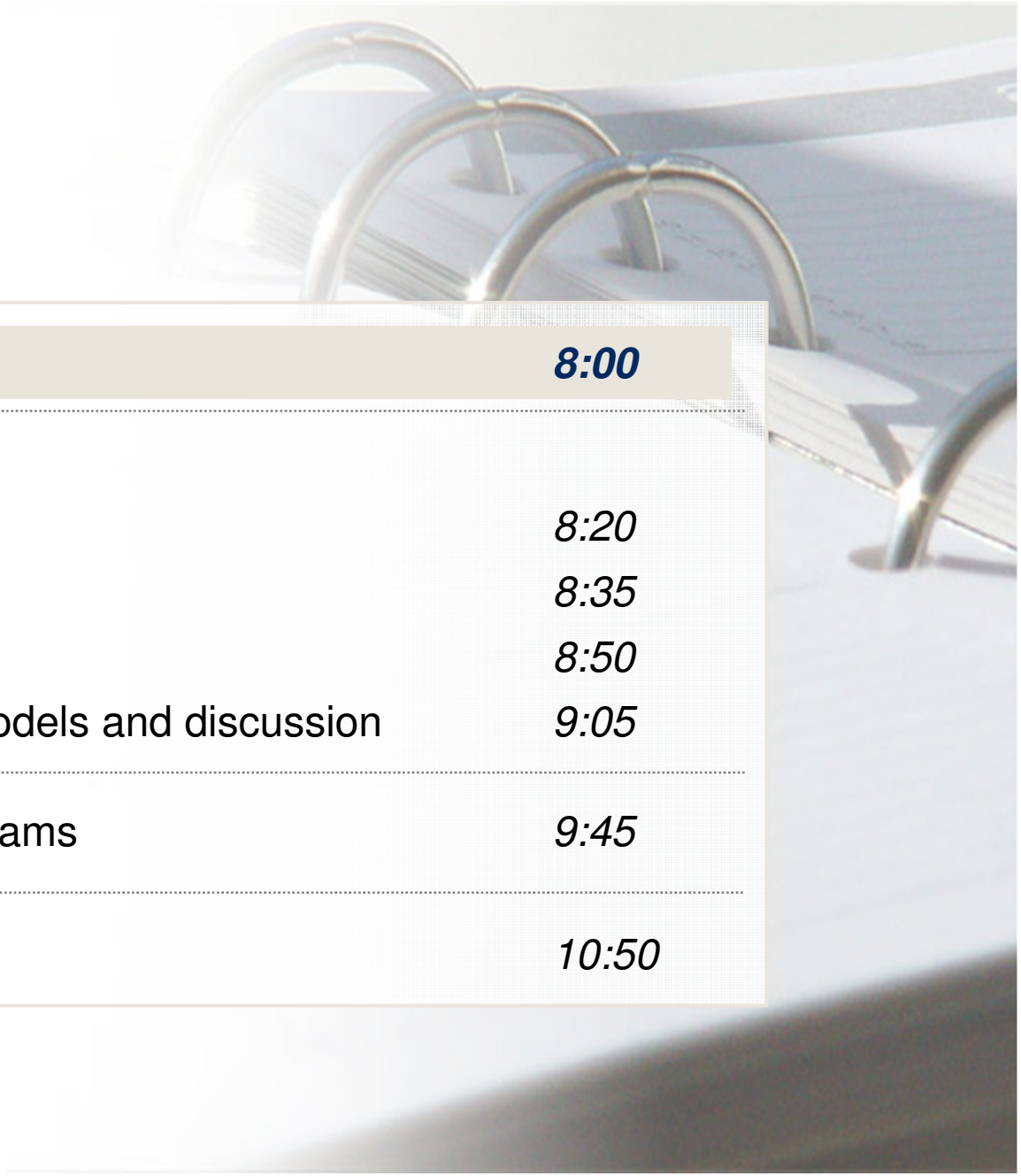
Transforming Delaware's Health:
A Model for State Health Care System Innovation

State Innovation Models (SIM) all-workstream meeting

June 26th, 2013


WELCOME

Agenda



Introduction	***8:00***
Emerging answers	
– Delivery system	*8:20*
– Population health	*8:35*
– Payment model	*8:50*
– Potential organizing models and discussion	*9:05*
Update for other workstreams	*9:45*
Wrap-up	*10:50*

Objectives for today

1. Check-in on where we are
2. Discuss working approach and your feedback on transformation
3. Review and discuss emerging perspectives across workstreams

Innovations in Healthcare :

for a *healthier* community

The "Triple Aim"

1. **Improving the health of Delawareans**
2. **Improving health outcomes**
3. **Reducing health care costs**

Reminder: Guiding principles

Impact

- Develop a health care transformation strategy that is **multi-payer and multi-stakeholder** and focuses on **achieving the "Triple Aim"**
- **Be one of the leading states** in innovation and impact
- Achieve measurable results in **three years** through practical implementable goals
- Meet the near term objective of developing the State Innovation Plan while focusing on the **primary goal of transforming Delaware's health care**

Approach

- Focus on the **best interests of all Delawareans** and respect the voice of consumers (not just traditional stakeholders)
- Have no **"sacred cows"**
- Make use of **best practice** where possible, applying pragmatic judgment
- Focus on **getting to a practical plan**, rather than a long conceptual debate

Think of yourself as: a patient, a client, a consumer, a caregiver

What is 'Consensor' and why are we using it?

What is it?

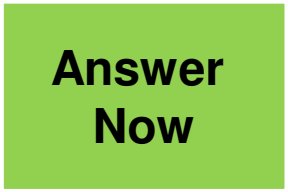
- Audience response system that collects responses from participants through a wireless handheld device
- Data collected and stored for immediate presentation

Why use it?

- Permits real-time, anonymous input
- Enables greater audience participation
- Highlights areas of alignment and misalignment

When to use it?

- If you see the image below, it is time to use Consensor:



Do not vote until you see this icon!

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

PRELIMINARY

6 workstreams

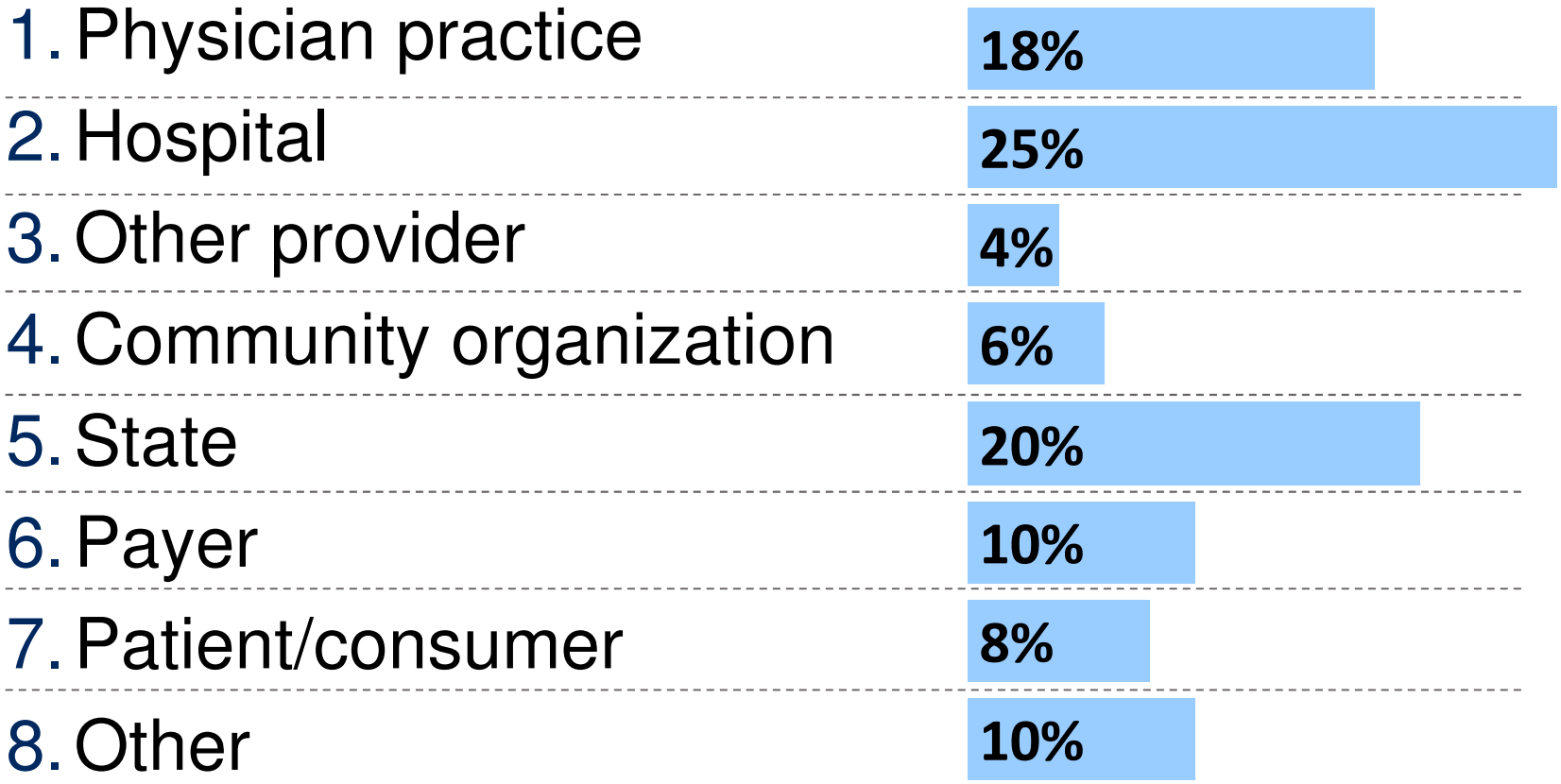
20 meetings totaling more than ***44*** hours

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

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

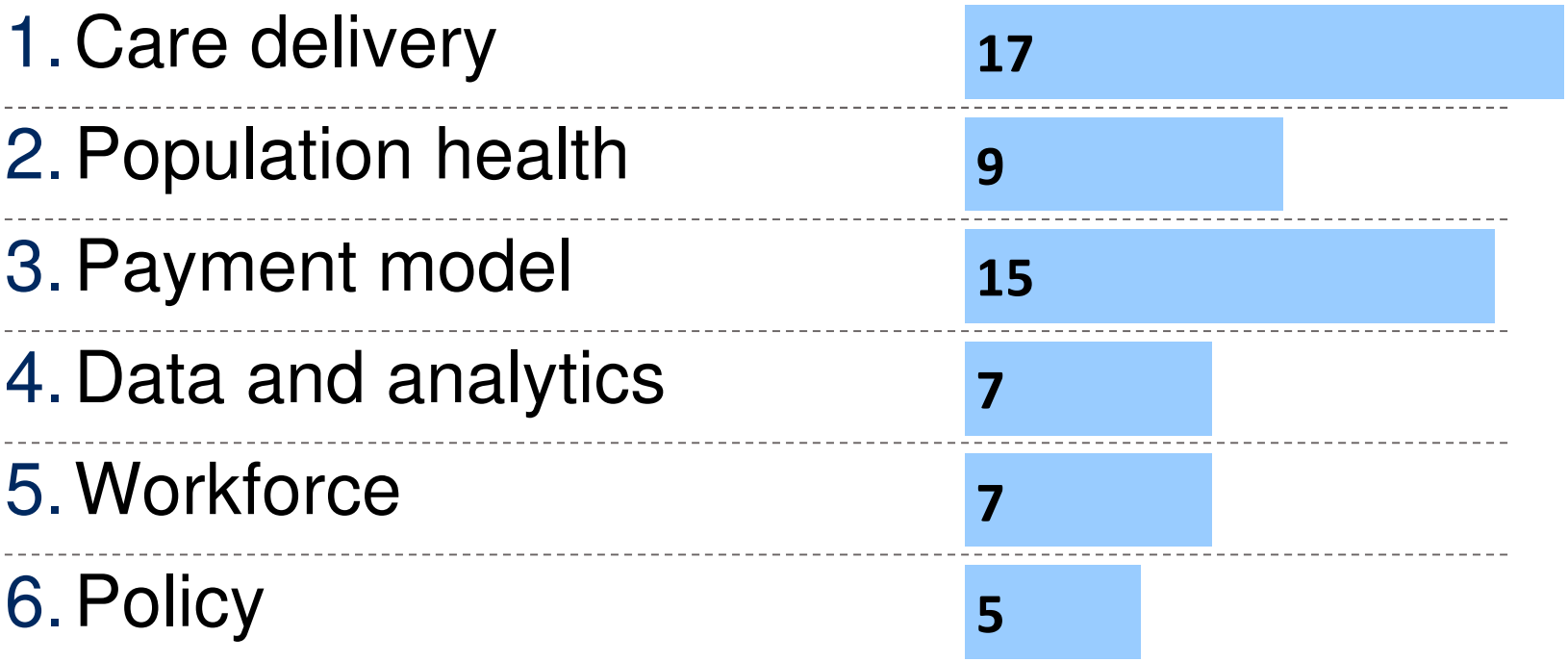
Who is in the room?

Which stakeholder group do you represent?



Who is in the room?

Which workstream sessions have you attended? **(multiple choice)**



Some reflections about working approach

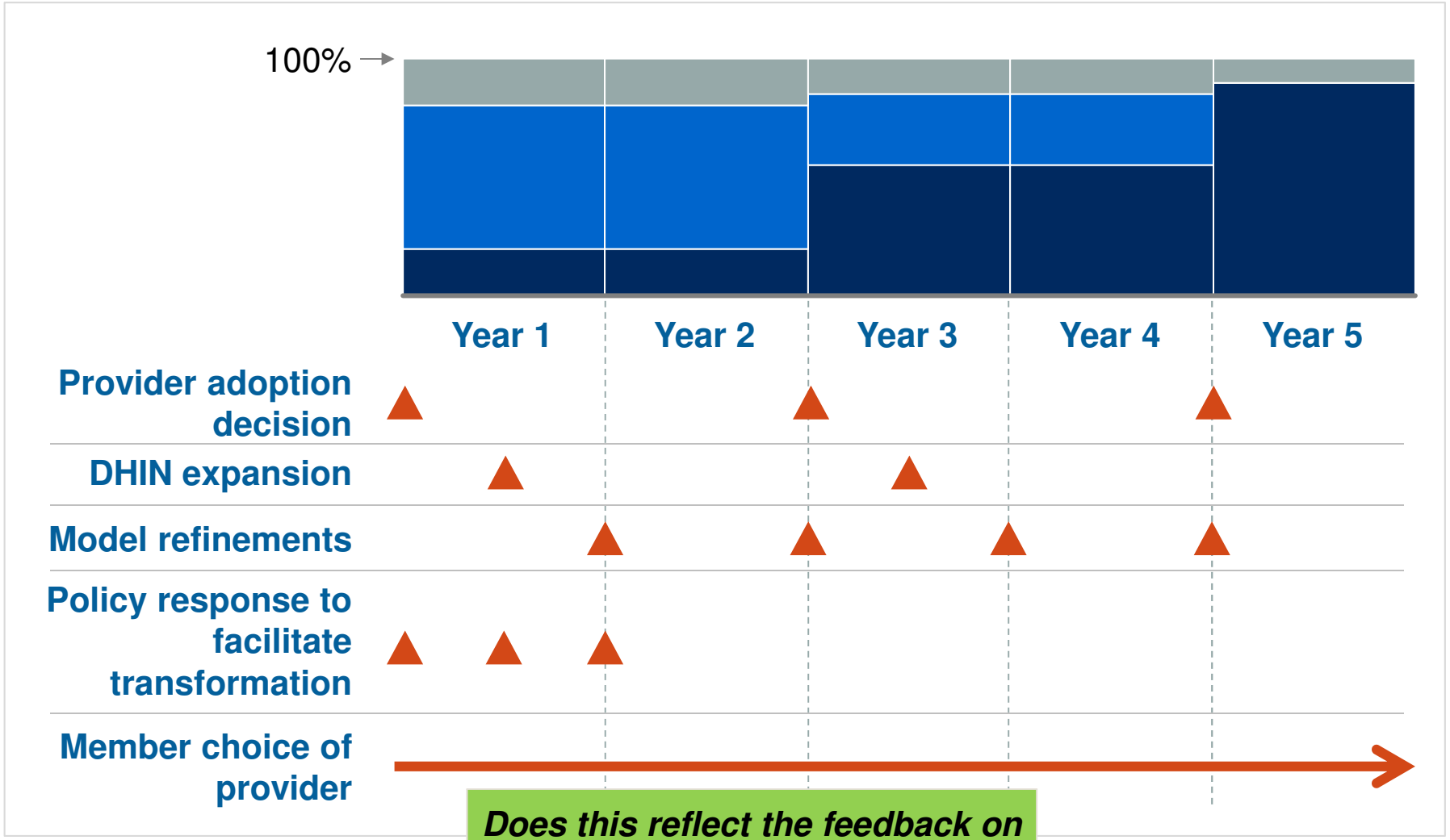
- The information presented comes from prior workstream and full group meeting discussions
- The goal is to generate discussion and thoughtful feedback to refine the ideas
- We share your excitement in jointly discovering the best answer for healthcare transformation in DE
- We have no predetermined answers

What we've heard from you about statewide health system transformation

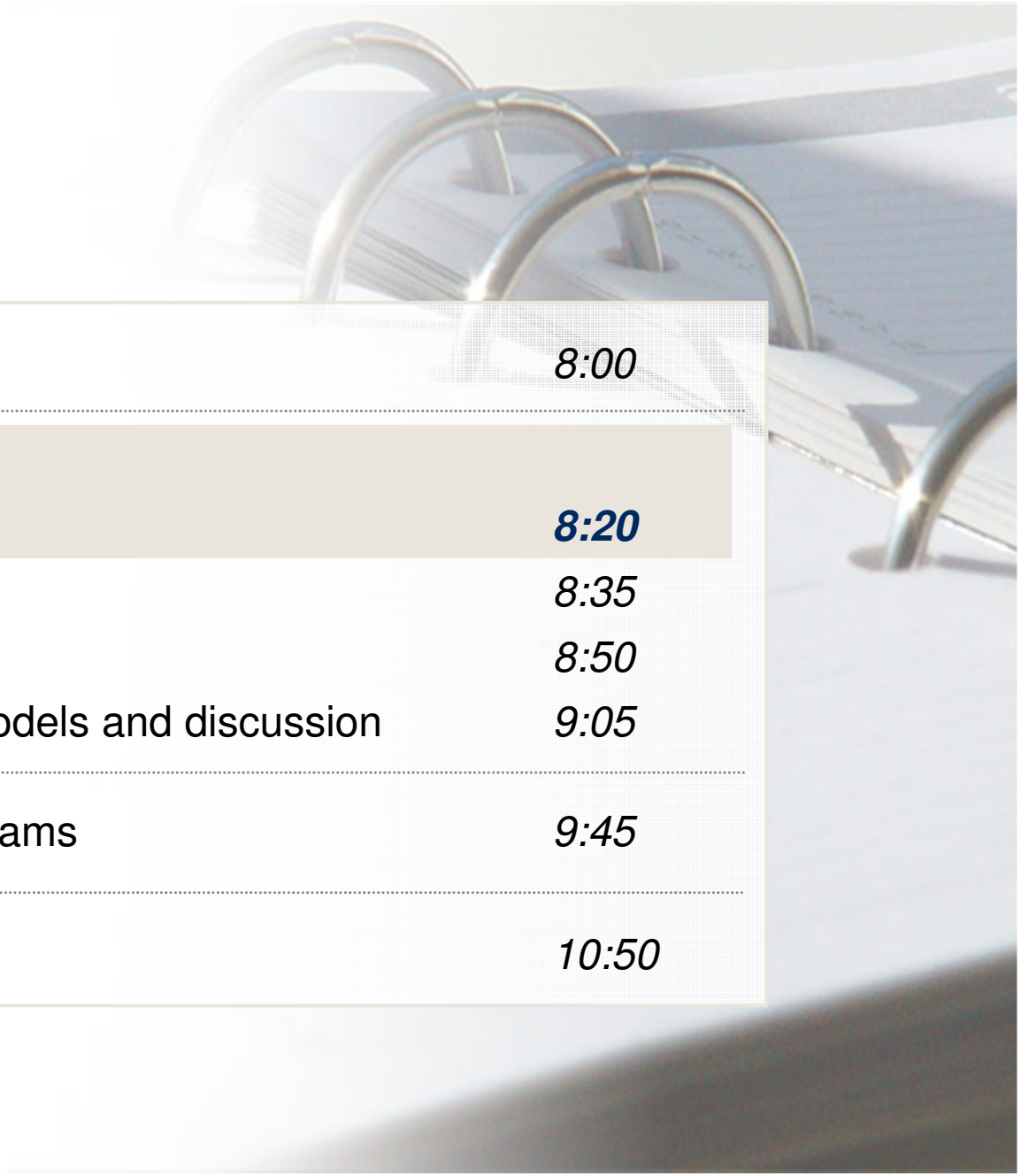
- We have a shared recognition of the opportunity to meaningfully improve health care for Delawareans
- Transformation is a multi-year process, and there are real benefits to designing to scale – as long as the model has "checkpoints" and enough tracking of data to support continuous improvement along the way
- The approach to transformation should build from and enable ongoing innovation
- There is a collective belief that patients—who can be viewed in many ways as clients or consumers—are the central focus of this effort, and their needs are the basis upon which this transformation is built

Example of how transformation could unfold in DE

ILLUSTRATIVE



Agenda



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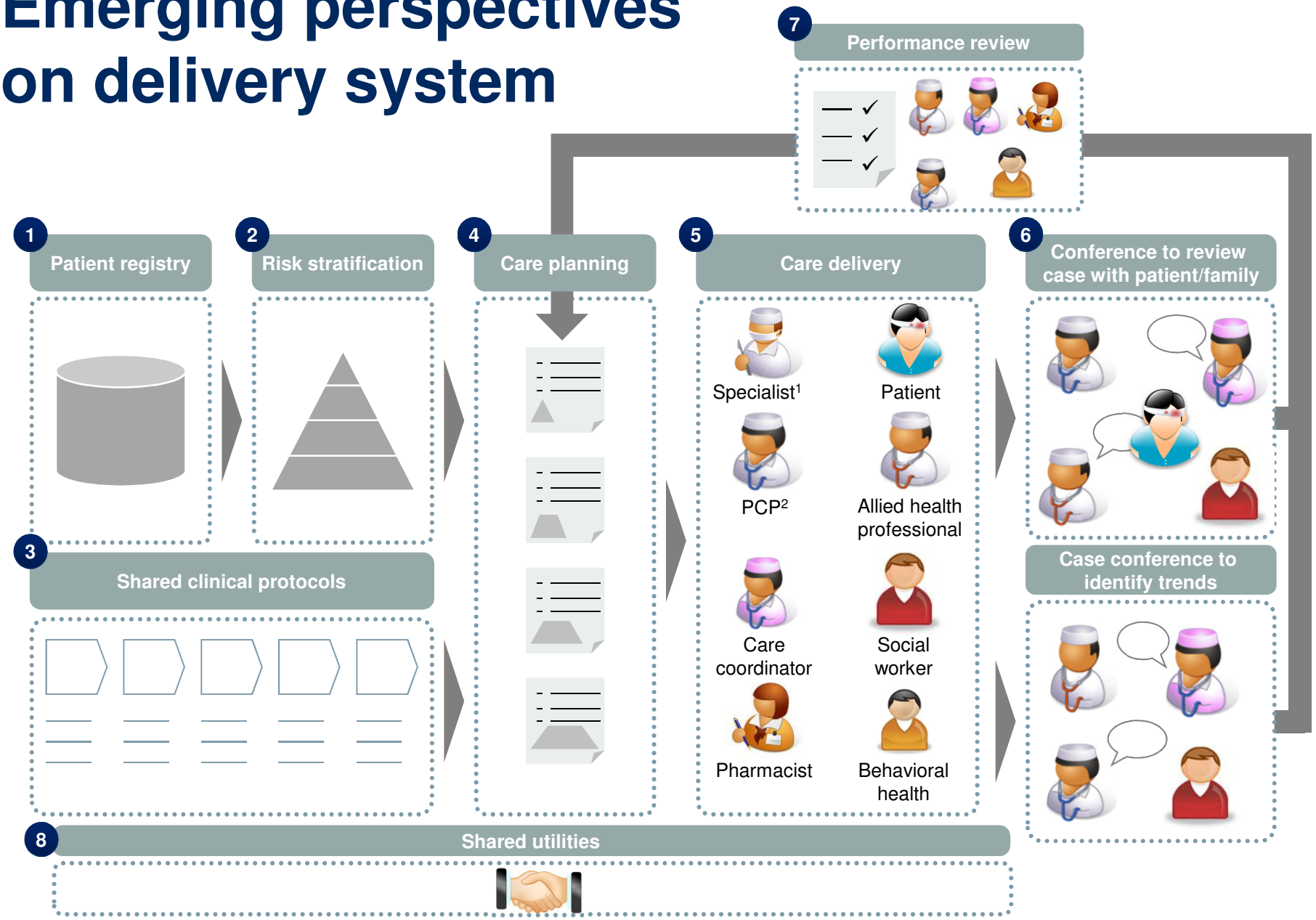
What we've heard from delivery system workstream meetings

1. Patients (or consumer/clients/individuals) should be at the center of delivery system transformation
2. There is a significant opportunity to improve; we should fix underlying challenges not just create temporary "band aids," and provide a framework for continuous improvement
3. Challenges in delivery exist in every care setting; solutions should be sufficiently comprehensive to address this
4. This transformation needs to be a focused effort
5. There should be focused care coordination on high cost population segments and effective diagnosis and treatment for all groups
6. The DE provider landscape is fragmented, suggesting that transformation will be a multi-year journey
7. There are pockets of innovation already taking place that should serve as building blocks upon which we construct this effort

Emerging perspectives on delivery system



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

Requirements for care delivery system (1/2)

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

Requirements for care delivery system (2/2)

On June 11, this group expressed:

- General alignment with a focus on care coordination and effective diagnosis and treatment
- Preference for at least some light touch level of care coordination being widely available even if the focus is on high risk
- The need for focusing on a limited number of high spend and high variation areas to improve effective diagnosis and treatment

In our last delivery system working session, we discussed the requirements for providing widespread effective care coordination and multi-disciplinary care and identified the need for:

- Significant transformation of practices patterns (e.g., institutionalizing performance reviews)
- Significant investment in tools, resources, and capabilities
- Alignment on who has accountability for care coordination

Preference for increasing clinical integration

NOT EXHAUSTIVE

Preferred options

Less integration

- **Independent / vendor driven model**
- **Formal provider networks**
- **Networks of physicians and community-based organizations**
- **Co-located networks of physicians and community-based organizations**
- **Co-located networks of physicians and community-based organizations at hospital site**

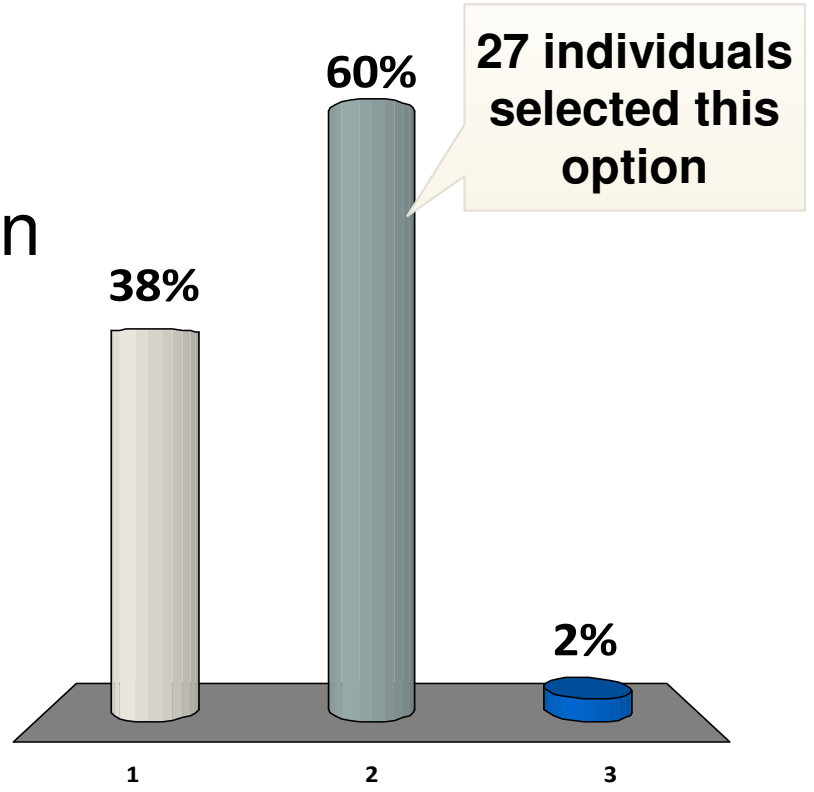
Greater integration

Quick feedback

TO GENERATE DISCUSSION ONLY –
NOT FOR DECISION-MAKING

What do you think of the **care delivery** model approach we are pursuing?

1. Headed in the right direction
2. Sounds good, but need more information
3. Headed in the wrong direction



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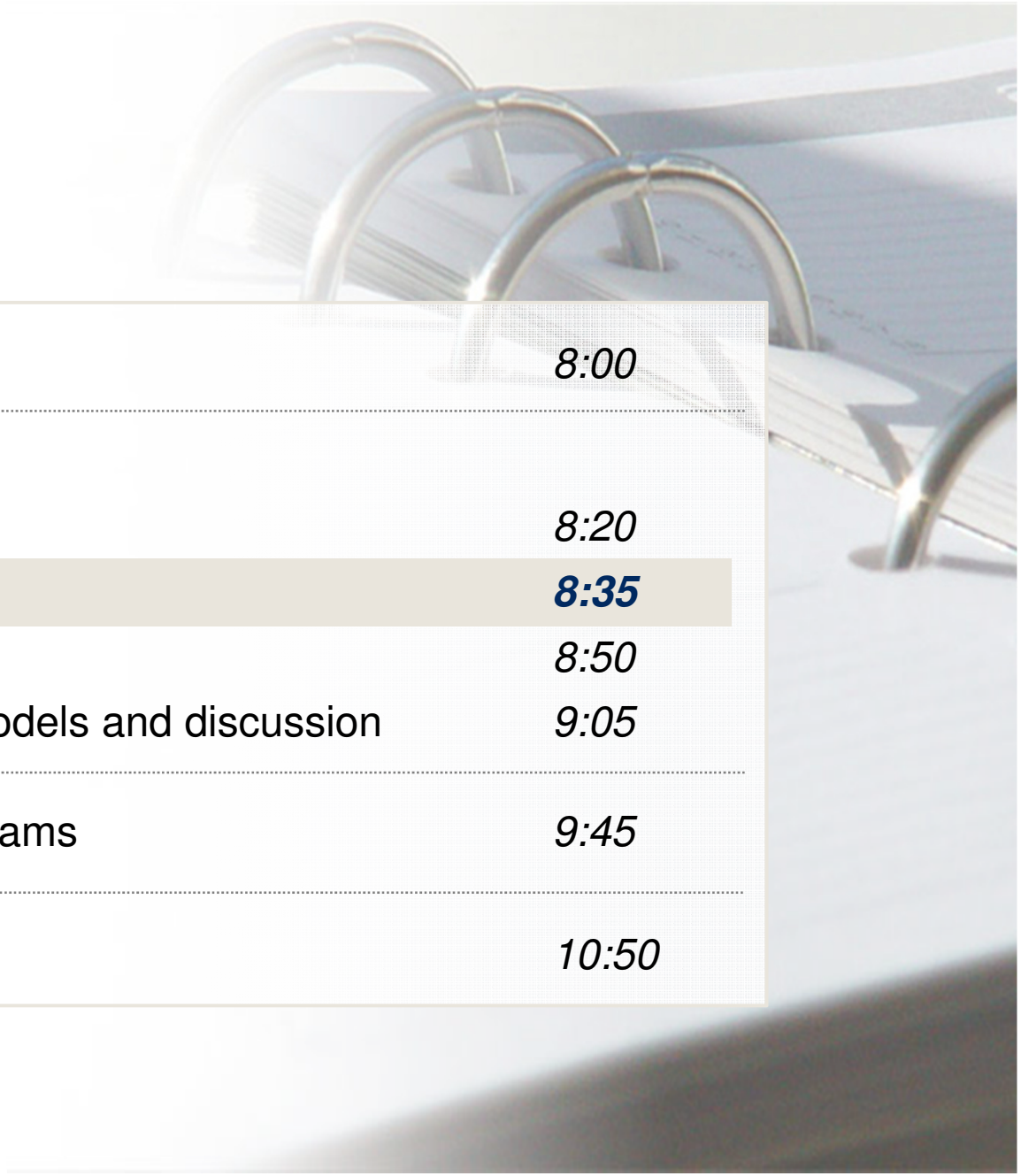

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What we've heard from population health workstream meetings

1. Significant efforts are ongoing in many areas
2. The lack of integration among existing efforts leads to
   - Inefficient use of limited resources
   - Confusion for patients and providers
3. Needs and resources vary significantly among neighborhoods across the state
4. There is a strong foundation to build from for need identification and potential tools/resources (e.g., from Governor's Council)

Emerging perspectives and integration

Establishment of zones and designation of local champions

Assessment of community needs and local action plan creation

Utilization of community health workers to promote integration

Creation of directories cataloging services offered regionally

Data at the neighborhood level and score-cards for evaluation

Platform for sharing of best practices across the state

- Emerging perspective for a balance between common framework and approach (e.g., on a few common outcomes, method of change) with significant room for local tailoring
- Need to identify how to align with delivery system

Healthy Neighborhoods potential structure

6 core program components

- Designation of zones and local champions
- Assessment of community needs and local action plan
- Utilization of community health workers to support integration
- Creation of directories of regional services offered
- Data at the neighborhood level and score-cards
- Platform for sharing of best practices across the state

An example of how it could work

Required DE-wide interventions

Program administration and oversight

- Designate Healthy Neighborhood Champion organizations in each DE zone
- Fund champions to design and execute community action plans

Coordination/program evaluation

- Establish priority focus areas
- Develop capability to measure neighborhood-level outcomes
- Create common scorecard
- Provide technical assistance
- Provide platform for sharing best practices

Healthy Neighborhood Champion role

Community assessment/planning

- Assemble local coalition from diverse stakeholders
- Assess landscape
- Develop integrated plan for improving performance

Implementation

- Recruit and train community integration workforce (e.g., volunteers)
- Train providers about community resources
- Track and report progress against target metrics

Quick feedback

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What do you think of the **population health** approach that we are pursuing?

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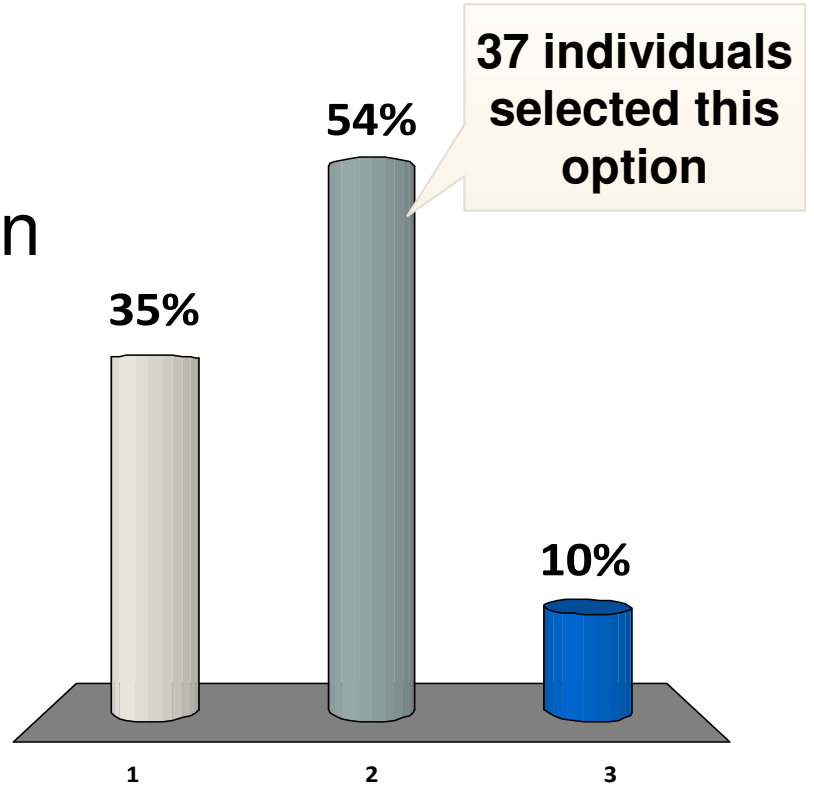
2. Sounds good, but need more information
3. Headed in the wrong direction



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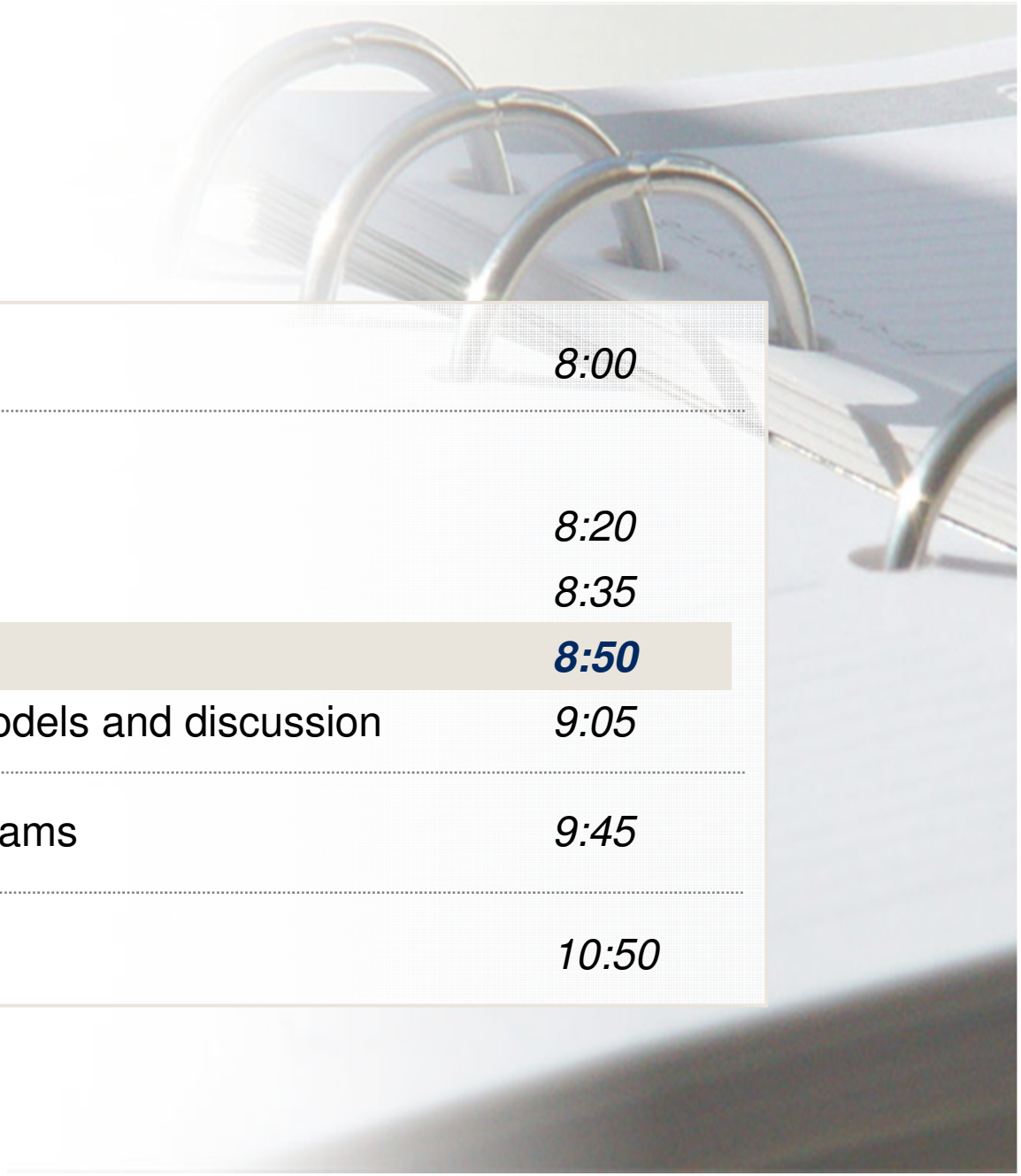

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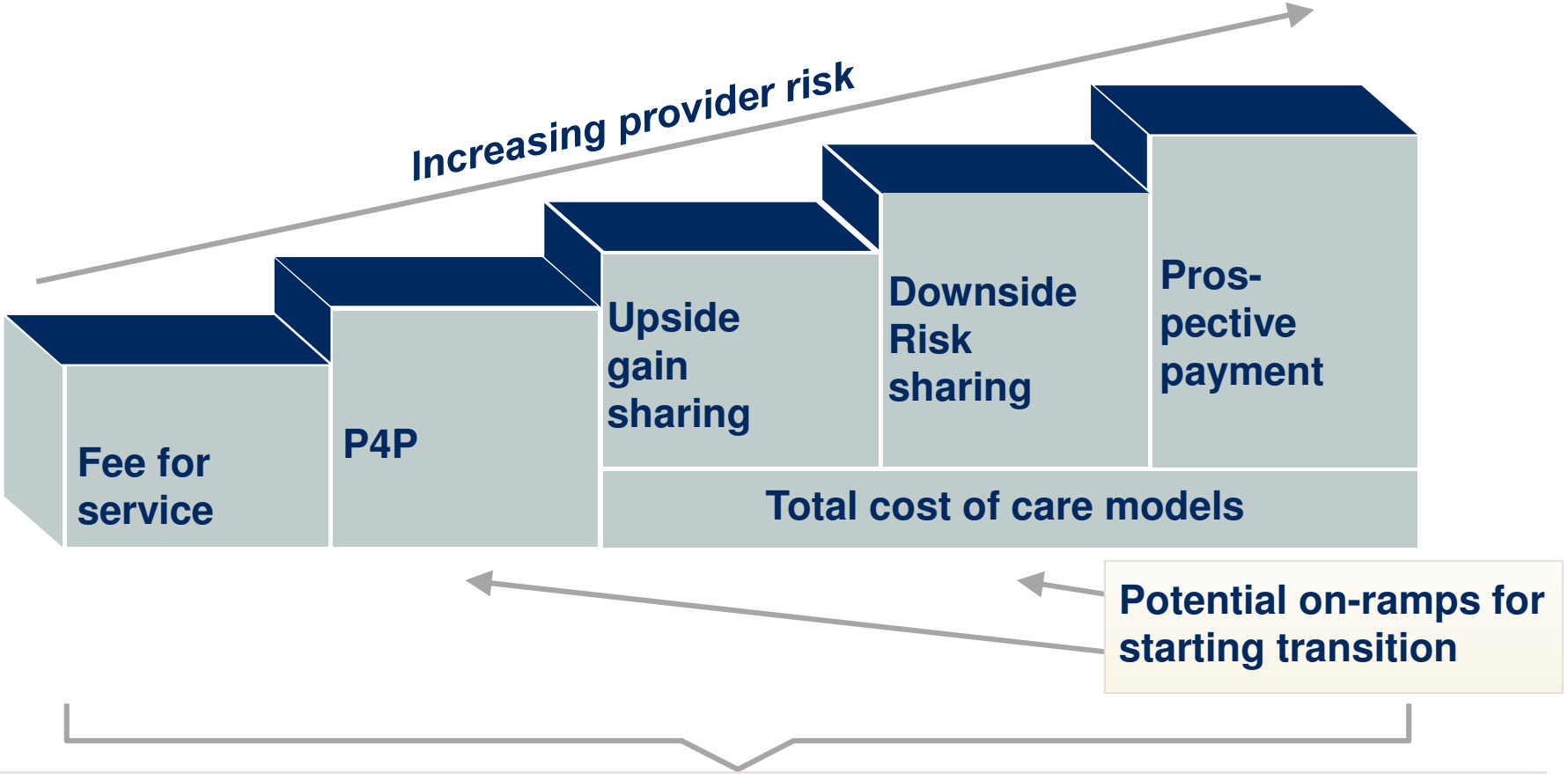
What we've heard from payment model discussions

1. Focus on population-based model as foundation with potential for episode and/or other models to be layered on in the future
2. Align payment model across payers to support business case for delivery system transformation, with some room for differences in patient populations
3. Establish a vision for a common end state for payment that includes accountability for total cost of care as well as access, quality, and experience
4. Establish two transition paths to that end-state, to account for differences, structure, and capabilities among providers
5. Establish checkpoints during transition for continuous improvement
6. Define rules for payment model participation that balance the advantages of scale, clinical integration, and competition
7. Design for scalability from the outset, even if we choose to stage rollout for operational or financial reasons
8. Confront the needs of some payers for administrative consistency with national standards
9. Plan for the transition costs to some providers (e.g., new capabilities for PCPs, reduced inpatient volume for hospitals)
10. Recognize that fee for service will continue to make sense for some payments

Reward structure options for payment

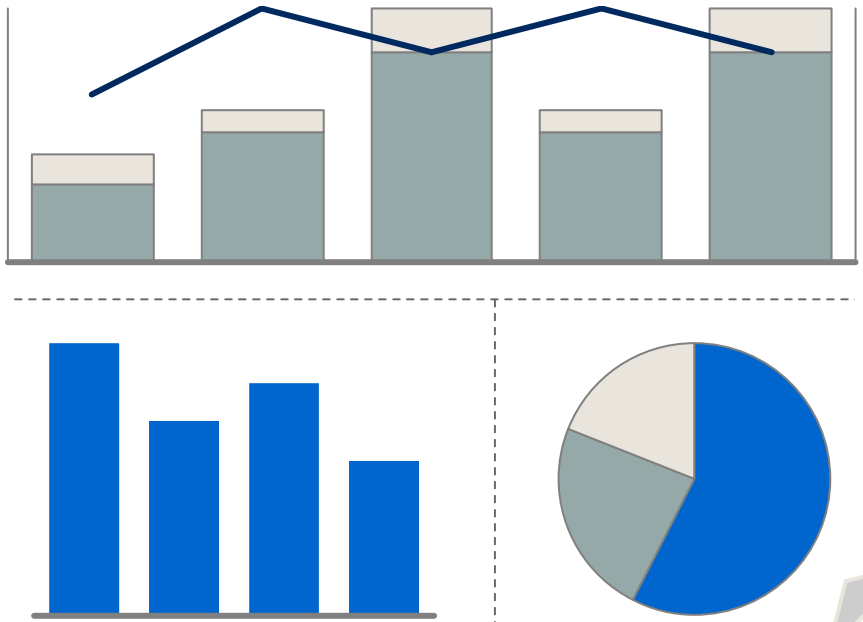


- **All** would be measured against **same scorecard of metrics**
- **All** would require meeting **quality measures** to qualify for gains
- For **P4P**, would measure **utilization** for payment (reporting **total cost** for information)
- For **total cost of care models**, would measure **total cost** for payment (reporting **utilization** for information)

Common scorecard

ILLUSTRATIVE

Example scorecard



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

Common vision of accountability for the Triple Aim

Proposed principles

- All payers should adopt common measures for Triple Aim: health, healthcare, and costs
- Metrics should be based on nationally recognized measure sets, to the extent possible
- Performance should be tracked and reported to providers independent of payment model

Goals	Types of metrics
Health	▪ Health risk factors (e.g. obesity) ▪ Prevalence of illness and injury
Health care	▪ Patient satisfaction ▪ Quality of care – Structure – Process – Outcomes
Costs	▪ Total cost of care ▪ Resource utilization, e.g., –Hospital days per 1,000 –Emergency room visits per 1,000 –Generic prescribing rates

Potential measure sets to be considered

- CMMI core measures
- HEDIS
- CAHPS
- DE PCMH / P4P programs
- Other payer programs

Factors to be considered in selecting specific metrics

- Stakeholder acceptability
- Ease of data capture
- Consistency / objectivity
- Availability of baseline data
- Fit with sources of value as prioritized by delivery system workgroup

Example of two population-based models for payment

FOR FEEDBACK

Proposed Principles

- All providers measured against same dashboard of metrics
- All providers must achieve goals for both efficiency and quality/experience to earn rewards
- Providers protected from differences in patient health risk through risk adjustment

		A: Pay-for-performance	B: Total cost of care
1	**Basis for estimating savings**	▪ Resource utilization (e.g., hospital days/1,000, ER visits, generic prescribing rate)	▪ Total cost per member per year
2	**Basis for qualifying for payouts**	▪ Experience ▪ Quality of care	▪ Experience ▪ Quality of care
3	**Basis for risk-adjustment**	▪ Health risk factors ▪ Prevalence of illness and injury	▪ Health risk factors ▪ Prevalence of illness and injury
4	**Informational purposes**	▪ Total cost per member per year	▪ Resource utilization

Detailed design decisions to come

- Patient population included/excluded from each metric
- Services included/excluded
- Definition of benchmark/target
- Risk-adjustment methodology
- Weighting of measures

Scale required for metrics to be reliable

Goals	Types of metrics	Minimum patient population*
Health	▪ Health risk factors (e.g. obesity) ▪ Prevalence of illness and injury	▪ Moderate (100-1,000)
Health care	▪ Patient satisfaction ▪ Quality of care – Structure – Process – Outcomes	▪ Low to moderate (<1,000) ▪ Depends on specific metrics – Low (<100) – Moderate (100-1,000) – High (5,000+)
Costs	▪ Total cost of care ▪ Resource utilization, e.g., –Hospital days per 1,000 –ER visits per 1,000 –Generic prescribing rates	▪ High (5,000+) ▪ Depends on specific metrics – Moderate (100-1,000) – Moderate (100-1,000) – Low (<100)

Implications for Delaware

- Moderate scale required for P4P likely to require aggregation across payers or across providers
- High scale required for Total Cost to require aggregation across payers and across providers

*Rule of thumb, to be validated for each metric based on relevant population

SOURCE: Survey of health services research

Quick feedback

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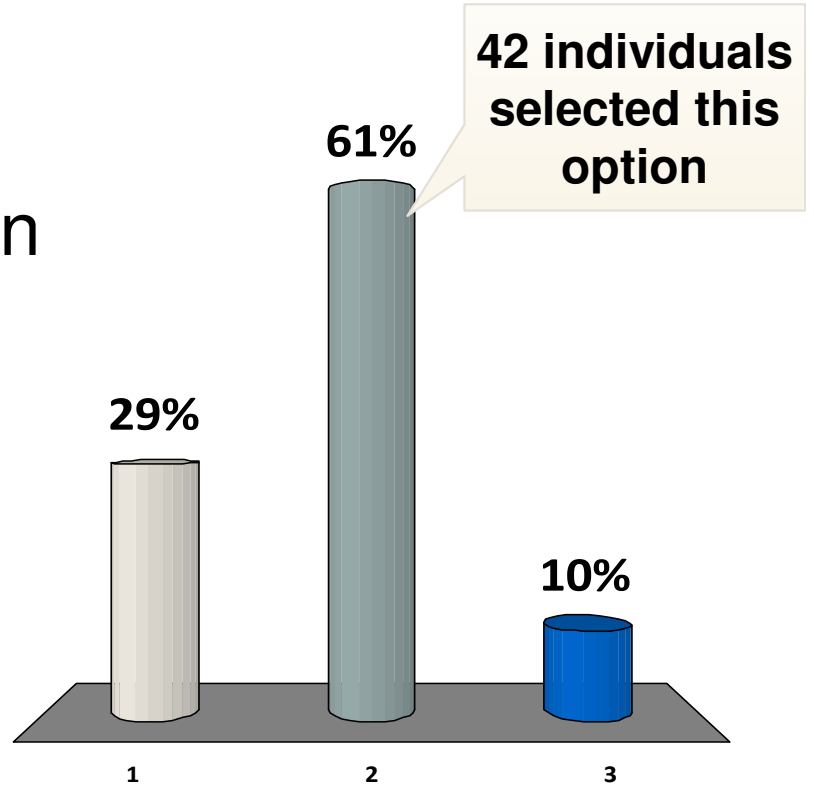

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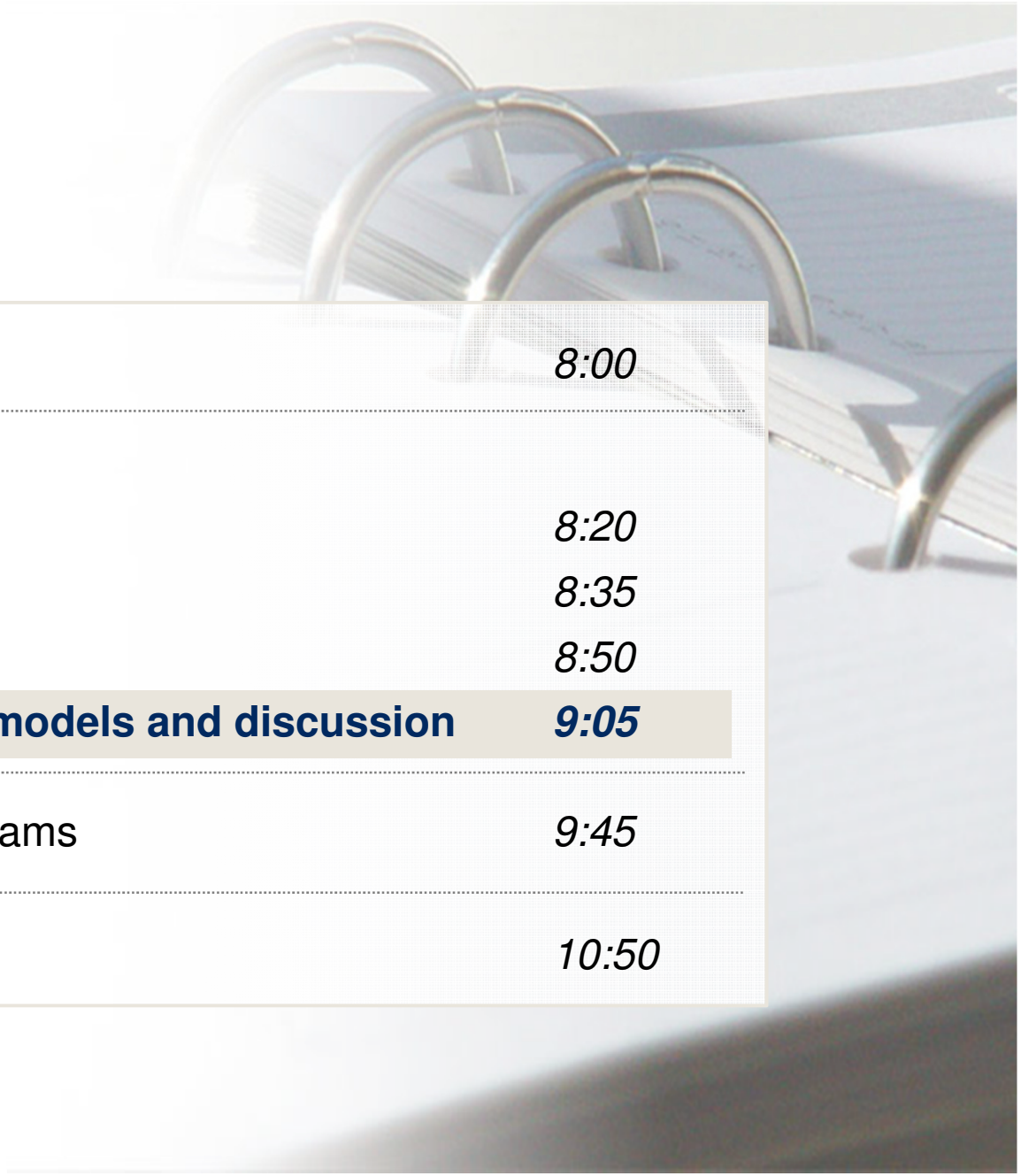

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Bringing it all together

1. Patient engagement strategy based on activating patients and supporting behavior change
2. Local health neighborhoods bringing together delivery system and community to set goals, review performance, align engagement efforts
3. Focus on high risk, high cost patient segments with care coordination
4. Effective diagnosis and treatment across the board supported with guidelines and transparency in reporting
5. Reimbursement mechanism aligned with total cost incentive model
6. Commitment to transparency across the system
7. Shared utilities in select areas (e.g., risk stratification)
8. Streamlined/system efficiency
9. Procurement/contracting that supports system change
10. Policy response to enable changes

Participant feedback on emerging answer

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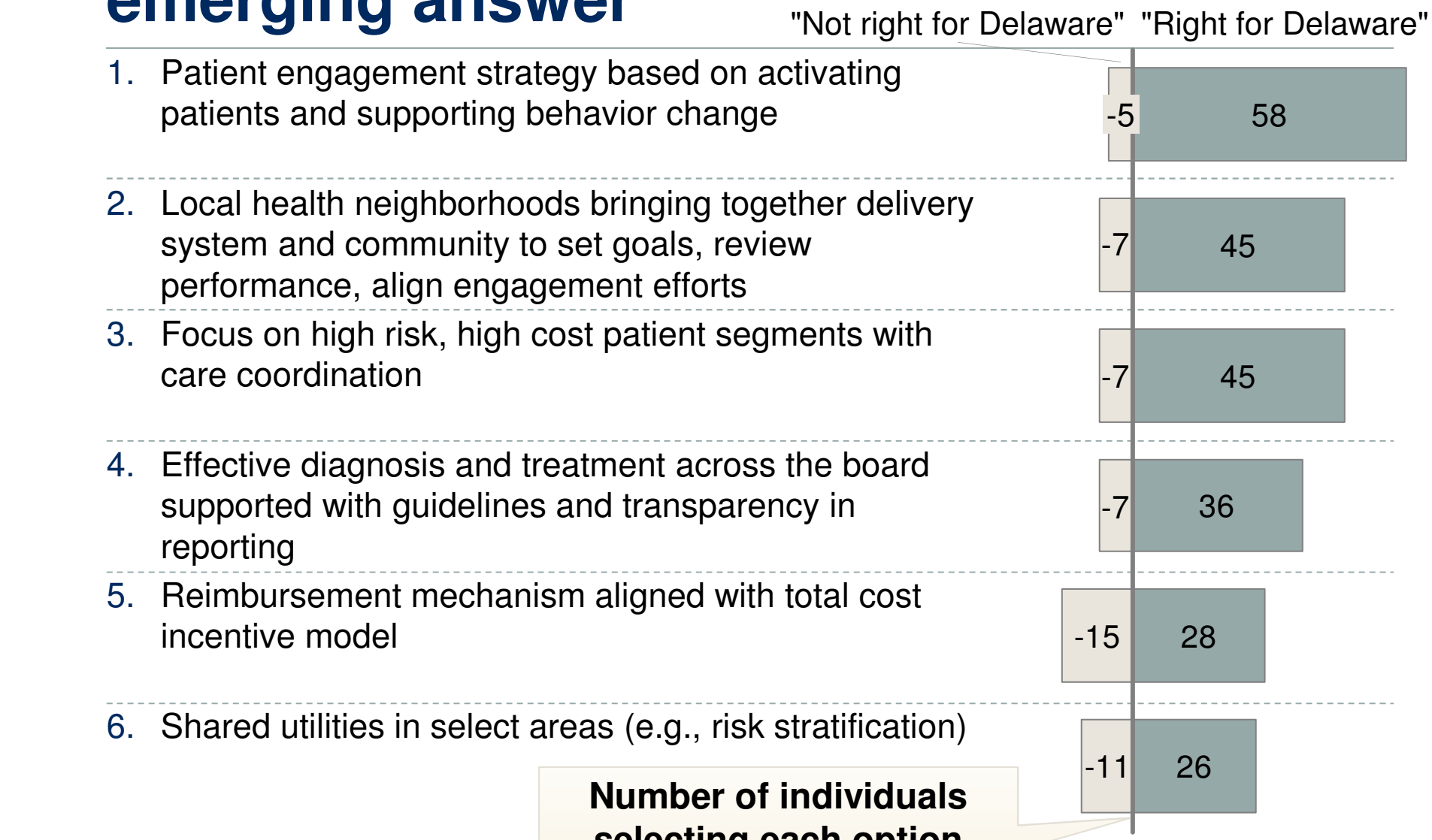


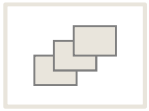
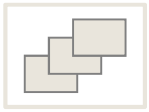
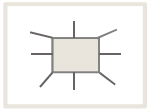
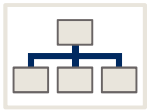
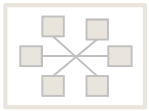
Context for organizing model

Need a provider organizing model(s) that allows for

- Greater clinical integration
- Alignment and integration of delivery system and population health
- Scale required to be able to take on accountability for total cost of care

Potential organizing models

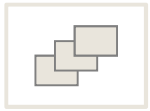
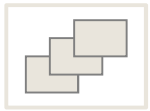
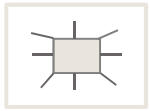
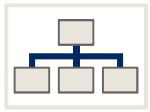
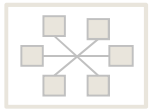
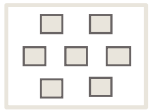
PRELIMINARY

	Name	Overview	Description	Organizer
Single corporate entity	1 Large physician practices		▪ Larger practices / provider organizations with shared reimbursement	▪ Provider leadership/ champion
	2 Hospital-based health system		▪ Hospital system including employed physicians and outpatient services	▪ Health system
Formal / Joint-venture	3 ACO with hospital		▪ Provider organizations united for reimbursement coordinated around hospital	▪ Hospital / Health system
	4 ACO without hospital		▪ Provider organizations united for reimbursement without hospital	▪ Provider organizations ▪ Community groups
Virtual	5 Virtual panels of provider organizations		▪ Small provider organizations join to create scale for transformation, risk	▪ Payer, provider organization, or vendor
N/A	6 Not participating		▪ Providers not participating in total cost of care model	▪ None

Attribution based on patient choice or retrospective primary care attribution (for patients who do not make a choice)

Implications of organizing model for care delivery and population health

PRELIMINARY

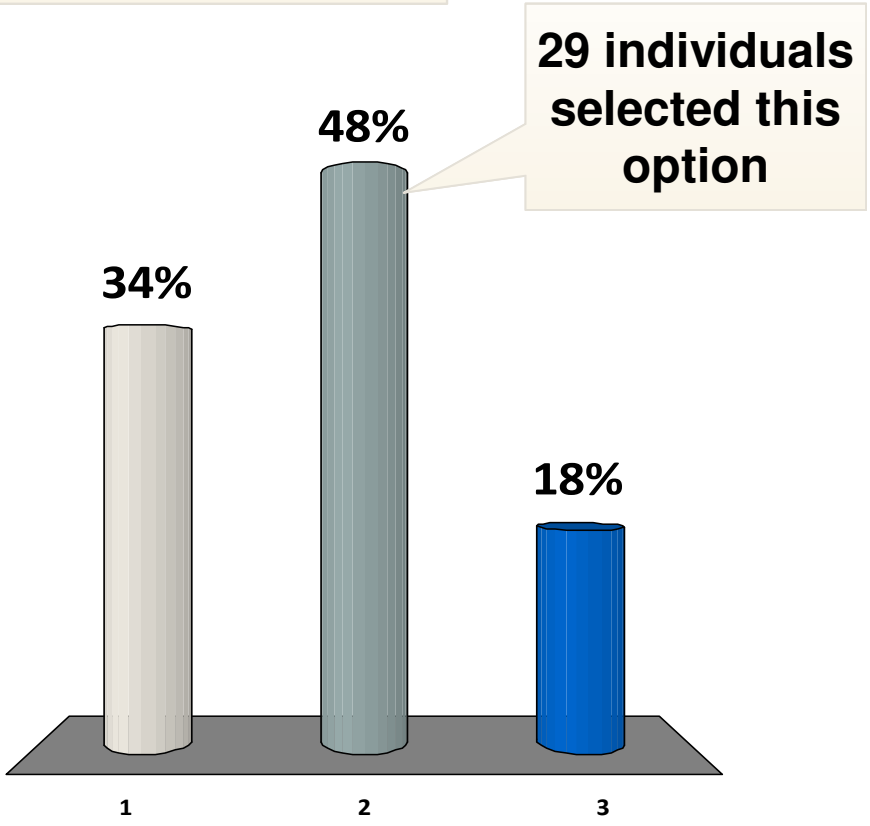
		Care delivery	Population health
1 Large physician practices		▪ Suggests more clinically integrated delivery model ▪ Models would ease care delivery transition (e.g., care coordination)	▪ Any model option would require clear lines and integration points aligned with community-based population measures
2 Hospital-based health system			
3 ACO with hospital			
4 ACO without hospital		▪ Potentially allows more flexibility for individual practices ▪ Efforts to coordinate care will have to be more intensive	
5 Virtual panels of providers			
6 Not participating			

Discussion and feedback

TO GENERATE DISCUSSION ONLY – NOT FOR DECISION-MAKING

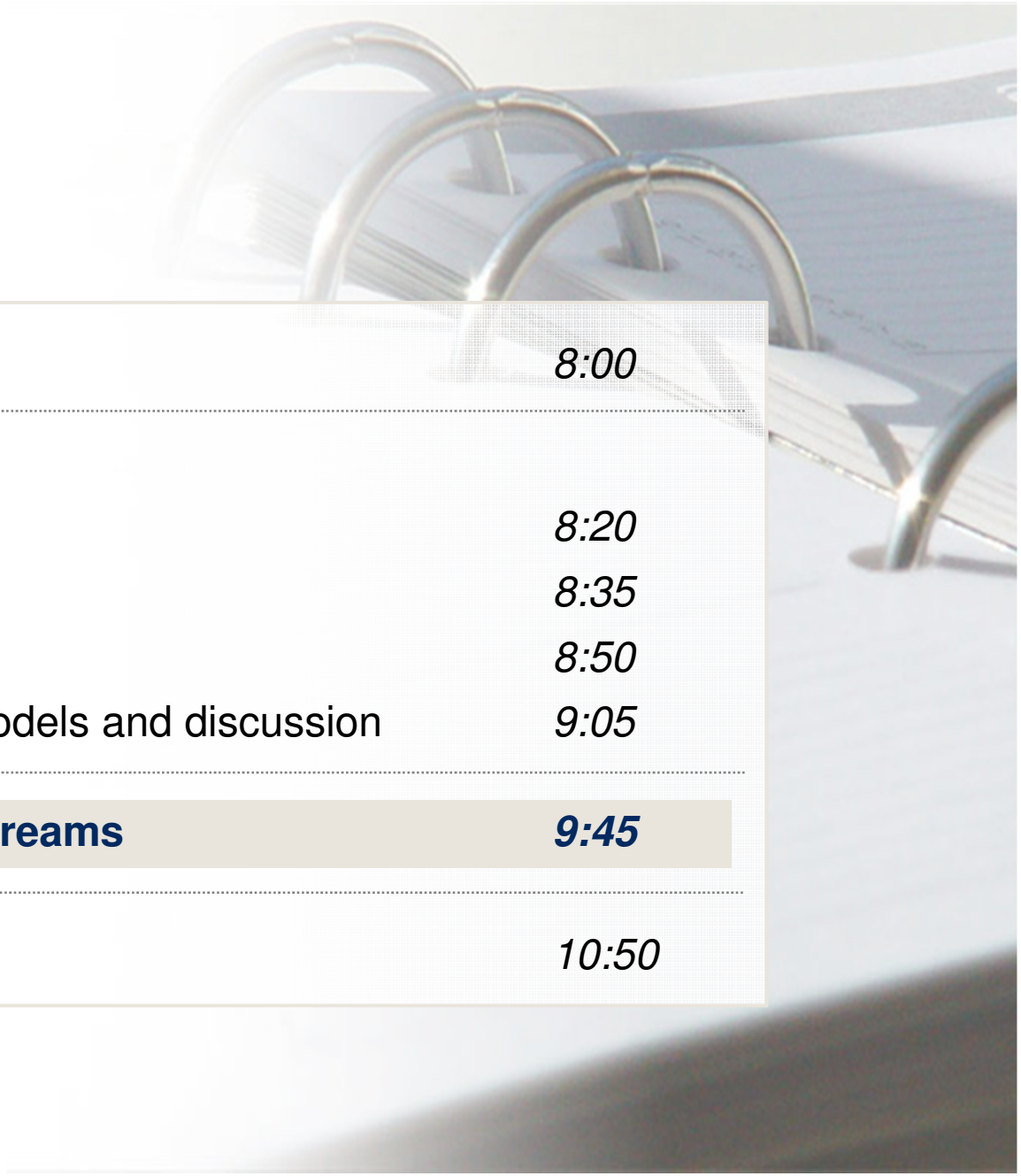
Of the **models** we have described, do you think **virtual** or **formal** structures would work best in Delaware?

1. Virtual
2. Formal
3. No opinion



Discussion and feedback

Agenda



▪ Introduction	*8:00*
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Key insights from the data and analytics workstream

Detail to follow

1. Ensure that data and analytics infrastructure **supports** the **new model**
2. Understand DE's **current assets/ uniqueness** and leverage them to the extent possible
3. **Enhance** DE's HIE functionality to create **distinctiveness**
4. Develop a roadmap that is **pragmatic**
5. Take an **iterative** approach to infrastructure strategy and **refine** continuously

3 Potential opportunities for DE to develop distinctiveness

WORK IN PROGRESS

More to follow

Need to create distinctive capabilities for Delaware

- CMS Innovation Center for SIM testing grant will likely be **competitive**
- Data and analytics solution must be **tailored** to DE's situation
  - What DE assets and uniqueness can be **leveraged** to create distinctive capabilities?
  - How should DE **develop** these distinctive capabilities?

Potential features of a distinctive data and analytics approach

- **Leverage connectivity**
  - Use DHIN's HIE functionality to rapidly enable and enhance connectivity based capabilities

- **Empower patients**
  - Develop tools for patients to engage providers and gain access to health information for informed decision making

- **Support care management**
  - Enable adoption of IT care management tools across providers to increase reach and enhance capabilities

3 Potential HIE functionality enhancement driven by SIM

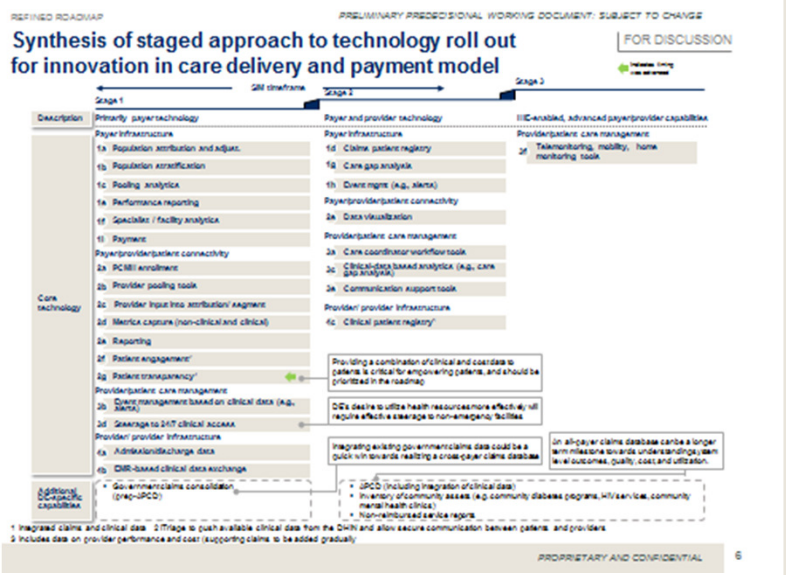
HIGHLY PRELIMINARY

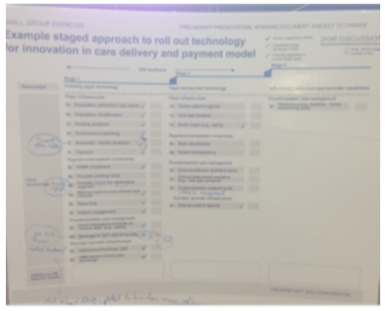
DHIN Delaware Health Information Network

	Description	Support to SIM
Enhance existing provider portal	▪ Enhance DHIN's web interface with a **central point of contact** between multi-payers and providers to support health information gathering and performance reporting	▪ Need a central portal to **streamline** provider processes: – Receipt of performance reports – Input of metrics for performance analysis
Capture ambul-atory data	▪ Develop **bi-directional** information sharing to allow EMR data upload from practices and hospitals	▪ Need local **ambulatory** data to – Enhance clinical data analytics – Deepen longitudinal patient record – Improve care management precision
Integrate claims data with clinical data	▪ **Integrate** claims data with clinical data in a **graduated** approach (e.g. start with government claims, then integrate commercial payer claims as possible)	▪ **Integrate** claims and clinical data to – Provide more cost/quality transparency – Complete longitudinal patient health records

4 Based on workstream discussions, we envision a capability roadmap

The group completed an exercise..





…to develop a capability roadmap

- **Stage 1** (Year 1)
  - Build foundational **tools**, **measures**, and **communication channels** for population based healthcare
  - Set up user-friendly platform for patients to **access health/cost data**
  - **Continue to enhance clinical data** communication b/w providers/payers
- **Stage 2** (Year 2-3)
  - Implement tools broadly to **automate** care coordination
  - Provide a **patient 360 view** by integrating claims and clinical data from multiple sources
- **Stage 3** (Year 3+)
  - **Improve continuously** to provide better care through tech-enablement

Initial perspectives from workforce discussion

1. Enhancing training and education
   - Support meaningful continuing education; position Delaware as "learning state“
   - Develop peer support programs
   - Integrate with the higher education community
   - Identify a set of core competencies across roles
2. Expanding workforce capacity
   - "Harness the masses” as well as the potential of retired providers
   - License a broader range of providers
   - Create awareness of health care jobs early on and focus on work readiness
   - Support better "demand management" for health care resources
   - Extend resources with technology
3. Optimizing cost and incentives
   - Reward and incentivize care coordination
   - Help reduce cost of degrees
4. Improving cross-role and group interaction
   - Create opportunities for innovation across groups
   - Foster shared decision making

Potential workforce levers

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

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

Key lessons that frame successful health care workforce strategies

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

Workforce strategy in SIM testing states

Strong emphasis
Addressed/mentioned
Not mentioned

Elements of workforce strategy in applications

State	Context	Education	Attraction/ recruiting[1]	Training (CME/CPT)	Regulation	Incentives	Productivity	Service configuration
AR	▪ Recent plan completed Apr 2012 ▪ Fragmented, geo-graphically dispersed, small practices	Strong	Addressed	Strong	Strong	Strong	Strong	Strong
MA	▪ Aims for statewide multi-payer model through PCMH	Not	Not	Addressed	Not	Addressed	Addressed	Addressed
ME	▪ Recent shifts to hospital-based practice ▪ Substantial FQHC proportion	Strong	Not	Strong	Not	Addressed	Not	Not
MN	▪ Aging and increasingly ethnically diverse population	Not	Addressed	Strong	Strong	Addressed	Addressed	Strong
OR	▪ Focus on primary and preventative care, more effective care coordination ▪ Driven by CCO2 model	Not	Strong	Strong	Strong	Not	Not	Addressed
VT	▪ Lack of supply and demand side data ▪ Focused on health profession surveys to collect data	Not	Strong	Strong	Strong	Not	Not	Not

* **Go to the website for CMMI and review plans of other states**

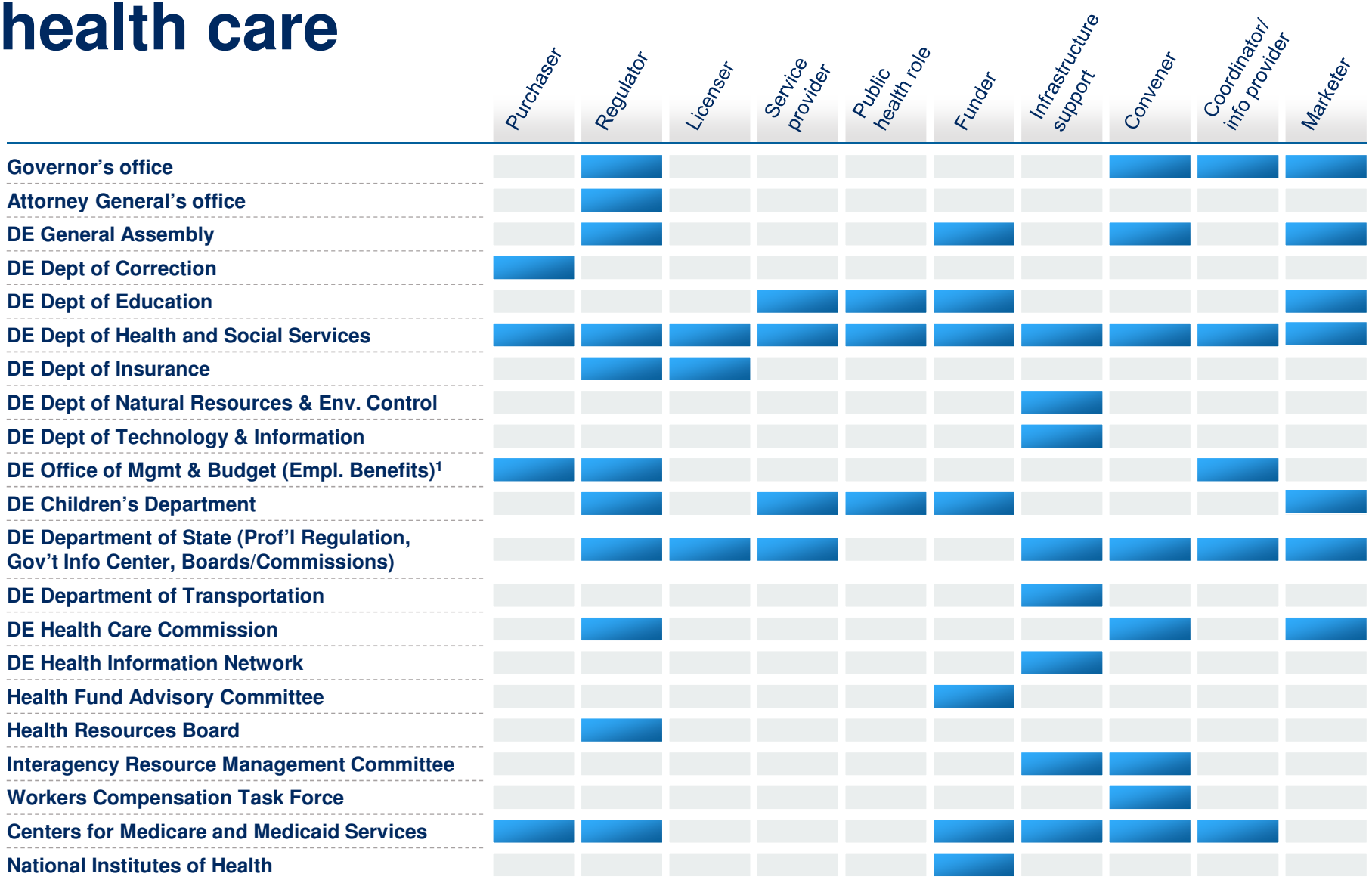
SOURCE: SIM Testing state applications

Initial perspectives from the policy group

- The potential roles and opportunities for state enablement of health system transformation are significant, including
  - The Governor's office, Department of Health and Social Services, and the Health Care Commission serving a convening role
  - The Departments of Health and Social Services, Insurance, and State serving a regulatory role
  - The General Assembly, Health Fund Advisory Committee, CMS, and NIH playing a funding role
- In addition to supporting this proposal, there is also interest in tackling related projects (e.g., mapping and centralizing healthcare information, addressing issues with licensing process, etc.)

Public agencies and roles in health care

PRELIMINARY

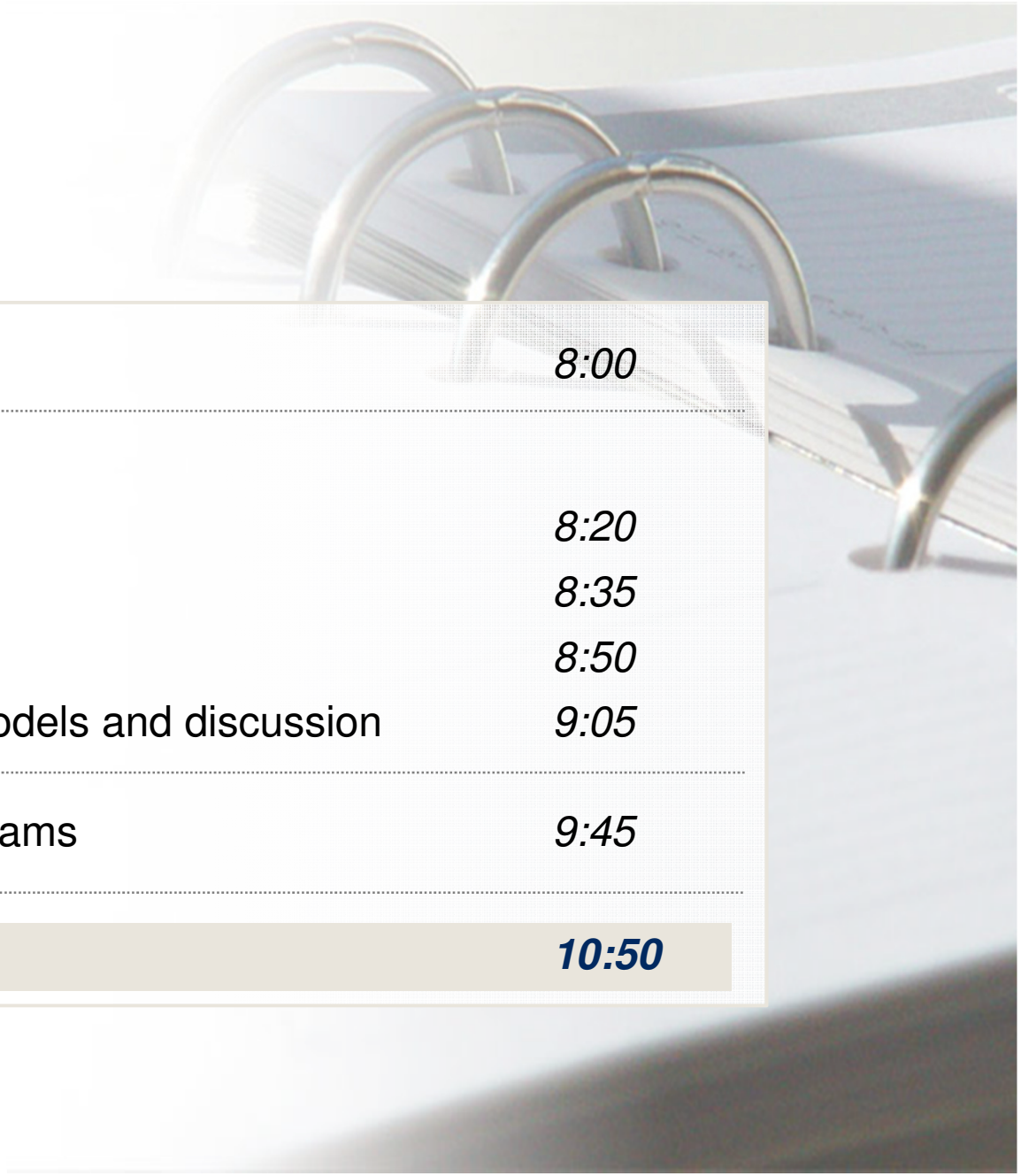


1 Also includes a clearinghouse of federal grant information

For discussion

- Are there additional governmental actors and/or roles not included?
- What are the most significant policy changes required to implement this healthcare transformation? How can we help make sure they happen?
- What policy changes need to take place first? Are there steps we can take to get started today?

Agenda



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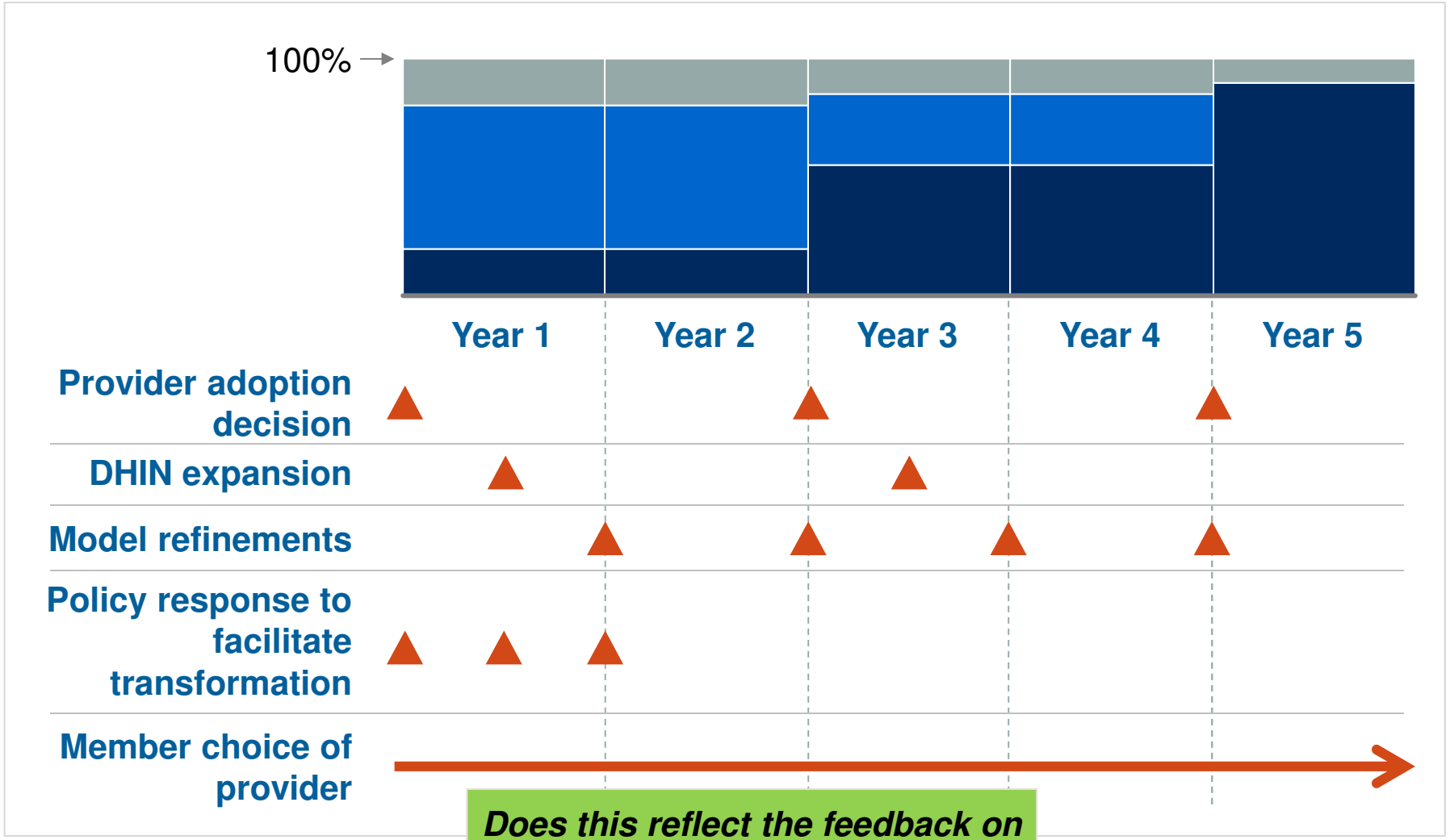
Recap: example of how transformation could unfold in DE

ILLUSTRATIVE



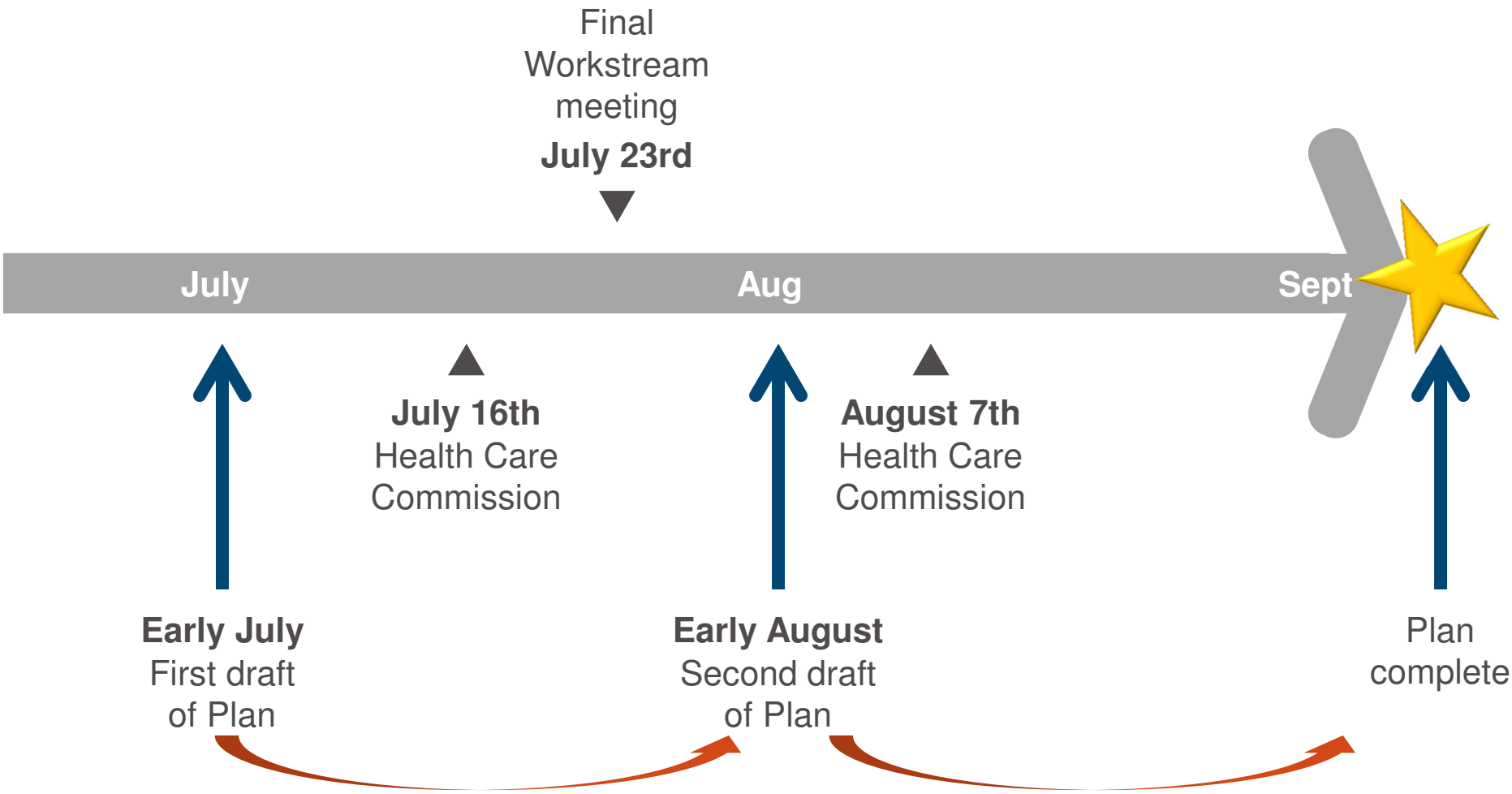
Recap: emerging answer

- Patient engagement strategy based on activating patients and supporting behavior change
- Local health neighborhoods bringing together delivery system and community to set goals, review performance, align engagement efforts
- Focus on high risk, high cost patient segments with care coordination
- Effective diagnosis and treatment across the board supported with guidelines and transparency in reporting
- Reimbursement mechanism aligned with total cost incentive model
- Shared utilities in select areas (e.g., risk stratification)
- Commitment to transparency across the system
- Streamlined/system efficiency
- Procurement/contracting that supports system change
- Policy response to enable changes

Any final comments?

Reminder: Timing of key meetings

Staff working sessions between meetings



Detailed public feedback on each draft