DC State Innovation Model

Better Health Together

DC SIM Advisory Committee Meeting

May 11, 2016

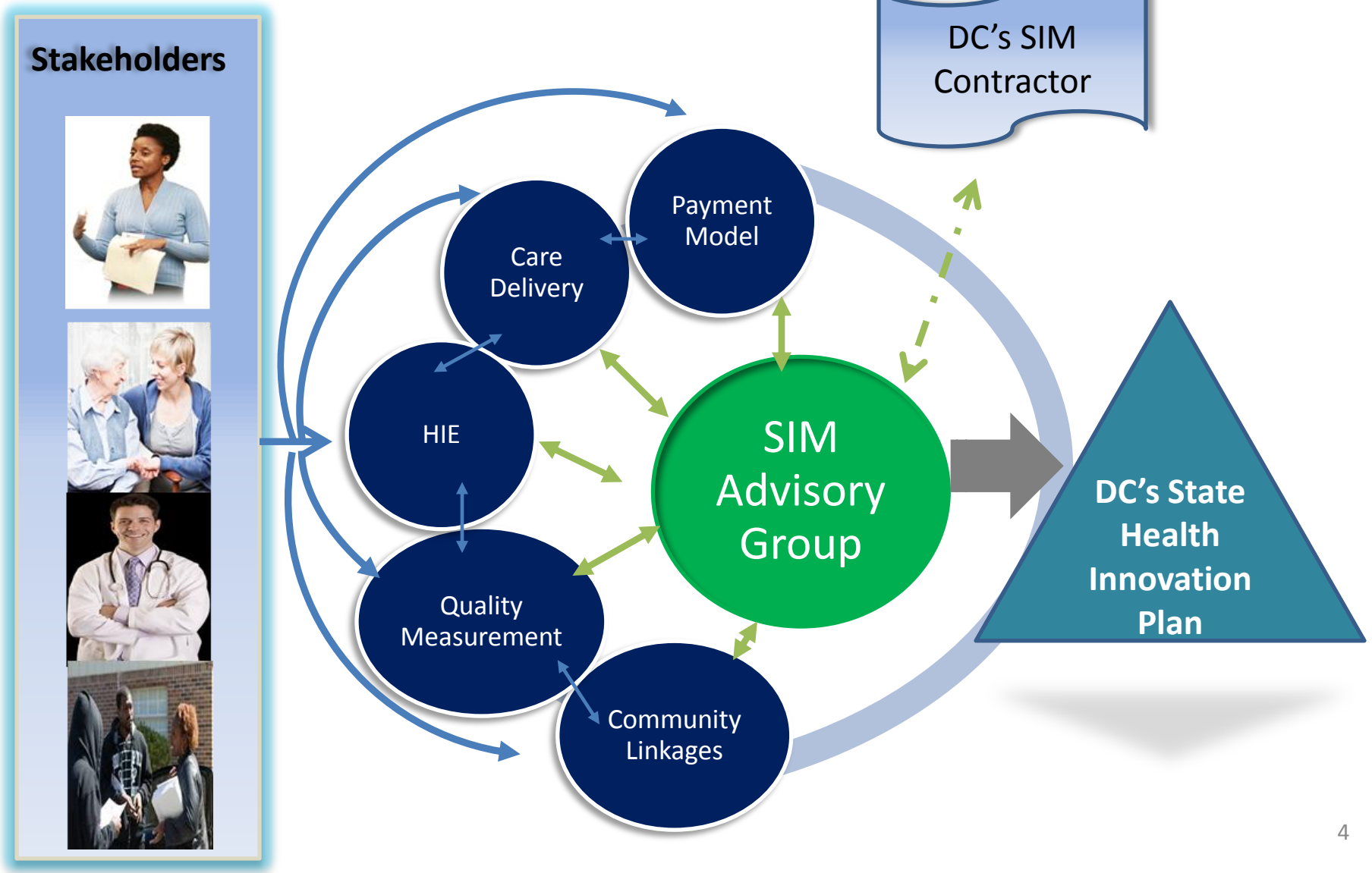
Agenda

- **Introductions**
- **Meeting Purpose**
- **SIM Process**
- **State Health Innovation Plan (SHIP)**
  - Pillar I – Care Delivery
  - Pillar II – Payment Reform
  - Pillar III – Community Linkages
  - Enabler A – Stakeholder Engagement
  - Enabler B – Health Information Technology
  - Enabler C – Workforce Development
  - Enabler D – Quality Improvement
- **Next Steps and Timeline**

Meeting's Purpose

- Present DC's Interim State Health Innovation Plan (SHIP) to SIM Advisory Committee
- Collect the Committee's feedback on key aspects of the SHIP
- Increase buy-in for strategies proposed in the SHIP

SHIP Development Process



SIM Communication & Outreach Efforts

- **33 Work Group Meetings** *with Stakeholders*
  - Care Delivery
  - Joint Community Linkages
  - Payment Models
  - Quality Metrics

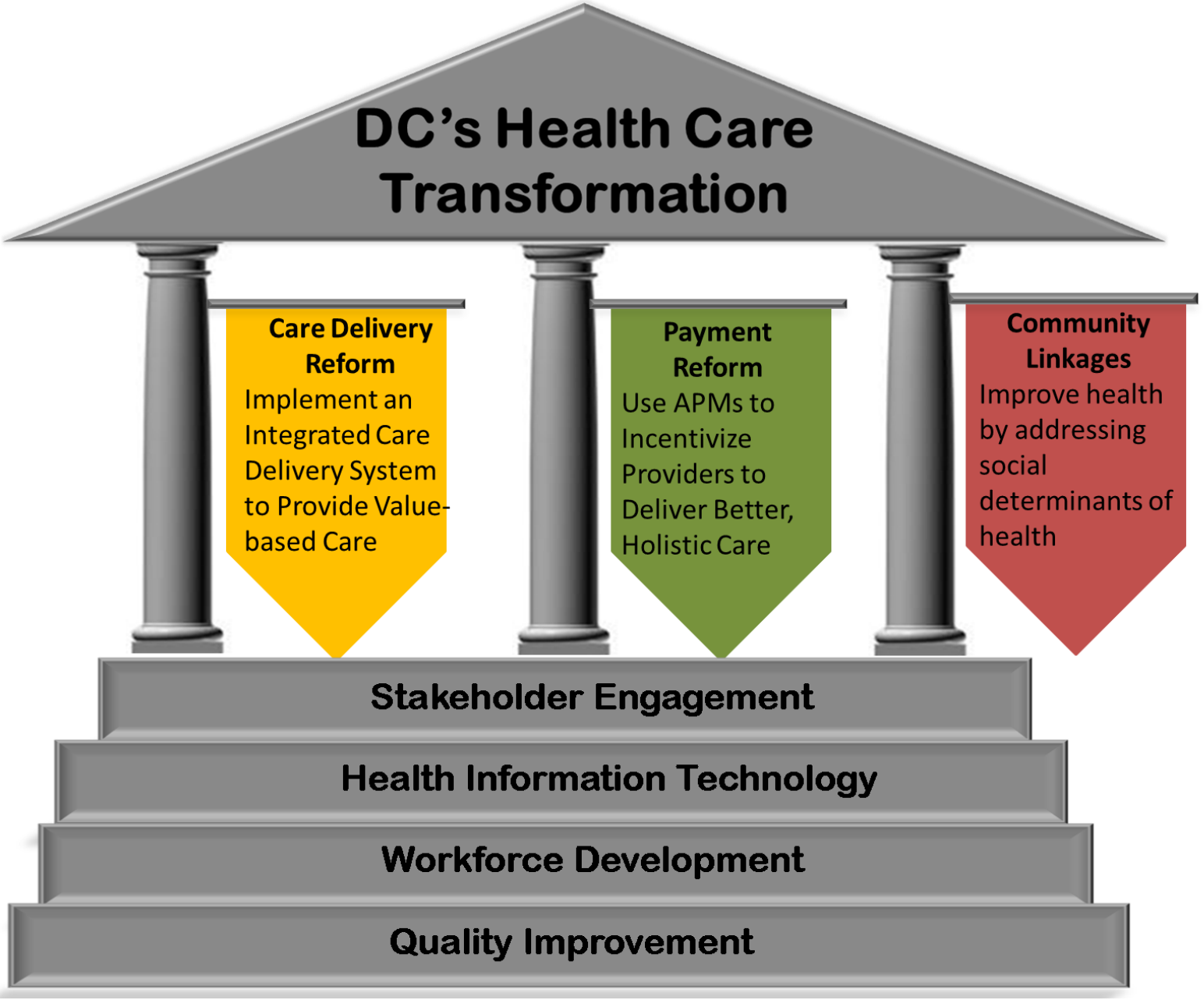
- **Innovation Updates –** SIM Weekly Newsletters

- **106 Consumer Interviews:** Soliciting feedback on healthcare in the District from consumer perspective, especially targeting super-utilizers
  - Consumer Interviews: Mary's Center, Unity, Providence, George Washington, Pathways to Housing DC
  - One Focus Group: Conducted March 30th

- **Provider Engagement** – Feedback on healthcare in the District from the provider perspective
  - Developed online survey and disseminated though trade associations, work groups and Medicaid billing
  - 24 providers have responded

Five Aims of DC's SHIP

District's Health Care Transformation



Pillar I – Care Delivery

Highlights: Health Home 2 Development

- **Target population:** ~25,000 beneficiaries (~2/3 FFS)
- **Eligibility:** 2 or more chronic conditions; or 1 chronic condition & historical chronic homelessness (i.e., matched to DC's Permanent Supportive Housing (PSH) program)*
- **Enrollment**: Patients will be assigned to a HH2 provider through an opt-out, with utilization trigger process. Patient attribution to HH2 provider will be based on a prior provider/patient relationship (2 year look-back), geography, provider capacity
- **Target Start Date:** January 2017

* To be rolled out at a later date

Proposed Recommendations

- More Coordinated Care: Reform the fragmented care delivery system; realign care to be interdisciplinary, coordinated, and patient-centered, particularly for individuals with chronic conditions

- On-going & Short-Term Vision: Health Home model of care for chronically-ill individuals; Promotes integrated person-centered care coordination to address medical, mental, behavioral and social determinants of health

- Long-Term Vision: Scaling elements/competencies advanced through the Health Homes model to accomplish systematic transition to more integrated and accountable care

Care Delivery – Long-term Objectives for Transformation

Leverage new capabilities/competencies in person-centered care delivery to implement a broader structure benefiting the larger District population, payment reforms and capacity building will support the transition

Payment	Linkages	HIE	Workforce	Quality
Align payments with value-based care goals, incentivizing care coordination, and health promotion services	Use HH2 as basis to broaden breadth and depth of community linkages to form a larger-scale support network	Expand use of care profiles, quality dashboards, and other HIE tools to better manage population health and inform care decisions	Leverage non-clinical providers, such as Community Health Workers, to maintain residents' health	Expand quality measurement to capture more data on effectiveness and inform care processes, payment systems, and population health

Pillar II – Payment Model

Highlights: Payment Reform Principles

- Care Delivery Transformation
  - Put the patient first and meet the patients where they are
  - Deliver the right care, right time, right place, right cost
  - Foster team-based care
  - Align across all providers (e.g. housing entities, behavioral health, etc.)
  - Include effective transitions of care, resourced at the provider level
- Infrastructure/ Resources to Support Care Delivery Transformation
  - Develop more integrated system(s) that aim to eliminate disparities and reduce inappropriate utilization of services
  - Share information that is accurate, actionable and accessible
  - Leverage existing strategies/resources
  - Align financial incentives with health system goals (e.g. shared accountability)
- District's Transformation Process
  - Allow all options to remain on the table
  - Be bold, but thoughtful with the timeline

Proposed Recommendations

- Flexibility: Empower providers to utilize a wider range of tools to achieve high-quality outcomes
- Capacity Building: Support providers through technical assistance and quality improvement initiatives
- Increased Provider Accountability: Encourage gradual progression towards value-based model implementation at the provider level, allowing for risk to be assumed as providers transform their practices to adopt more risk over five years

Payment Model – Roadmap for Transformation

	2017	2018	2019	2020	2021
Key Activities	• Baseline year	Year 1 of P4P payments	Menu of Payment Options (P4P, APMs)		
Base Payment	Enhanced FFS		• Enhanced FFS; or • APM (e.g. Shared Savings; Full-Risk)		
Supplemental Payment(s)	• Care Coordination Payments (HH1, HH2, EPD, DD, MCO) • P4P (e.g. bonuses and/or penalties related to readmission rates, preventable IP/ED use, hospital acquired conditions) • Other (e.g. partnership with Hospital ACO)				
Capacity Building	• Health Information Exchange (e.g. IAPD tools) • Health Home 1 and 2 (e.g. flexible PMPM dollars) • Accountable Health Communities (e.g. screening/referral resource) • Lump Sum Payment for APM/Capacity Building (see Medicare)				
Outcomes	Set baseline for LANE, Re-admissions, and IP measures	Set reduction targets (%)	• Reset baseline • Add measures based on data/priorities	Reset baseline	Reset baseline
Non-Traditional FFS Payments	• 0% APM • 30% tied to value	• 20% APM • 50% tied to value	• 30% APM • 70% tied to value	• 50% APM • 90% tied to value	

Pillar III – Community Linkages

Highlights: Short- and Long-term Goals

The District is taking a multifaceted approach to encouraging community linkages, including using:

- Care coordination initiatives
- Payment incentives
- Health information technology
- Formal policy changes
- Capacity building to create a well-connected community

Proposed Recommendations

- Social Determinants of Health (SDOH): SDOH impact the degree of health disparities experienced in DC, resulting in negative health outcomes acutely felt in particular geographic areas
- Interdisciplinary Teams: By building linkages within interdisciplinary team of clinical and health-related social services, the District can address SDOH and improve health outcomes and health status
- Key Initiatives to Support Community Linkages: Collaboration between clinical and health-related social services will be enabled by Health Homes model, Accountable Health Communities, health information technology, and an updated referral process

Enabler A – Stakeholder Engagement

Highlights: Consumer Interview Results

PATIENT EXPERIENCE	EMERGENCY DEPT. UTILIZATION	GAPS IN CARE/SERVICES
~30% of surveyed Medicaid beneficiaries do not understand their benefits & would like more education on the benefits they are provided	Participants in hospital emergency departments (ED) were less satisfied with their PCP & were more likely to use ED services before calling their PCP	Access to timely primary care appointments; availability of dental/vision care were the most common gaps in health services identified by respondents
Patient education on healthy eating & healthy living habits would be the most helpful services to manage chronic disease	Chronic pain is the most common cause for ED visits among the sample population (accounts for 44% of ED visits discussed during survey)	Housing & food insecurity were the most common social service gaps among respondents

Highlights: Consumer Focus Group Results

PATIENT EXPERIENCE

Participants did not understand Medicaid covered benefits

Beneficiaries value independence & feeling control of their life and health

The Ombudsman is a valuable resource for beneficiaries; those that contacted the Ombudsman are satisfied with their resolution

Feelings of mutual trust and respect with providers have a great impact on when and how often individuals seek care from that provider

Office staff are a significant part of the healthcare experience; Patients reported not calling office for advice on visiting the ED when they were unsatisfied with the office staff

GAPS IN CARE/SERVICES

Access and acceptability of vendors for wheelchairs & other supplies greatly influence experiences in & opinions of the health system

Participants expressed the need for mental health services despite significant stigma regarding mental health remains

Proposed Recommendations

- **Health Literacy Strategies**
  - Public education/awareness on available benefits
- **Patient Empowerment**
  - Increasing access to services
  - Utilizing patient satisfaction surveys
- **Patient Accountability**

Enabler B – Health Information Technology

Highlights: Health Information Technology

- Barriers/Challenges to Data Exchange
  - Need a better understanding of how key health-related data currently flows in the District
  - Identifying gaps in DC's current HIT/HIE infrastructure will pinpoint areas to prioritize in support of SIM Pillar initiatives

- Overarching HIT/HIE Infrastructure
  - Core set of HIE requirements and standards is essential to establishing a more unified, interconnected data architecture in the District

- Improved HIE Capabilities
  - District's current HIT/HIE capabilities must be enhanced to support the various SIM Pilar recommendations
  - This includes improving providers' ability to care for individuals and managing specific populations, in addition to improving provider performance and patient outcomes

Proposed Recommendations

- **Comprehensive data map:** Detail the flows of information among & between HIE users; Identify current gaps in DC's HIE landscape
- **HIE designation process**: Create a set standards for HIEs in DC related to interoperability, privacy, etc.
- **DC's Centralized Data Warehouse**: Increase the capacities & capabilities of repository for claims, health outcomes & admin. data for use via HIEs
- **Expanded HIE functionality**: Launch tools/initiatives that bolster DC's HIE usefulness including:
  - *Patient Care Profile* to support coordination at point of care
  - *eCQM Tool & Dashboard* to facilitate quality measurement and improvement efforts
  - *OB/Prenatal Registry* to enable sub-population management and analyses
  - *Analytical Population Dashboard* for population health monitoring and specialized reporting
  - *Ambulatory provider support* to increase HIE connectivity and use

Enabler C – Workforce Development

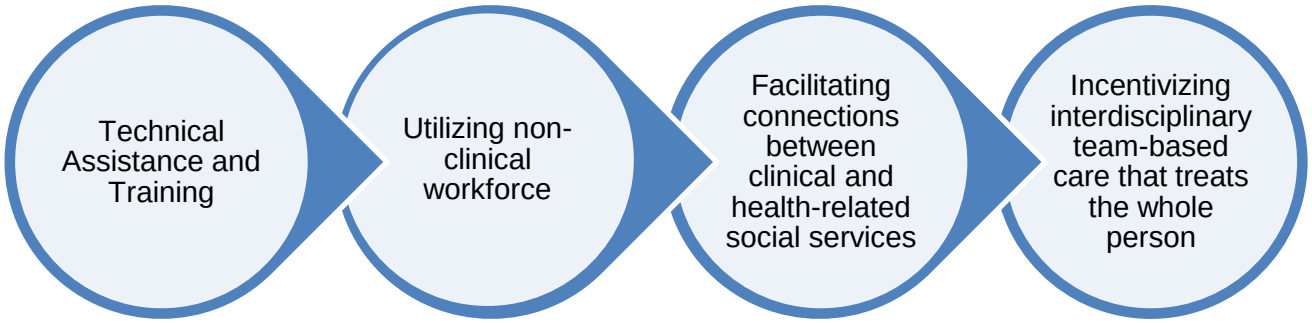
Highlights: Workforce Development

- Coordination: Multiple government agencies are focused on systems to develop workforce
- Social Service Providers: Social service providers have been minimally engaged in workforce development discussions
- Interdisciplinary Teams: Knowledge on how to implement this approach is limited

Proposed Recommendations

- Development: A well-developed and well-trained workforce is essential for implementing and sustaining short- and long-term transformation initiatives, especially for care delivery reform and enhancing community linkages

- Capacity Building: Establish methods for building the workforce capacity through: technical assistance and training, investing in non-clinical communication and collaboration between clinical and health-related social services, and incentivizing a holistic approach to care though payment reform



Enabler D – Quality Improvement

Highlights: Quality Improvement

- Siloed Environment: Many reporting initiatives, but no standardized collection of measures or District-wide performance monitoring system
- Duplication of Efforts: Creates reporting burden on provider
- Need for Standardized Collection: HIT & data collection systems will use an eCQM tool to efficiently & accurately collect data for population health efforts

Proposed Recommendations

- Develop core measure set that aligns with existing performance reporting initiatives and represents priority topic areas in the District
- Obtain buy-in from commercial payers
- Build quality reporting in HIE
  - Implement a practice- and population-level dashboard
  - Ability to view measure data specific to their attributed patients, both on an individual and/or practice level
- Leverage existing dashboards (i.e., DC HP2020) to monitor population health

Alignment Across Initiatives

TOPIC AREAS	DC HEALTH PEOPLE 2020 (Leading Health Indicators)	MEDICAID	MEDICARE	FQHC	DC HEALTHY COMMUNITY COLLABORATIVE*	OTHER COMMUNITY HEALTH NEEDS ASSESSMENT	CMMI INITIATIVES	CDC RACIAL AND ETHNIC APPROACHES (REACH)
Sexual Health	✓✓✓	✓✓✓		✓✓✓	✓✓✓		✓✓✓	
Asthma		✓✓✓		✓✓✓	✓✓✓	✓✓✓	✓✓✓	
Cancer	✓✓✓	✓✓✓	✓✓✓			✓✓✓		
Cardiovascular Disease	✓✓✓	✓✓✓	✓✓✓	✓✓✓		✓✓✓	✓✓✓	✓✓✓
Diabetes	✓✓✓	✓✓✓	✓✓✓	✓✓✓		✓✓✓	✓✓✓	✓✓✓
Behavioral Health	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓		✓✓✓	
Oral Health	✓✓✓	✓✓✓		✓✓✓				
Maternal and Infant Health	✓✓✓	✓✓✓		✓✓✓	✓✓✓		✓✓✓	

Other CMMI initiatives are: ER and hospitalization, Avoidable hospitalizations, Co-morbidities (Joslin Diabetes Center)
* Represents Areas of Focus until June 2016

Next Steps

- Revise Interim SHIP based on feedback
- Incorporate Advisory Committee thoughts on missing elements prior to public comment period
- Update SHIP sections with consumer and provider engagement results
- Formulate the District's long-term vision for care delivery, payment model, and HIE transformation beyond applying to Health Homes.

SHIP Development Timeline

Interim SHIP Report

- **5/11/16 –** Present to Advisory Committee
- **5/13/16 –** Finalize Interim SHIP
- **5/16/16 –** Share Interim SHIP w/ Work Groups
- **6/01/16 –** Begin Public Comment Period on Revised Draft

Final SHIP Report

- **7/6/16 –** Submit Final SHIP to Advisory Committee for Approval
- **7/31/16 –** Submit SHIP to CMS