shock/AMI ▪ Infant mortality
Care Improvement	Delaware goal	▪ DE's ranking on the 14 care improvement measures
	Quality of care	▪ Percent of primary care providers meeting benchmark for at least 10 out of 14 quality of care measures
	Patient experience of care	▪ Survey/measure for patient access and physician effectiveness (e.g., CAHPS)
Cost reduction	Delaware goal	▪ Actual total cost of care per patient vs. expected total cost of care (based on historic growth rate)
	Total cost of care	▪ Risk-adjusted, total of cost of care per patient
	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
Implementation	Delivery	▪ Percent of eligible patient population (i.e., top 10-15% highest risk) with a care plan
	Payment	▪ Percent of total healthcare spend linked to value-based plans
	Workforce strategy	▪ Percent of primary care providers/organizations with staff attending programs to build capabilities to support care coordination or integrated care
	Population health	▪ Percent of population covered by a Healthy Neighborhood
	Data strategy	▪ Percent of practices receiving the common provider scorecard
Provider transformation	Provider performance	▪ Percent of practice offering expanded access to care ▪ Percent of patients needing care plans (i.e. top 10-15% highest risk) that have them
Payer transformation	Payer performance	▪ Average medical loss ratio (across payers) ▪ Growth rate of healthcare premiums vs. growth rate of total cost of care in DE

Handout should be on your seat

Scorecard prioritization activity

Goal

- Prioritize key measures for overall scorecard

Approach

- **Poster activity (15 min):**
  - You have 6 green dots and 6 red dots to allocate across all areas which means you will have to prioritize
  - Place a green dot in “yes” if measure is one of the top priorities that should be on the scorecard
  - Place a red dot in “no” if measure is lower priority or should be removed
- **Report back and reflect (5 min)**

Overall scorecard: Health improvement

	Metrics	Initial votes[1] Yes	Initial votes[1] No
Delaware goal	▪ DE's rank in America's Health Rankings (or some other ranking system)	4	9
Behavioral risk factors	▪ Percent cigarette smoking	16	-
	▪ Percent of Delawareans eating fruits and vegetables	3	28
	▪ Percent of Delawareans who report physical inactivity	5	20
Prevalence and incidence	▪ Hypertension prevalence	3	2
	▪ Diabetes prevalence	15	-
	▪ Obesity prevalence	21	-
Health outcomes	▪ Cancer deaths per 100,000	-	7
	▪ Coronary heart disease deaths	2	3
	▪ 30 Day Mortality Rate, all-cause, risk-adjusted post PCI intervention/cardiogenic shock/AMI	5	18
	▪ Infant mortality	22	-

1 Does not fully reflect discussion that followed

Overall scorecard: Care improvement and cost reduction

Roll-up from common provider scorecard

	Metrics	Initial votes[1] Yes	Initial votes[1] No
Delaware goal	▪ DE's ranking on the 14 care improvement measures	5	-
Quality of care	▪ Percent of primary care providers meeting benchmark for at least 10 out of 14 quality of care measures	20	-
Patient experience of care	▪ Survey/measure for patient access and physician effectiveness (e.g., CAHPS)	23	-
Delaware goal	▪ Actual total cost of care per patient vs. expected total cost of care (based on historic growth rate)	6	17
Total cost of care	▪ Risk-adjusted, total of cost of care per patient	9	2
Utilization	▪ Inpatient admissions per 1000 patients	1	3
	▪ ED visits per 1000 patients	9	11
	▪ Hospital All-Cause Unplanned Readmissions, Risk Adjusted	16	-
	▪ Hospital ED Visit Rate that did not Result in hospital admission	2	26

1 Does not fully reflect discussion that followed

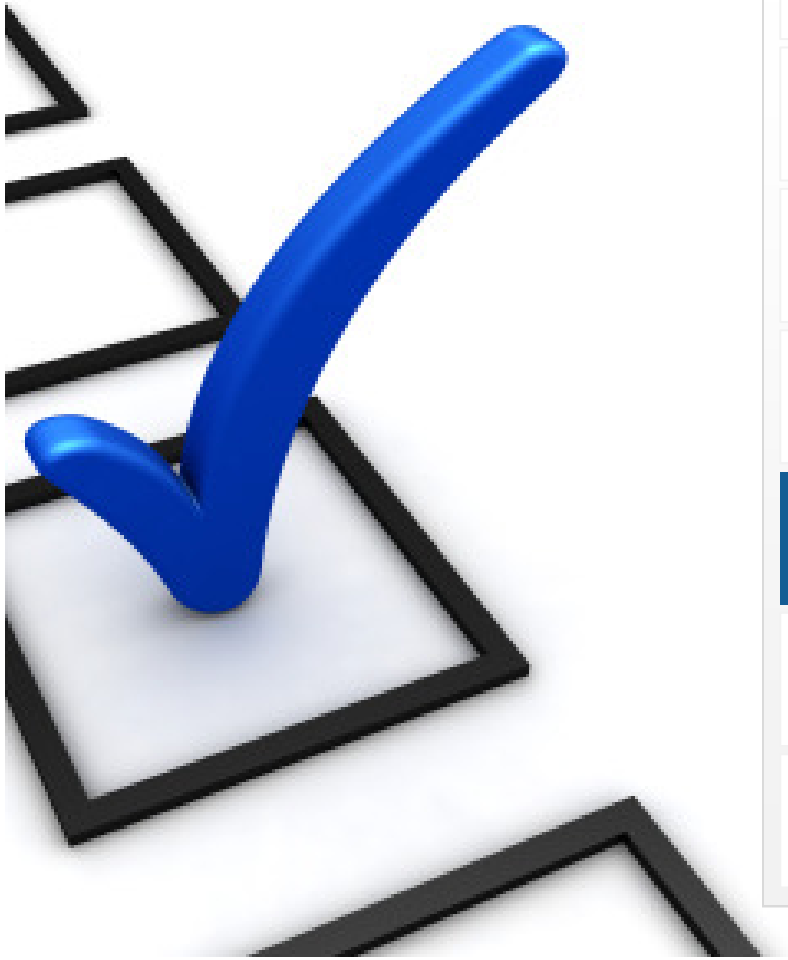
Overall scorecard: Implementation and transformation

Roll-up from common provider scorecard

	Metrics	Initial votes[1] Yes	Initial votes[1] No
Delivery	▪ Percent of eligible patient population (i.e., top 10-15% highest risk) with a care plan	9	3
Payment	▪ Percent of total healthcare spend linked to value-based plans	1	18
Workforce strategy	▪ Percent of primary care providers/ organizations with staff attending programs to build capabilities to support care coordination or integrated care	6	3
Population health	▪ Percent of population covered by a Healthy Neighborhood	15	3
Data strategy	▪ Percent of practices receiving the common provider scorecard	3	-
Provider performance	▪ Percent of practice offering expanded access to care	18	1
	▪ Percent of patients needing care plans (i.e. top 10-15% highest risk) that have them	10	0
Payer performance	▪ Average medical loss ratio (across payers)	8	2
	▪ Growth rate of healthcare premiums vs. growth rate of total cost of care in DE	17	8

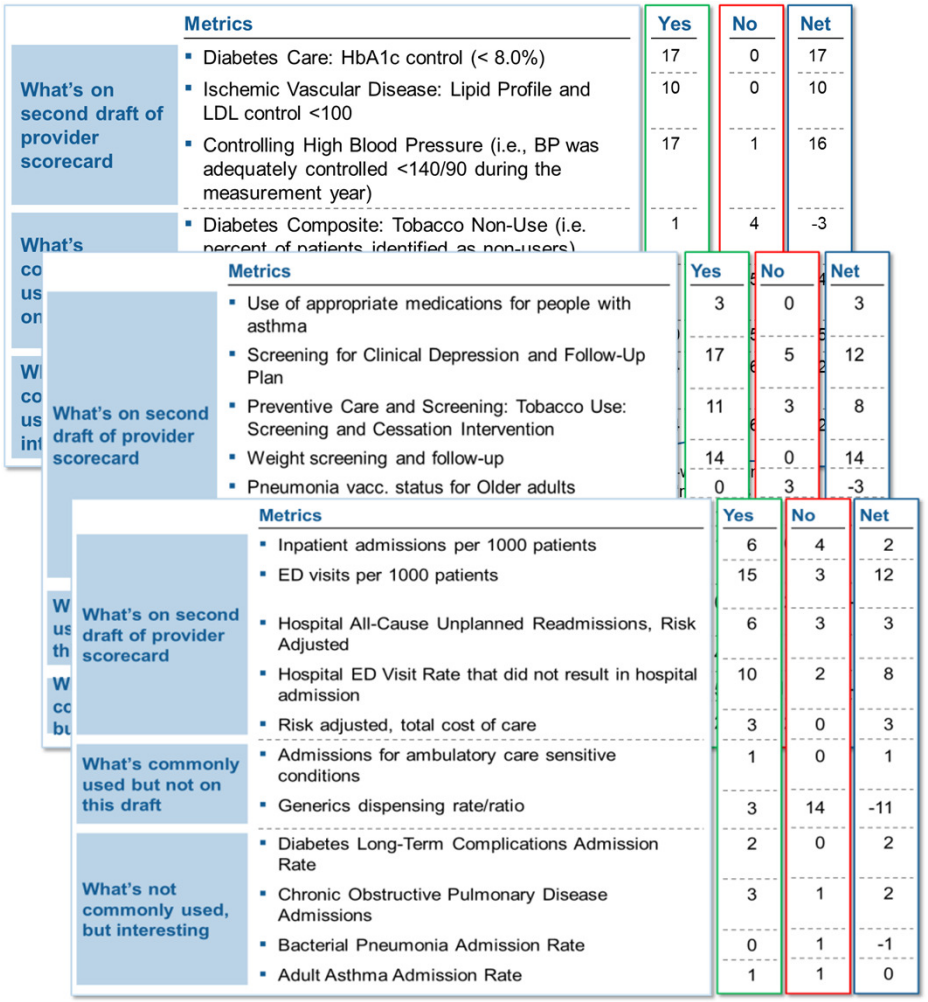
1 Does not fully reflect discussion that followed

Agenda



Time	Topic
08:30-8:40	Status update
08:40-9:00	Recap from Workforce Symposium
09:00-9:15	Transition to Innovation Center
09:15-9:45	Overall scorecard
09:45-10:15	**Common provider scorecard**
10:15-10:30	*Break*
10:30-12:00	Integration across delivery and Healthy Neighborhoods

Current status



	Metrics	Yes	No	Net
What's on second draft of provider scorecard	Diabetes Care: HbA1c control (< 8.0%)	17	0	17
	Ischemic Vascular Disease: Lipid Profile and LDL control <100	10	0	10
	Controlling High Blood Pressure (i.e., BP was adequately controlled <140/90 during the measurement year)	17	1	16
What's	Diabetes Composite: Tobacco Non-Use (i.e. percent of patients identified as non-users)	1	4	-3

	Metrics	Yes	No	Net
What's on second draft of provider scorecard	Use of appropriate medications for people with asthma	3	0	3
	Screening for Clinical Depression and Follow-Up Plan	17	5	12
	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	11	3	8
	Weight screening and follow-up	14	0	14
	Pneumonia vacc. status for Older adults	0	3	-3

	Metrics	Yes	No	Net
What's on second draft of provider scorecard	Inpatient admissions per 1000 patients	6	4	2
	ED visits per 1000 patients	15	3	12
	Hospital All-Cause Unplanned Readmissions, Risk Adjusted	6	3	3
	Hospital ED Visit Rate that did not result in hospital admission	10	2	8
	Risk adjusted, total cost of care	3	0	3
What's commonly used but not on this draft	Admissions for ambulatory care sensitive conditions	1	0	1
	Generics dispensing rate/ratio	3	14	-11
What's not commonly used, but interesting	Diabetes Long-Term Complications Admission Rate	2	0	2
	Chronic Obstructive Pulmonary Disease Admissions	3	1	2
	Bacterial Pneumonia Admission Rate	0	1	-1
	Adult Asthma Admission Rate	1	1	0

- At last cross-workstream meeting, we had "sticky dot" exercise to prioritize measures and discussed important open questions
- Updated draft and first draft of "transformation milestones" sent as pre-read
- Goal for today is to discuss latest draft with you
- Important to finalize measures soon to give clarity to data team
- Very short online survey will be available for feedback on scorecard after this session

How the scorecard could be used

- Scorecard represents a **set of core measures** to serve as a **common base across payers**
- Allows for an **aggregated view of a provider's performance** across the whole patient panel
- Some **payers may add additional measures** based on their program
- Most measures are **recognized and defined** by national organizations (e.g., HEDIS)

Common provider scorecard (current draft)

Domain	Category	Metrics
Care improve-ment	Quality of care – outcomes[1]	▪ Diabetes care: HbA1c control (< 9.0%) ▪ Controlling high blood pressure (i.e., BP was adequately controlled <150/90 during the measurement year)
	Quality of care – process	▪ Use of appropriate medications for people with asthma ▪ Avoidance of antibiotic treatment in adults with acute bronchitis ▪ Appropriate treatment for children with URI ▪ Adherence to statin therapy for individuals with coronary artery disease ▪ Screening for clinical depression and follow-up plan ▪ Preventive care and screening: tobacco use – screening and cessation intervention ▪ Colorectal cancer screening ▪ Adult weight screening and follow-up ▪ Weight assessment and counseling for nutrition and physical Activity for children/adolescents (WCC) ▪ Pneumonia vacc. status for older adults ▪ Childhood immunization status ▪ Hemoglobin A1c (HbA1c) testing for pediatric patients
	Transformation	▪ Transformation milestones over the initial years of the program (details follow)
Cost Reduc-tion	Patient experience	▪ Measures on patient experience/access (e.g., CAHPS)
	Total cost of care	▪ Risk adjusted, total cost of care per patient
	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

1 Goals to be refined

Handout should be on your seat

Proposed methodology for transformation milestones

1	Understand **current landscape** metrics and best practices	
2	Agree on principles for scorecard design and **criteria to prioritize metrics**	
3	Build an **initial data set** based on most commonly used metrics	
4	Prioritize metrics to develop **first draft scorecard**	
5	Refine draft scorecard with **stakeholder input**	

Sources for transformation measures/milestones

	Description	No. of transformation measures
NCQA PCMH 2011/2014	▪ PCMH model supported by non-profit NCQA	▪ 16[1]
Comprehensive Primary Care Initiative	▪ 4-year, CMMI led multi-payer initiative designed to test primary care practice redesign models	▪ 9
APII PCMH	▪ Statewide, multi-payer PCMH program	▪ 13
Oklahoma SoonerCare	▪ Medicaid led PCMH program	▪ 27[2]

- 42 unique measures across these four sets
- 6 measures common across majority[3] of sets

1 Standards break into 149 separate sub-standards
2 Tier 3 PCMH standards for SoonerCare
3 All or all but one of the sets

SOURCE: NCQA PCMH 2011, CPCI, APII, Oklahoma SoonerCare

Priority transformation milestones (first draft)

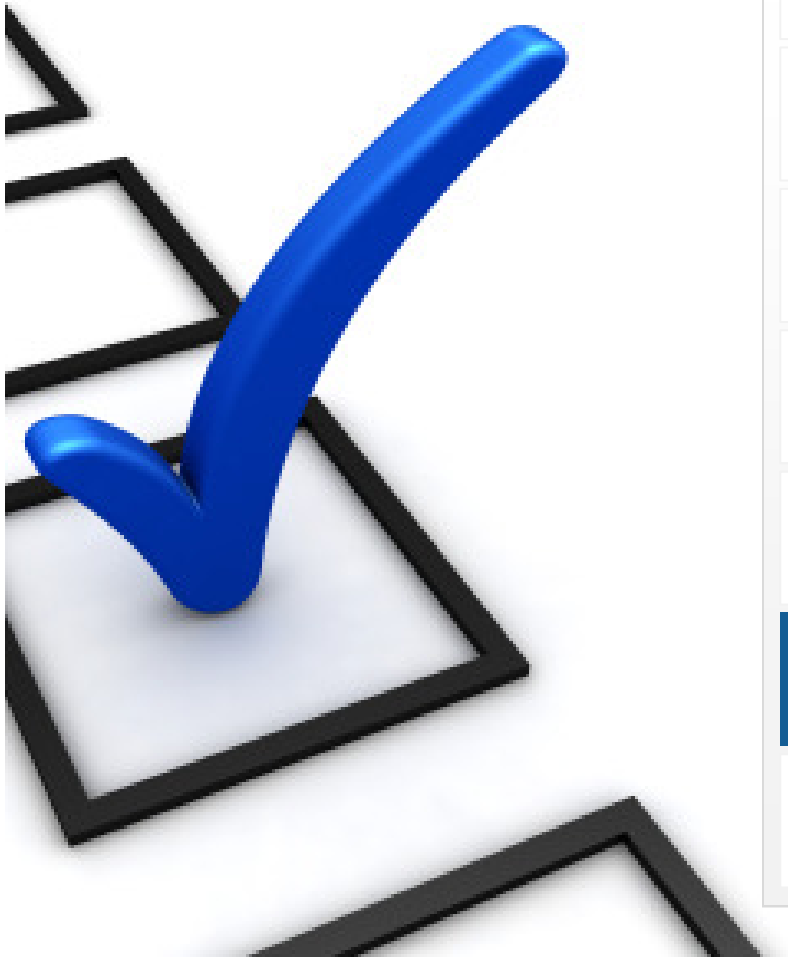
Category	Measure	Time in program
Panel Management	▪ Identify top X% of high-priority patients and submit list	3 months
Access improvement	▪ Document approach to same-day appointments and/or afterhours access to care	6 months
	▪ Supply voice-to-voice coverage to panels members 24/7 where patient speaks to licensed health professional	12 months
Care management	▪ Document MDT[1] working with X% of high risk patients to develop a care plan and process to assess/address barriers if goals are not met (i.e. care plans)	12 months*
Patient engagement	▪ Document approach to contact patients who did not get preventive care	18 months
Team-based care coordination	▪ Document investment in behavioral health integration (e.g., 1 hour per week coordinating with BH hub, offering new BH services (more than screenings), hiring a health coach or giving your staff health coach training), or having co-located BH specialist 3 hours per week	18 months

NOTE: Transformation milestones are intend[illegible]he way they work with other practices and patients to better coordinate care

Handout should be on your seat

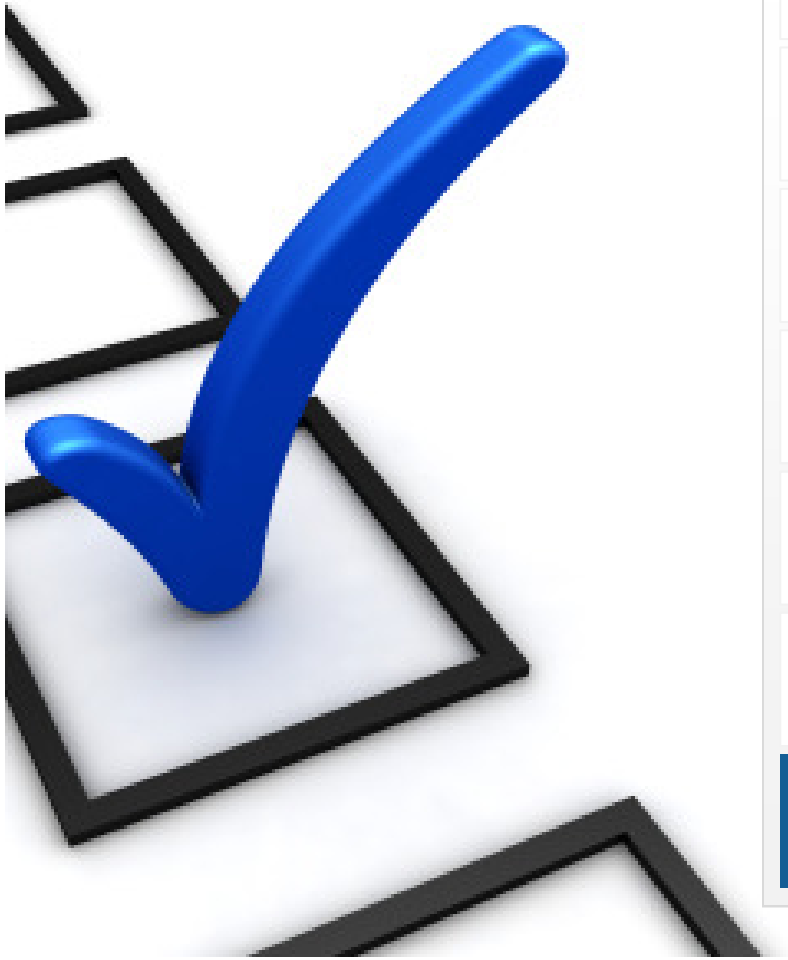
1 Multi-disciplinary team
* indicates milestones that would be repeated at 24 months

Agenda



Time	Topic
08:30-8:40	Status update
08:40-9:00	Recap from Workforce Symposium
09:00-9:15	Transition to Innovation Center
09:15-9:45	Overall scorecard
09:45-10:15	Common provider scorecard
10:15-10:30	***Break***
10:30-12:00	Integration across delivery and Healthy Neighborhoods

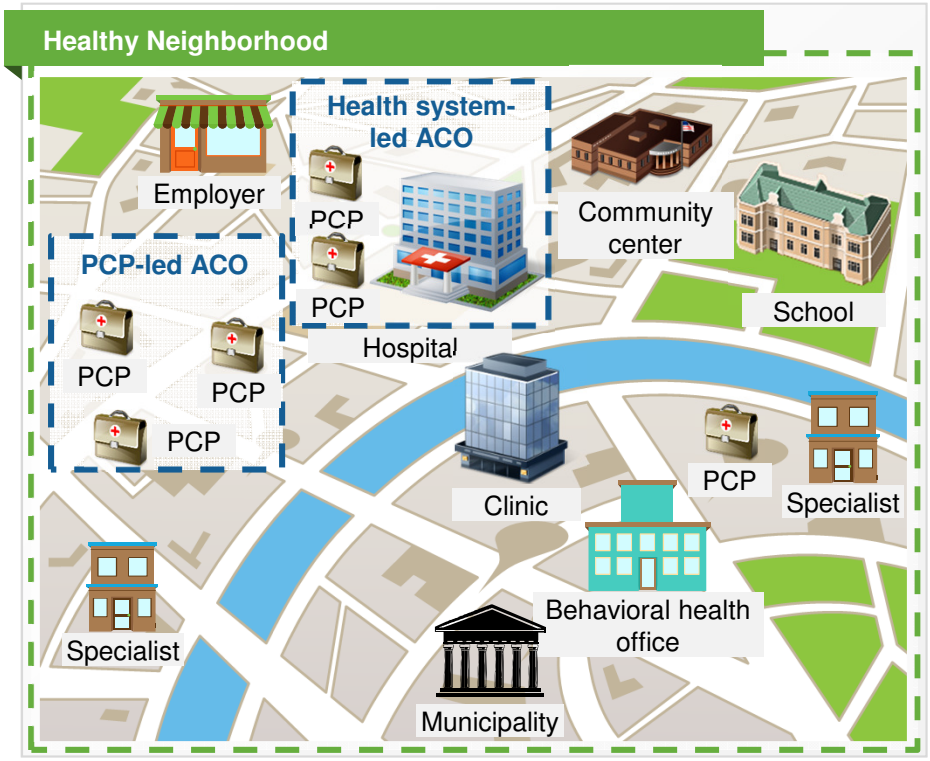
Agenda



Time	Topic
08:30-8:40	Status update
08:40-9:00	Recap from Workforce Symposium
09:00-9:15	Transition to Innovation Center
09:15-9:45	Overall scorecard
09:45-10:15	Common provider scorecard
10:15-10:30	*Break*
10:30-12:00	**Integration across delivery and Healthy Neighborhoods**

Delaware's model for health and health care

Delaware's model for health and health care



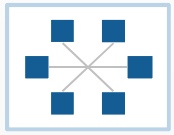
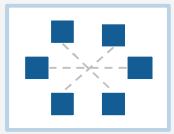
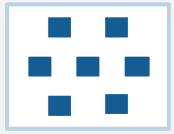
Healthy Neighborhoods

- In each local community
  - Enabling healthy behavior
  - Promoting prevention
  - Supporting better access to care
- Organized around local communities of 50-100K, with at least 1 health system or FQHC included in each Neighborhood
- Primary focus on healthy and "at risk" individuals
- Funded through grants/ foundations and potentially other resources

Delivery system (Medical Neighborhood)

- "Accountable care entities" incentivized to integrate/ coordinate care and manage quality and costs for full panel of patients
- Organized around primary care
- Primary focus is on 5-15% individuals with multiple chronic medical and behavioral health needs
- Funded through care coordination fees + shared savings

Reminder – Potential organizing models

	Name	Overview
Single corporate entity	1 Large practices	
Single corporate entity	2 Hospital-based health system	
Formal / Joint-venture	3 ACO with hospital	
Formal / Joint-venture	4 ACO without hospital	
Virtual	5 Virtual panels of provider organizations	
N/A	6 Not participating	

- The framework supports and enables all models
- Any provider structure can succeed
- Flexible by design

Examples of how Healthy Neighborhoods might achieve their goals

Description	How Neighborhood would work with accountable care entities
1 Healthy Neighborhood prioritizes preventive care, focused on **screening for breast cancer** – Goal to increase screening rates by 10% – Approach is for all organizations to participate in awareness campaign	▪ Primary care practices participate in planning and strategy sessions and engage with patients to test messages to support more effective awareness campaign
2 Healthy Neighborhood **improving access to care** by – Creating transparency on office hours for all primary care practices in community – Coordinating all transportation services to optimize availability	▪ Primary care practices identify individuals who need support to HN leads (with patient consent) ▪ Several primary care practices agree to “cross cover” for evening / weekend hours

Examples of how accountable entities may work with HNs for high risk coordination

Accountable entity activity/focus	Role of Neighborhood	Why organizations would pursue this model
1 Providing care in multi-disciplinary care teams	▪ Create community health teams with social worker, Behavioral Health Specialists, Community Health Worker to support practices within a region, co-funded with care coordination fees	▪ **Accountable entities**: demonstrate progress on integrating with Behavioral Health Better connect with other practices without formal affiliations ▪ **Healthy Neighborhoods**: additional funding, focus on key health need
2 Engaging patients	▪ Develop consumer outreach program to individuals who have not received primary or preventive care ▪ Community health workers join with care coordinators to lead outreach	▪ **Accountable entities**: improve outcomes metrics affected by consumer behavior ▪ **Healthy Neighborhoods**: make progress on health/prevention goals in Population Health scorecard

Breakout discussions

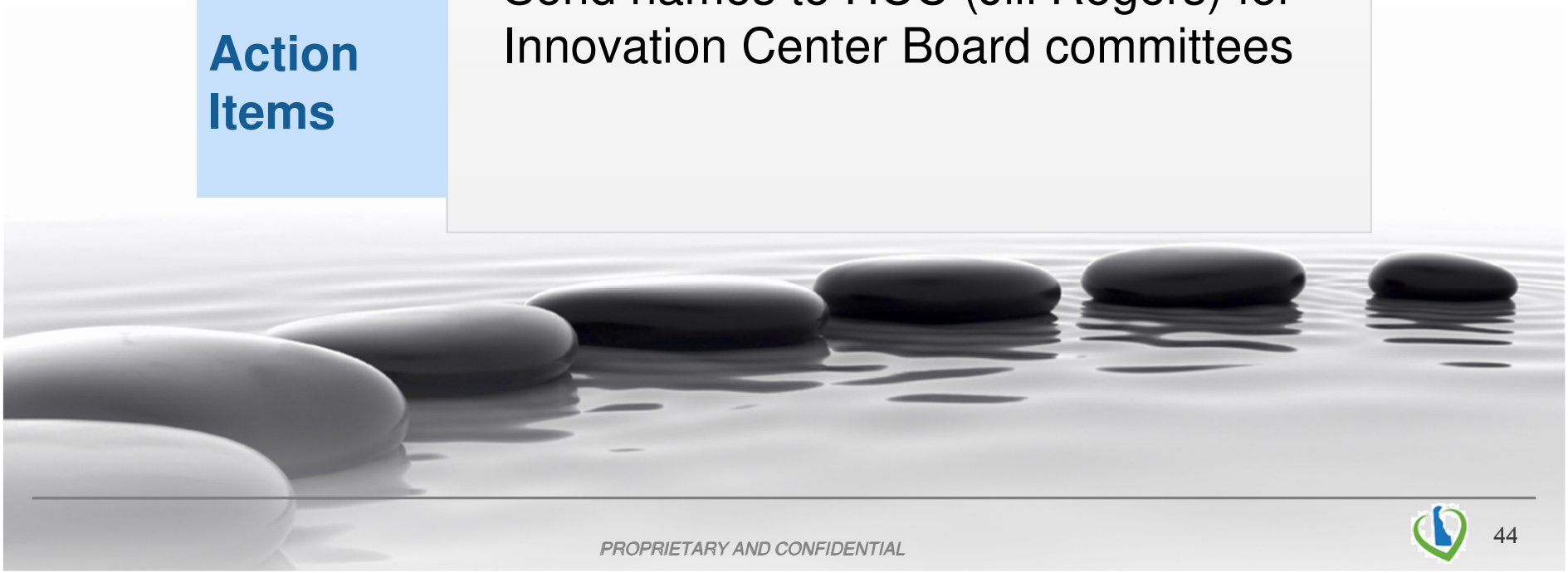
Breakout discussions (groups of 5 people, 20 minutes)

- What are the three most important areas where providers would want to work with Healthy Neighborhoods to address needs in your community?
- Which organizations in your community would be most likely to facilitate forming the connections between Healthy Neighborhoods and primary care?
- What sort of infrastructure would be helpful to support these joint efforts?

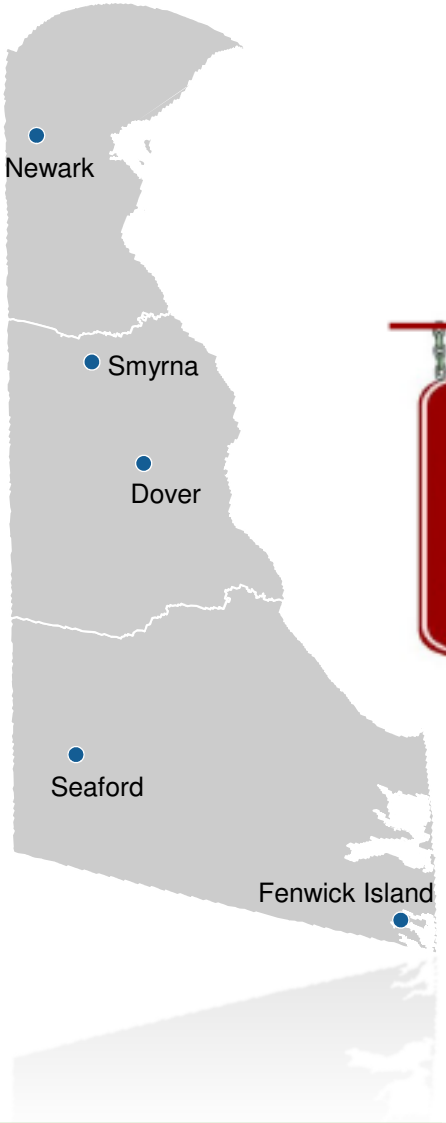
Share back with plenary (10 minutes)

Next steps

Meetings	▪ Next HCC meeting: June 5th ▪ Next cross-workstream meeting will follow launch of Innovation Center
Action Items	▪ Send names to HCC (Jill Rogers) for Innovation Center Board committees



Join us tonight



The Delaware Recognition *for* Community Health Promotion

Communities Promoting HEALTH

May 20, 2014
6:00 p.m. — 7:30 p.m.

Sewell C. Biggs Museum of American Art
Choptank Foundation Gallery
406 Federal Street
Dover, DE 19901