ChooseHealth DELAWARE

Delaware's State Innovation Model (SIM) Update

May 1st, 2014

Topics for today's discussion

- Update on Innovation Center
- Emerging areas of agreement across workstreams
- Next steps

Delaware Center for Health Innovation Board nominees

Role	Name	Organization	Term (years)
One member of **patient or consumer groups**	Matt Swanson	Innovative Schools; FineStationary.com	3
One practicing **physician**	Nancy Fan, MD	Women to Women OB/GYN; Saint Francis Hospital	3
One practicing **physician**	Gregory Bahtiarian, DO	Mid-Atlantic Family Practice	1
One practicing **non-physician clinician**	Traci Bolander, Psy.D.	Mid-Atlantic Behavioral Health	2
Chair of the Health Care Commission	Bettina Riveros, Esq.	Delaware Health Care Commission	
One member with expertise in **hospital/health system administration**	Alan Greenglass, MD	The Medical Group of Christiana Care; Christiana Care Quality Partners	2
One member with expertise in **hospital/health system administration**	Gary Siegelman, MD	Bayhealth Medical Center	1
Secretary of the Department of Health and Social Services	Rita Landgraf	Department of Health and Social Services	
One member with expertise in **payor administration**	Paul Kaplan, MD	Highmark Blue Cross Blue Shield Delaware	2
One member with experience in **administration of a community health provider**	Lolita Lopez	Westside Family Healthcare	3
One member involved in **purchasing health care coverage for employees**	TBD	TBD	1
Director of the Office of Management and Budget	Ann Visalli	Office of Management and Budget	
One representative of an **institution of higher education**	Kathy Janvier, Ph.D.	Delaware Technical Community College	2
At large	Thomas Brown	Nanticoke Health Services, Nanticoke Physician Network	3
At large	TBD	TBD	1
The **Executive Director** of the Center	TBD	TBD	
The **CEO of the DHIN**	Jan Lee, MD	Delaware Health Information Network	

Next steps on Innovation Center in May and June

Set up

- Assemble background information / materials needed for launch (e.g., website)
- Provide briefing materials with context on each workstream and overall approach
- Set up initial in-person orientation session(s) so all Board members have a common foundation

Launch (by July)

- Schedule and hold first Board meeting
- Stand up each Committee (define number and profile of committee members and identify members)

Please send recommendations to HCC

Case for change

Delaware begins transformation with many strengths

- **Better coverage**, better cancer screening coverage
- Has **significant assets** to support the health care system
- **Innovation** yielding positive outcomes in specific efforts

Significant gaps remain vs. Triple Aim

- **Delaware remains unhealthy**
- Health care **quality** generally **average**, **experience** often **below average**
- **Spends 25% more per capita** than national average

Given strengths and investment, current situation is surprising

Understanding why we are here

Structural barriers

- **Payment incentivizes volume of services – not quality**
- **Care delivery is concentrated and highly fragmented**
- Population health approach **not connected** with care delivery

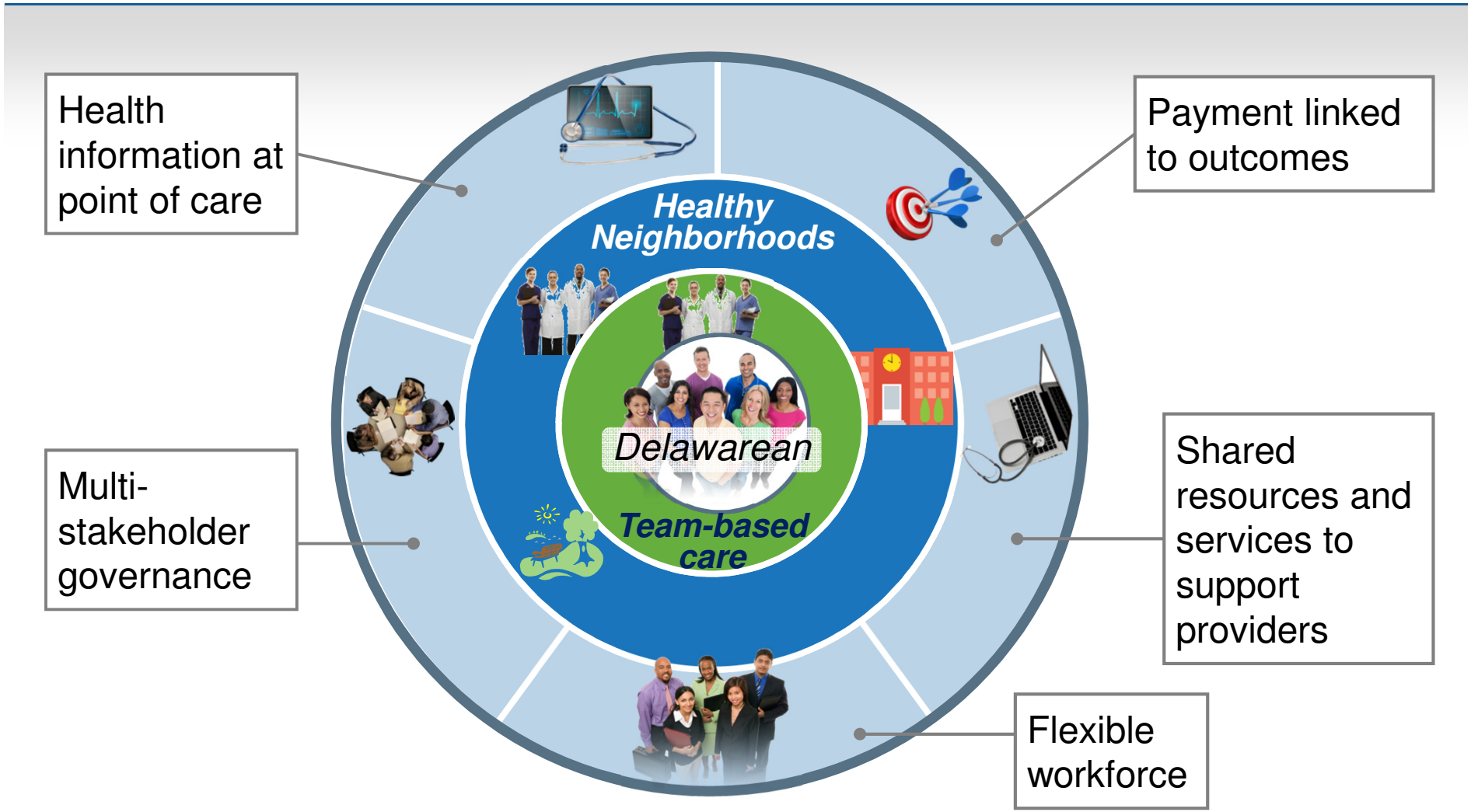
…and operational challenges

- **Workforce has major gaps** in specialties, geographies, and skills
- **Limited transparency** on quality and cost for patients and providers
- **Lack of payer alignment** on payment model, measures, and areas of focus
- **Sustained preference for pilots** vs. designing for scale
- **Community resources spread thin** across many prevention areas
- 10% of Delawareans remain **uninsured**

Delaware's goals by 2019

- Delaware will be one of the five **healthiest states in the nation;** and
- Delaware will be in the top ten percent **in health care quality and patient experience**; and
- Delaware will **reduce** health care **costs** by 6% (versus expected)

Delaware's framework



Clinical

PRELIMINARY

- Core focus for care delivery is on
  - More effective diagnosis and treatment (reducing variation in care) for acute visits from healthy individuals
  - More integrated, coordinated care for high risk (those with complex chronic conditions) individuals, particularly high risk elderly and adults including better integration with behavioral health

- Align on a common vision of how integrated and coordinated care looks and feels to patients with 11 core steps defined and agreed to. These include, at the outset, identification of high risk patients by payers for review and agreement by providers. Expectation that provider organizations will take many approaches to delivering this care, although clear preference for care coordinators shared across practices

- The Clinical Committee will organize clinicians to identify guidelines and protocols in areas where there is a need to focus on variation in care and to clarify best practice in care coordination

- Recognizing that some providers will have already started organizing to deliver this while others have not (care coordination survey: ~50% of total respondents, ~30% of outpatient clinics have care coordination programs), three shared services will be available to providers (in addition to technology tools over time). In each case, the intent is for these to build from ongoing resources and success in Delaware
  - Care coordination: current preference is for a menu of potential services including support for sharing care coordinators across practices
  - Practice transformation: preference is for access to at least two levels (one for new adopters and one for organizations that have already started to transform) with access to vendors that could work with practices over an extended period of time
  - Learning collaboratives: periodic facilitated peer-to-peer programs to share best practices and emerging insights

- There will be a common provider scorecard to set goals, measure performance against these, and provide basis for incentives
  - The scorecard will have dimensions for quality, transformation, patient experience, and utilization/total cost of care and will have measures to incentivize both more effective diagnosis and treatment and more coordinated care
  - It will be adopted by all payers and used by all providers

Payment

PRELIMINARY

- To enable both care coordination and effective diagnosis and treatment, the goal is for all or most care in the state to transition to outcomes-based payments that incentivizes both quality and management of total medical expenditures over the next five years

- There are a number of different models, but stakeholders have agreed that there will be at least two
  - **Pay for value:** providers earn bonuses for meeting both a set of quality measures and managing resource utilization
  - **Total cost of care:** providers share in savings generated by the system if they meet both a set of quality measures (just like in pay for value) and reduce health care costs per member for their patients compared against a benchmark. There are several types of total cost of care models, which vary in the level of potential savings shared with providers and the level of risk taken by providers

- Guiding principles: design a population-based model; seek multi-payer alignment; unite around a common vision; design multiple transition paths; plan for continuous improvement; hold balanced rules for participation; design for scalability; strive for administrative simplicity; plan for the transition costs to some providers; keep a role for fee-for service; maintain flexibility for providers; align incentives with care for highest risk patients

- The plan is to launch value-based payment models, linked to the metrics defined in the common scorecard, across payers on July 1st, 2015 and have at least 80% of the population under these new payment models within 5 years

- The payment model will be built around primary care and allow for flexible structures for providers to organize for participation (including groups of primary care practices in a PCMH model, ACOs with or without health systems, and large practices or clinically integrated health system networks)

Data

PRELIMINARY

- Modifications will be necessary to current data and analytics systems to ensure that the right information and tools are available at the right time and the right place to enable the successful implementation of the payment system, common provider scorecard, overall system scorecard, and population health scorecard

- Guiding principles for launch of common provider scorecard
  - Cost: seek to implement a cost-effective solution
  - Speed: implement a solution with critical functionality for payment launch by Q3 2015 with desired or enhancing provider, patient, or payer functionality rolled out in phases
  - Existing assets: build upon existing assets where possible. For instance, we will make technical decisions that will facilitate integration with the existing HIE in the long term where appropriate

- Minimum stakeholder needs for launching provider reporting
  - Provider needs: 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

- Core requirement for provider reporting:
  - Providers must electronically transfer selected clinical information and practice transformation information to payers on a regular (e.g., quarterly) basis
  - Payers must combine cost (e.g., claims), clinical, and practice transformation data to provide a static report (e.g., pdf) to each provider on a quarterly basis

Workforce

PRELIMINARY

- Core needs for workforce are: (i) a workforce planning function to assess capacity gaps, identify roles with future capability needs, and do long-term workforce data tracking and planning, (ii) a plan to address capacity constraints, in particular the need to coordinate care for top 10-15% of population (requiring recruitment, training/retraining for potential significant number of care coordinators and other individuals who can enable coordinated care)

- The Workforce Committee will manage the long term tracking and planning and will pull and analyze data from different sources including DHIN, AAMC, Delaware Department of Labor, Delaware Department of Professional Regulation, etc.

- For care coordination, the workforce will work in multi-disciplinary teams, operate at “top of license” and training, have the capability to support the behavioral change of individuals, use data and analysis more effectively, shift in setting from acute to ambulatory setting, and make use of new technologies to deliver care

- The competencies required for care coordination include (i) skills for managing a care team (providing assistance in accessing specialty care and mental health treatment, integrating specialty care into delivery, coordinating inpatient care and directing discharge plans, holding multidisciplinary meetings), (ii) connecting with patients and their networks (working collaboratively with the patient’s family and support system to create and implement plan, connecting patients to community support and social services, delivering population-focused care), (iii) overseeing an end-to-end care plan (developing care plan, motivational interviewing, following protocols, following up with patients), and (iv) operating technical tools/data and the newest technologies (monitoring individual care plans, selecting patients to manage)

- Close gap for delivering more integrated, coordinated care in the near-term with a 1-2 year learning and development program using existing learning networks and modules from many local educational institutions, including the University of Delaware, Delaware Technical College, Christiana, Jefferson, and others, to retrain and upgrade the skills of the current workforce. The program will educate participants about the new care delivery model and build the skills and competencies required for care coordination. This can be facilitated through a mix of symposia, lectures, group-based coaching, projects, and practical experience (exchanges/secondments)

Healthy Neighborhoods

PRELIMINARY

Statewide program that will offer funding and resources for individual communities to

- Convene forums for community leaders to discuss local health needs
- Align on priority health areas of focus
- Assess existing resources
- Facilitate targeted interventions tailored to neighborhood demographics and needs
- 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 coordinate each neighborhood
- Data/analytics support to 1) help quantify and assess local health needs; 2) track health outcomes over time
- Support in building an inventory of Delaware's existing community health resources
- Materials to guide health programs, including prioritization frameworks and potential interventions

State wide roles

- Healthy Neighborhoods Committee (DE Center for Health Innovation): a) Create program funding pool; b) Oversee Neighborhood designation and grant renewals; c) Set statewide priority health goals and scorecard and monitor progress/outcomes over time
- Division of Public Health: a) Assist with data and infrastructure needs; b) Share tools/resources to help prioritize goals/interventions; c) Initiate inventory of existing community health resources
- Healthy Neighborhoods Program Director: a) Provide leadership and coordination across all neighborhoods; b) Meet regularly with Healthy Neighborhood Coordinators to help set local priorities, assess needs for coordination and intervention, and c) monitor progress

Local roles

- Council (~15 leaders): a) Identify 2-3 priority local health goals and interventions; b) Populate and maintain database for existing resources; c) Allocate funding among initiatives
- Champion (part time, voluntary): chair Council meetings and promote Neighborhood mission
- Coordinator (full-time paid): a) set up Council and quarterly general meetings; b) apply for grants and manage distribution of funds; c) Coordinate activities and interventions in Neighborhood, d) track progress against agreed scorecards and report outcomes to the Council

Where we are today: current status and areas of focus

	Core elements of SHIP	Current status
Overall (Sec Landgraf, Bettina, Jill)	▪ Set up Innovation Center ▪ Develop statewide scorecard	▪ Defined nearly final proposal for Innovation Center including structure, committee function, membership ▪ Developed early draft of overall scorecard
Clinical (Alan Greenglass, Sec Landgraf)	▪ Focus on care coordination and effective diagnosis/ treatment ▪ Develop common scorecard ▪ Set up shared services	▪ Developed draft scorecard ▪ Defined care coordination and what it entails with leading clinicians, conducted survey to assess needs, and defined role for shared service
Healthy Neighborhoods (Matt Swanson, Lolita Lopez)	▪ Create "Healthy Neighborhoods" to better integrate existing programs, improve access, and support healthier behaviors	▪ Drafted detail of core functions of healthy neighborhoods support by reference to successes elsewhere ▪ Drafted detailed approach for how to operationalize including approach for establishing neighborhoods, setting goals, key roles, and resources required
Payment (Sec Landgraf, Steve Groff[1], Bettina)	▪ Introduce 2 types of value based payment (pay for value and total cost of care) across all payers linked to scorecard ▪ Reach 80% penetration in 5 years	▪ Supported embedding payment approach in MCO RFP ▪ Drafted most payment technical details for Medicaid ▪ Defined potential approach for state employees ▪ Framed approaches to funding coordinated care
Data / Analytics (Jan Lee, Jill)	▪ Create provider and patient portals ▪ Enable provider reports ▪ Build provider support tools	▪ Defined critical path for launch of payment and delivery ▪ Started on critical path components – developing approach to create, deliver, and access performance reports
Workforce and Education (Kathy Matt, Jill)	▪ Position DE as "learning state" ▪ Define key new roles and skills and develop learning program ▪ Build workforce planning capacity	▪ Assessed gap between supply and need for key roles ▪ Defined key roles and set up workforce symposium on Apr 8 to launch learning program

1 For Medicaid

Next steps

- Next cross-workstream meeting May 20 in Dover (location TBD)
- Please send names of potential candidates for Committees to the HCC