ChooseHealth DELAWARE

# All-workstream stakeholder meeting

February 11th, 2014

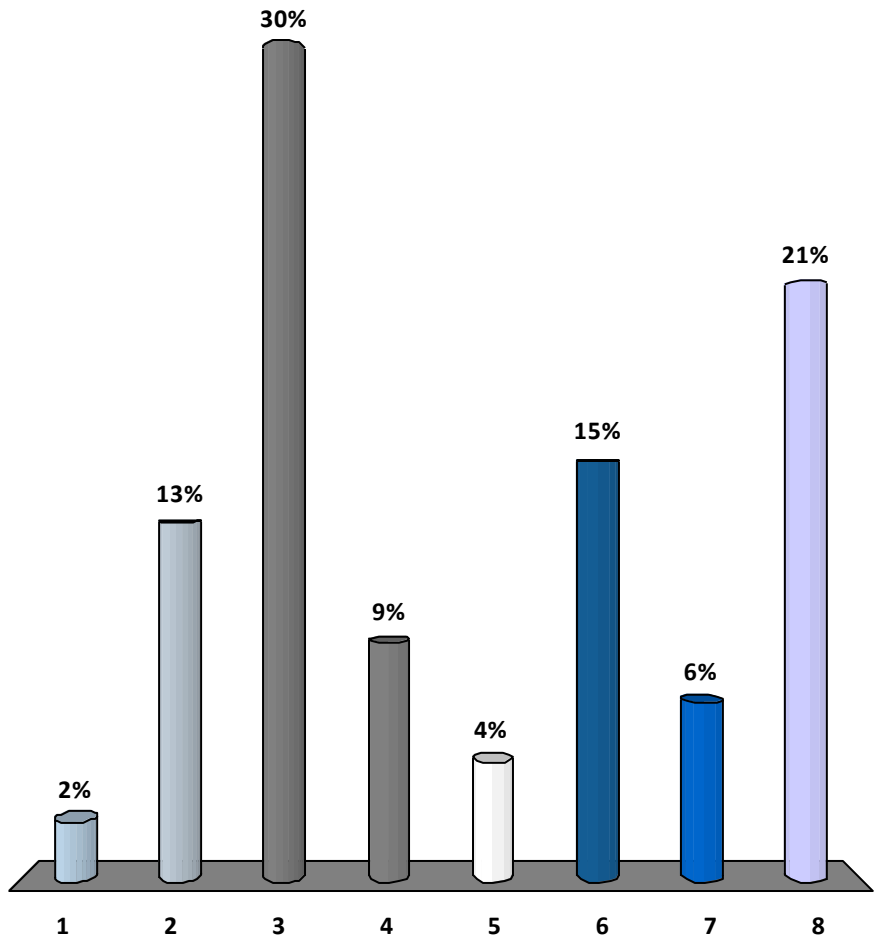
# Agenda

| Time | Topic |
|---|---|
| 8:30-9:30 | Recap and where we are today |
| 9:30-10:00 | Timeline and approach going forward |
| *10:00-10:15* | *Break* |
| 10:15-11:00 | Workforce discussion |
| 11:00-11:45 | Provider scorecard discussion |
| 11:45-12:00 | Wrap up and next steps |

# Welcome back: Who is in the room?

## Which stakeholder group do you represent?

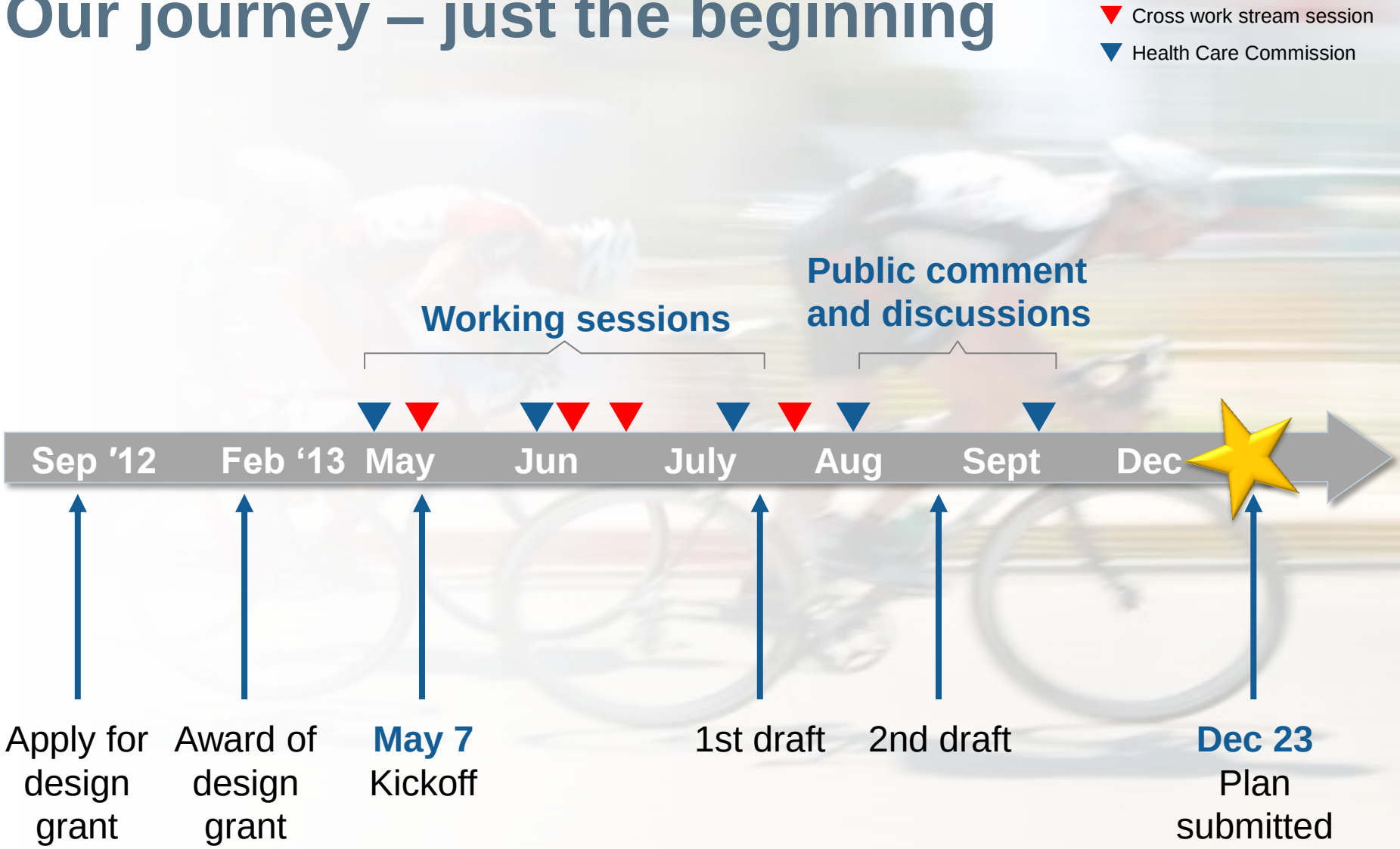
1. Patient/consumer
2. Physician
3. Health system
4. Nurses, behavioral health specialists and other providers
5. Community organization
6. State
7. Payer
8. Other



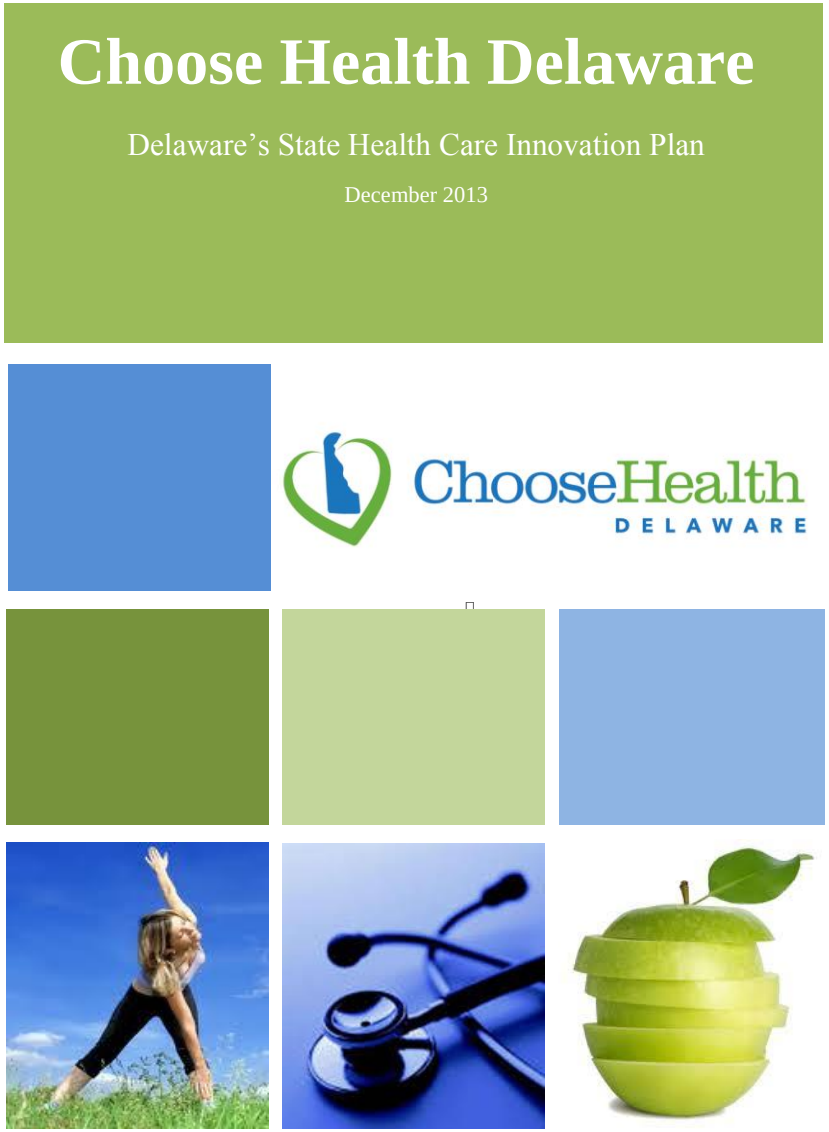
# Objectives for this section

- Recap of where we are today and core components of the plan
- Discussion of savings estimates

# Our journey – just the beginning



# Where we are today




- Plan submitted to CMMI on December 23 (online at HCC website)
- FOA for Model Testing funds expected in February, with submission expected in April
- Guidance that it will be critical to demonstrate progress on having infrastructure in place prior to submitting grant

# Reminder: Delaware's goals

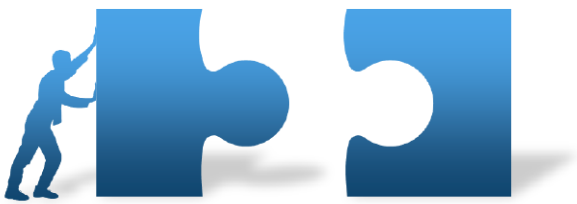
- Delaware will be one of the five **healthiest states in the nation;** and
- Delaware will be in the top ten percent **in health care quality and patient experience** by 2019; and
- Delaware will **reduce** health care **costs** by 6%

# Reminder: 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**

# Reminder: 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

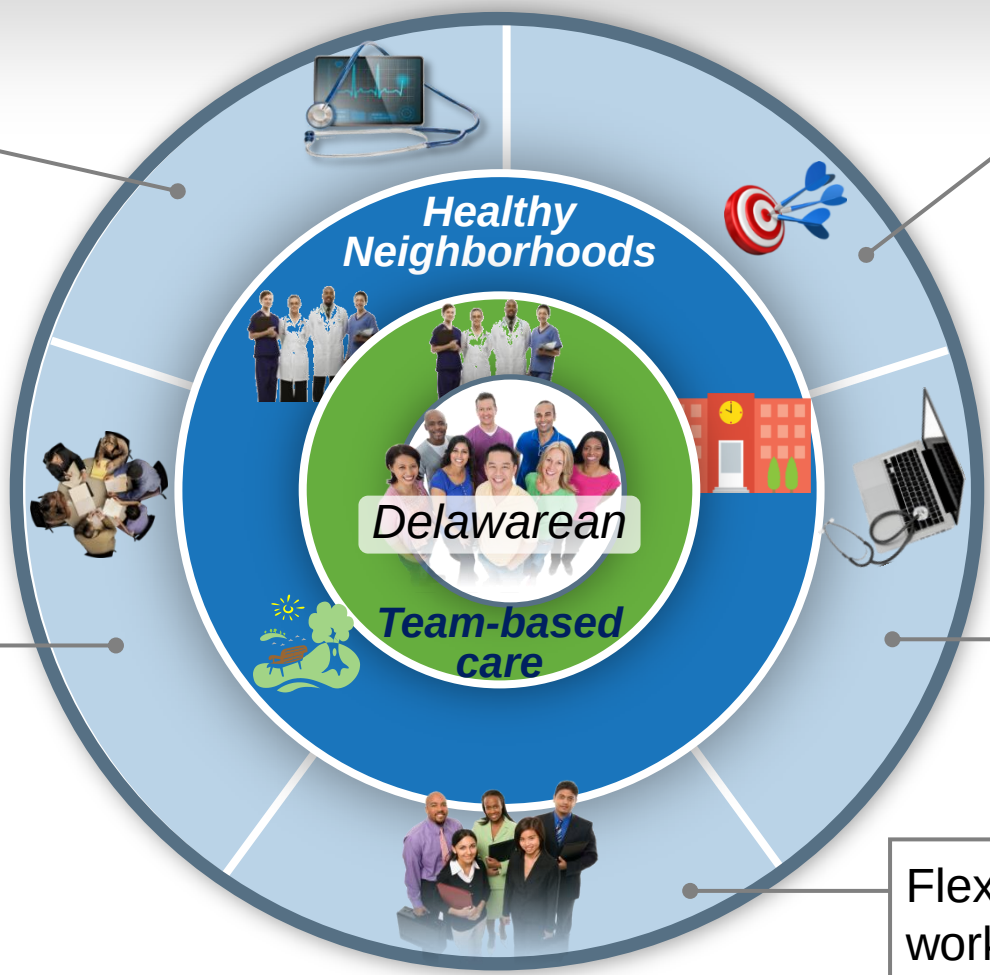
## …and operational challenges

- **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**

# Reminder: Delaware's framework

Health information at point of care

Payment linked to outcomes




Multi-stakeholder governance

Shared resources and services to support providers

Flexible workforce

# Taking the first steps: Medicaid MCO RFP reflects core elements

**Examples reflected in the RFP**

- ✓ Payment and delivery reform consistent with Delaware's State Health Care Innovation Plan
- ✓ Focus on care coordination
- ✓ Implementation of P4V and total cost of care payment models
- ✓ Detailed approach to ensuring effective diagnosis and treatment through evaluation and metrics
- ✓ Data infrastructure supporting reporting and care coordination

# Structure for organizing going forward: Delaware Center for Health Innovation

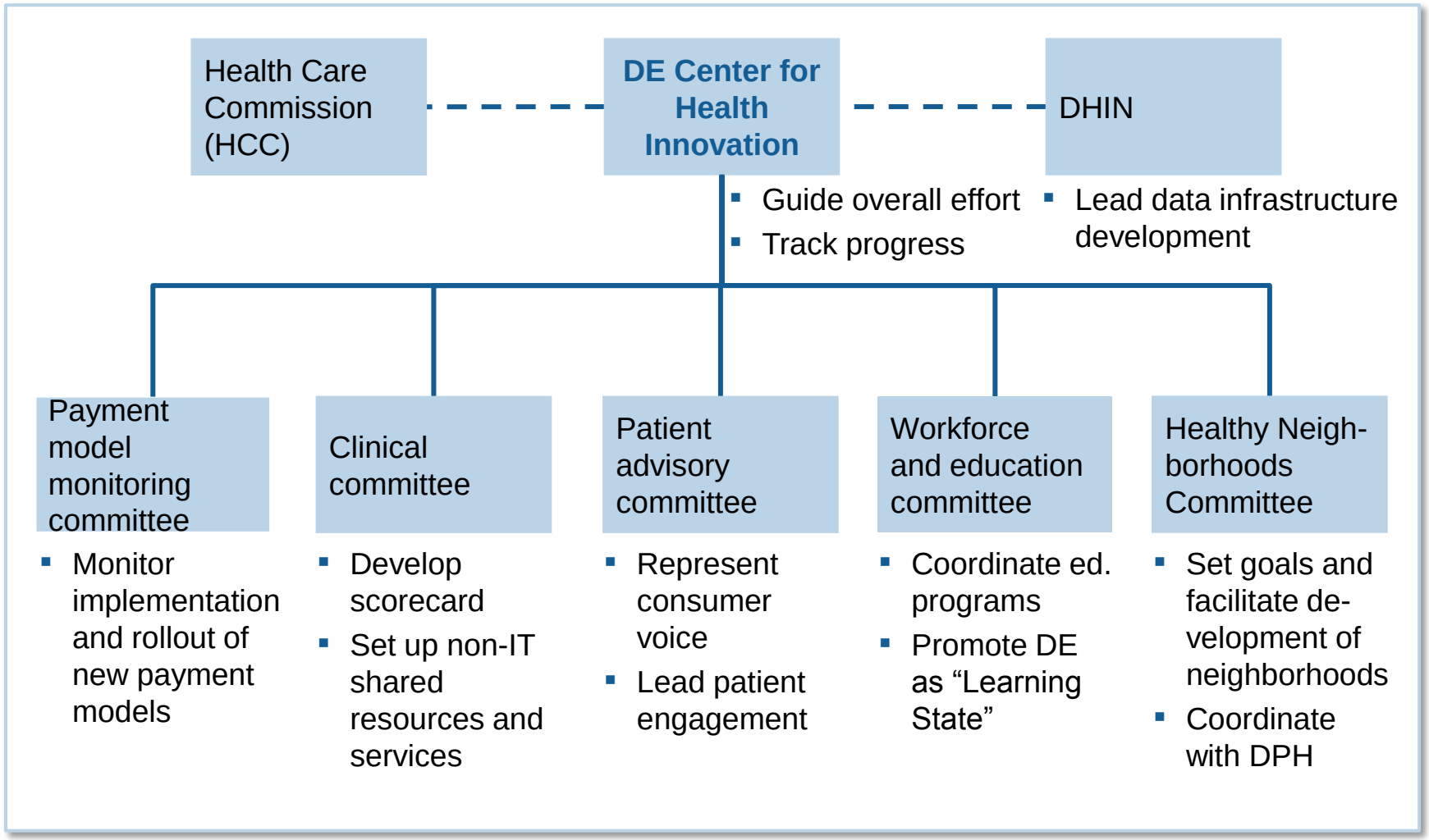
## What it is

- ✓ Meant to continue the way we have worked together so far
- ✓ Help to build from existing initiatives and implement core elements of the plan
- ✓ Designed to be representative and inclusive

## What it is not

- ✗ Government led
- ✗ Organization with authority to replace ongoing initiatives
- ✗ Designed to be a large bureaucratic organization

# Reminder: proposed approach

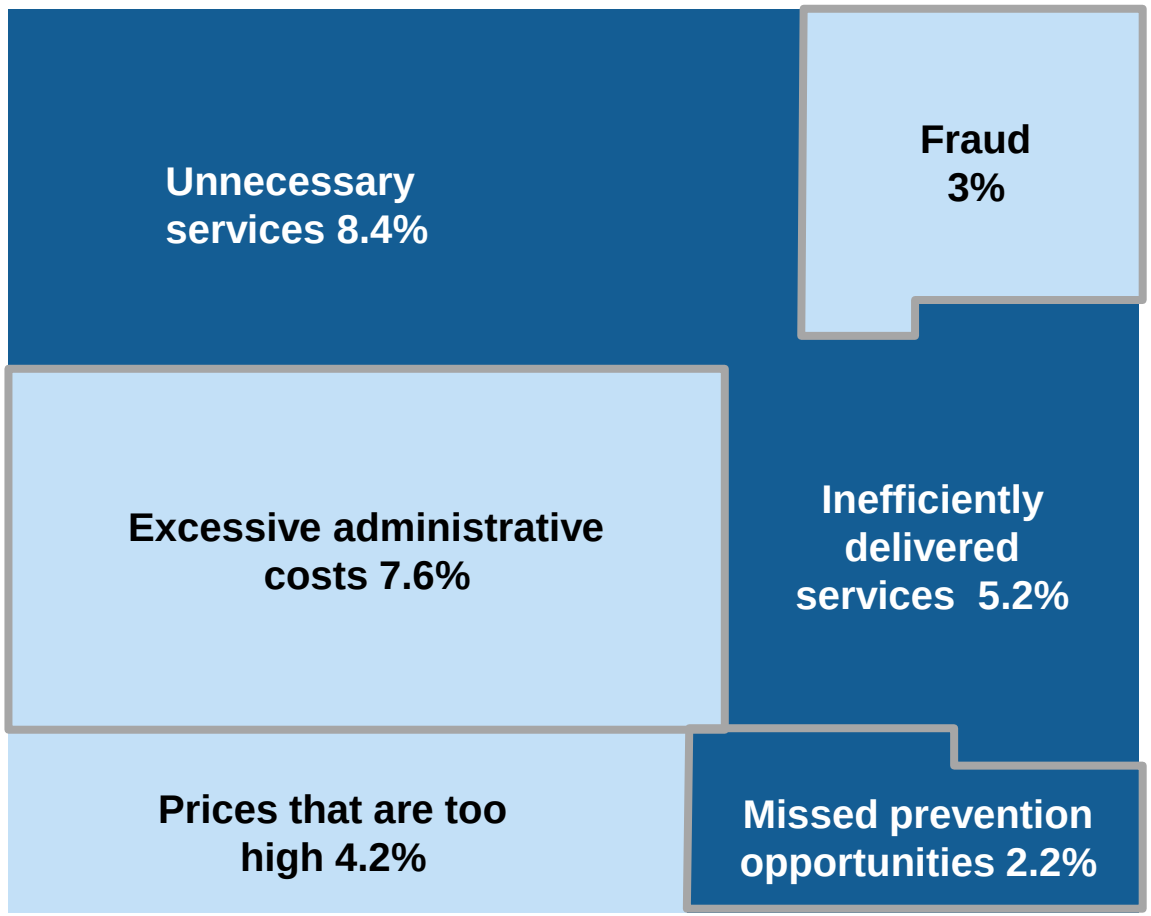


# Innovation Center Board overview

| | |
|---|---|
| **Overview** | ▪ Board of 9-15 Directors, 2 non-voting Directors<br>▪ Board members must be knowledgeable about delivery, reimbursement, and/or regulation of health care services |
| **Expertise required** | ▪ Board should include at least the following members<br>– One member of the public and/or from consumer advocacy groups<br>– One practicing physician<br>– Chair of the Health Care Commission<br>– One member with expertise in hospital/health system administration<br>– Secretary of the Department of Health and Social Services<br>– One member with expertise in payor administration<br>– One member involved in purchasing health care coverage for employers<br>– Director of the Office of Management and Budget<br>– One member representing institutions of higher education<br>▪ Non-voting Directors<br>– The Executive Director of the Board<br>– The Executive Director of the DHIN |

# Sources of value from payment and delivery system reform

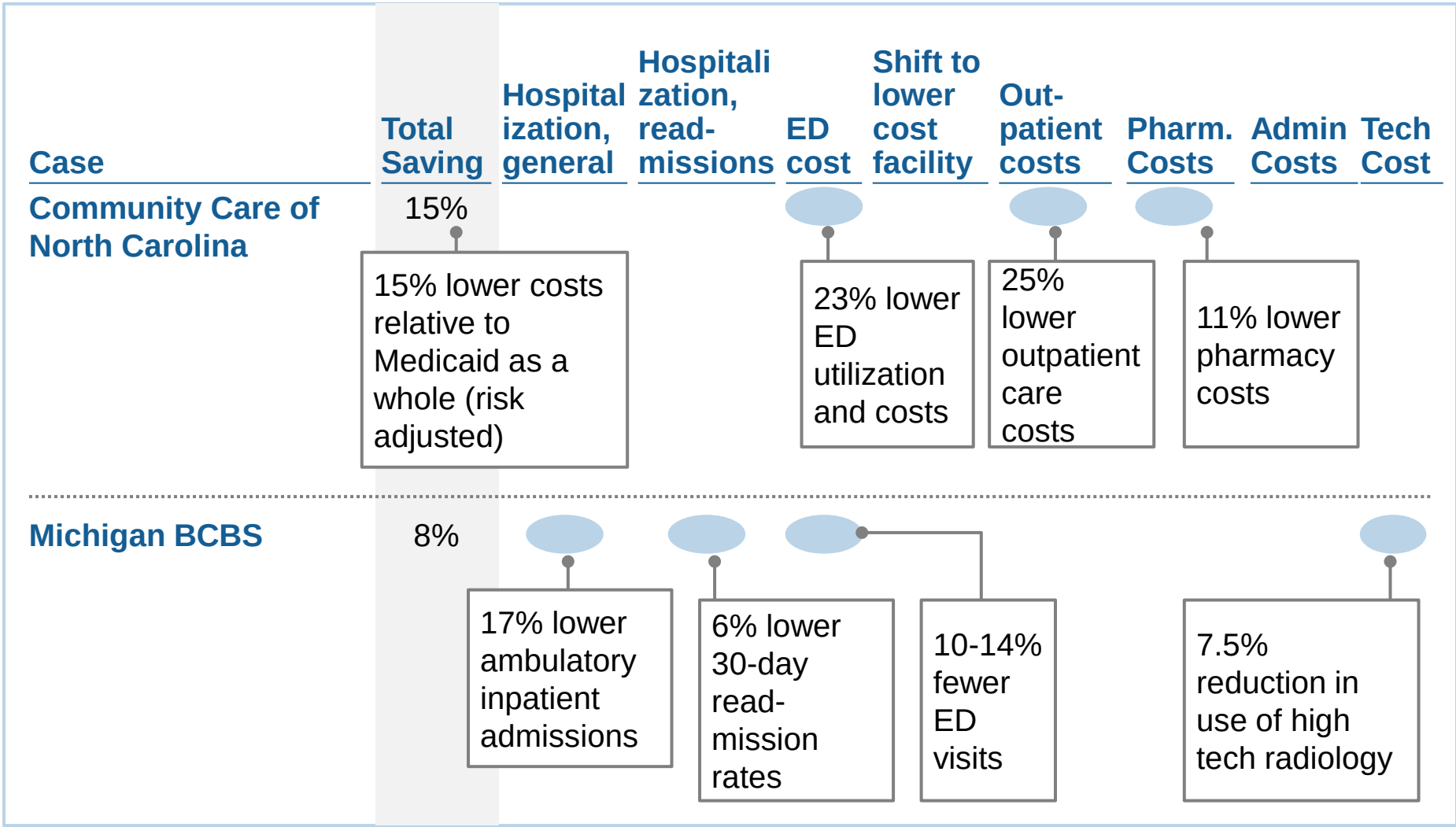
## 30% savings identified




- Core focus of payment and delivery system reform in DE
- Partial focus of payment and delivery system reform in DE

SOURCE: The Institute of Medicine, http://resources.iom.edu/widgets/vsrt/healthcare-waste.html

# Examples of how programs achieve savings




SOURCE: Patient Centered Care Collaborative, Community Care of North Carolina, Michigan BCBS

# Delaware's potential – background

## Core assumptions

- Expected spending based on CMS national expenditures
- By 2019, DE achieves goal of >80% participation in new models
  - TCC 40% in 2015, growing to 85% in 2019
  - Balance a mix of P4V and not participation
- TCC achieves 9% gross savings, P4V achieves 3% gross savings over 7 years
- Care coordination, practice transformation, and other shared services funded at 2% of TCC
- Surplus net of investments shared with providers in form of shared savings or bonus payments

## Estimates in the plan

| Baseline | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Spend per capita ($) | 6468 | 6600 | 6825 | 7117 | 7451 | 7872 | 8344 | 8827 | 9358 | 9921 | 10518 |
| Total spend ($M) | 5504 | 5766 | 6169 | 6538 | 6955 | 7481 | 8030 | 8575 | 9183 | 9824 | 10511 |

| Gross impact | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Savings ($M) | – | 19 | 76 | 157 | 284 | 442 | 593 | 686 | 744 | 796 | 852 |
| Impact as % of Spend for participants | – | 0% | 1% | 3% | 4% | 6% | 8% | 8% | 8% | 8% | 8% |

| Recurrent costs ($M) | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Care coordination fees | – | 30 | 39 | 49 | 58 | 65 | 74 | 84 | 91 | 98 | 106 |
| Shared savings | – | 1 | 19 | 45 | 75 | 109 | 115 | 85 | 48 | 23 | 13 |

| Fixed investments ($M) | 2014 | 2015 | 2016 | 2017 | 2018 | 2019[1] | 2020[1] | 2021[1] | 2022[1] | 2023[1] | 2024[1] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Transformation support | 2.9 | 2.3 | 1.5 | 0.8 | 0.6 | 3.0 | 3.0 | 3.0 | 3.0 | 3.0 | 3.0 |
| Delivery system | 3.0 | 10.8 | 10.0 | 10.0 | 4.0 | – | – | – | – | – | – |
| Population health | 2.0 | 4.8 | 4.2 | 2.4 | 1.8 | – | – | – | – | – | – |
| Payment | 3.0 | 1.5 | 1.5 | 0.8 | 0.6 | – | – | – | – | – | – |
| Data & analytics | 4.0 | 14.0 | 13.6 | 11.8 | 11.2 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| Workforce | 1.2 | 2.9 | 2.9 | 2.3 | 2.3 | – | – | – | – | – | – |
| Policy | 0.8 | 0.8 | 0.8 | 0.4 | 0.4 | – | – | – | – | – | – |

| Net Savings | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total ($M) | (17) | (49) | (16) | 43 | 139 | 258 | 392 | 515 | 615 | 678 | 729 |
| Percent of baseline | 0.0% | -0.9% | -0.3% | 0.7% | 2.0% | 3.4% | 4.9% | 6.0% | 6.7% | 6.9% | 6.9% |

1 Estimate for 2019-2024 is for in-kind support that may spread across multiple areas of focus depending on need; included in transformation support for simplicity

# Delaware's potential – key figures

**Achieving similar results to other programs and successfully implementing the plan could result in…**

- **Spending to rise** from $5.5 billion to $10.5 billion in the base case
- Greater than **8% gross savings or $850 million is possible** to achieve through the changes identified (with 6% achieved by 2019)
- **Non-recurring spending of about $160m** spread over 10 years will be needed for IT, practice transformation and support to implement these changes
- **Recurring spending of up to $190m per year, falling to $120m per year over time, will be required** for care coordination fees and shared savings payments to providers
- Total **recurring net savings of over $700m per year** relative to baseline once full impact is reached

# Questions

# Agenda

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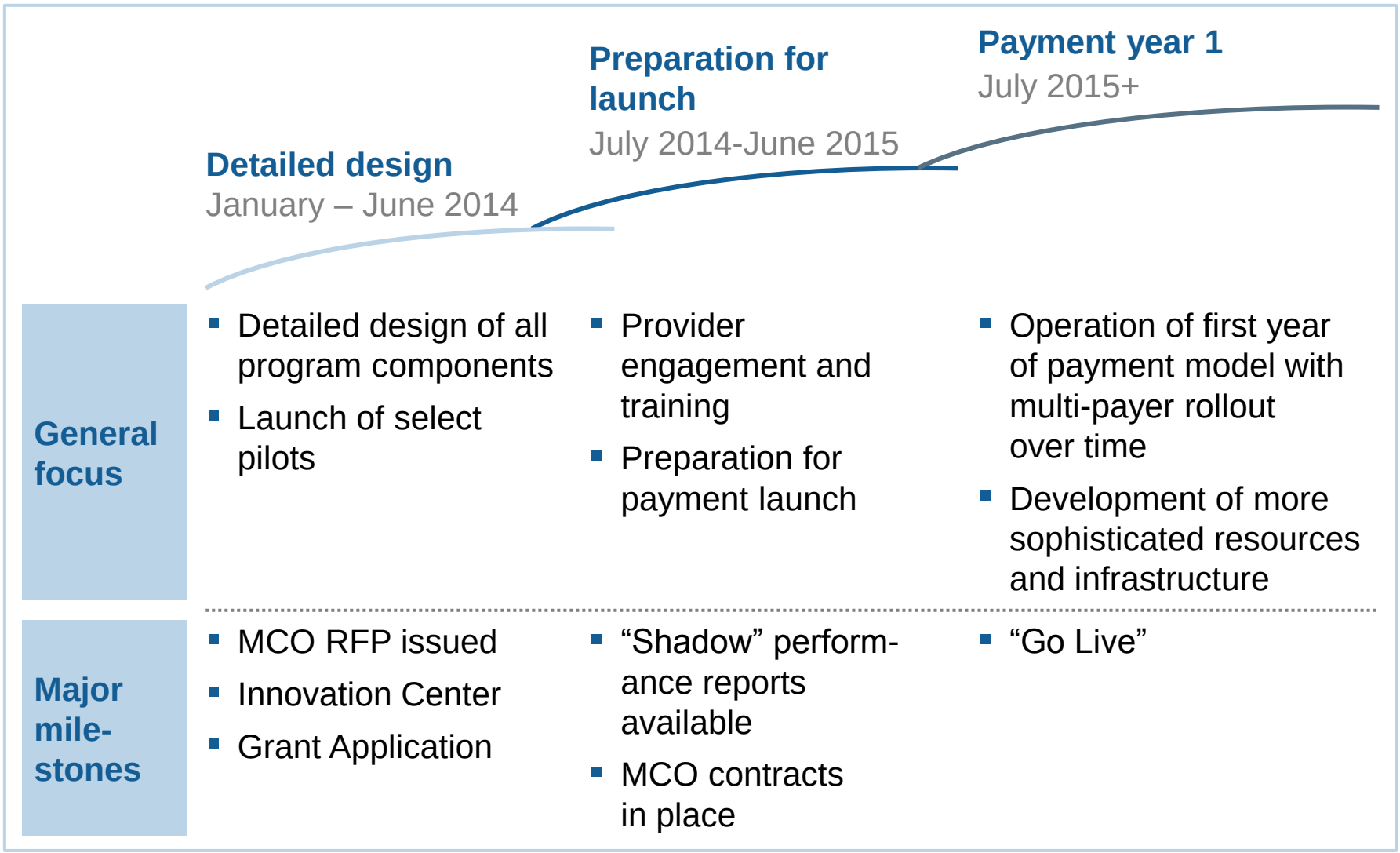
# High-level timeline



# Near-term focus

**Clinical (Delivery)**

- Common provider scorecard
- Shared services initial scope and design (further on care coordination)


**Healthy Neighborhoods (Pop. health)**

- Healthy Neighborhood Program structure and technical design

**Payment**

- Technical rules, participation rules, rollout timeline, supporting analysis

**Data and Analytics**

- Decision structure
- Report designs/approach
- Portal scope/functionality

**Workforce and education**

- Training/retraining strategy

- Goal: Full draft of each by end of March!
- Policy to be led by the HCC – focus on licensing/ credentialing

# Leadership and approach

| | |
|---|---|
| **Clinical (Delivery)** | ▪ Rita Landgraf/ Bettina Riveros<br>▪ Alan Greenglass |
| **Healthy Neighborhoods (Pop. Health)** | ▪ Matt Swanson, Lolita Lopez |
| **Payment Models** | ▪ Each payer<br>▪ Medicaid: Rita Landgraf /Steve Groff |
| **Data / analytics** | ▪ Jan Lee<br>▪ Jill Rogers/Bettina Riveros |
| **Workforce and education** | ▪ Kathy Matt<br>▪ Jill Rogers |

## Approach

- Continue HCC and cross-workstream meetings
- Workstreams will have fewer working sessions and more staff work between broad meetings
- Draw on technical support across the state as needed
- Identify and build on existing initiatives where possible

# We will engage through five channels

## 1 Website

- Single reference point for background, key documents, logistics, and announcements

## 2 Monthly emails


- Update stakeholders on recent progress

## 3 Surveys

- Request feedback
- Collect data about status of working groups/ committees

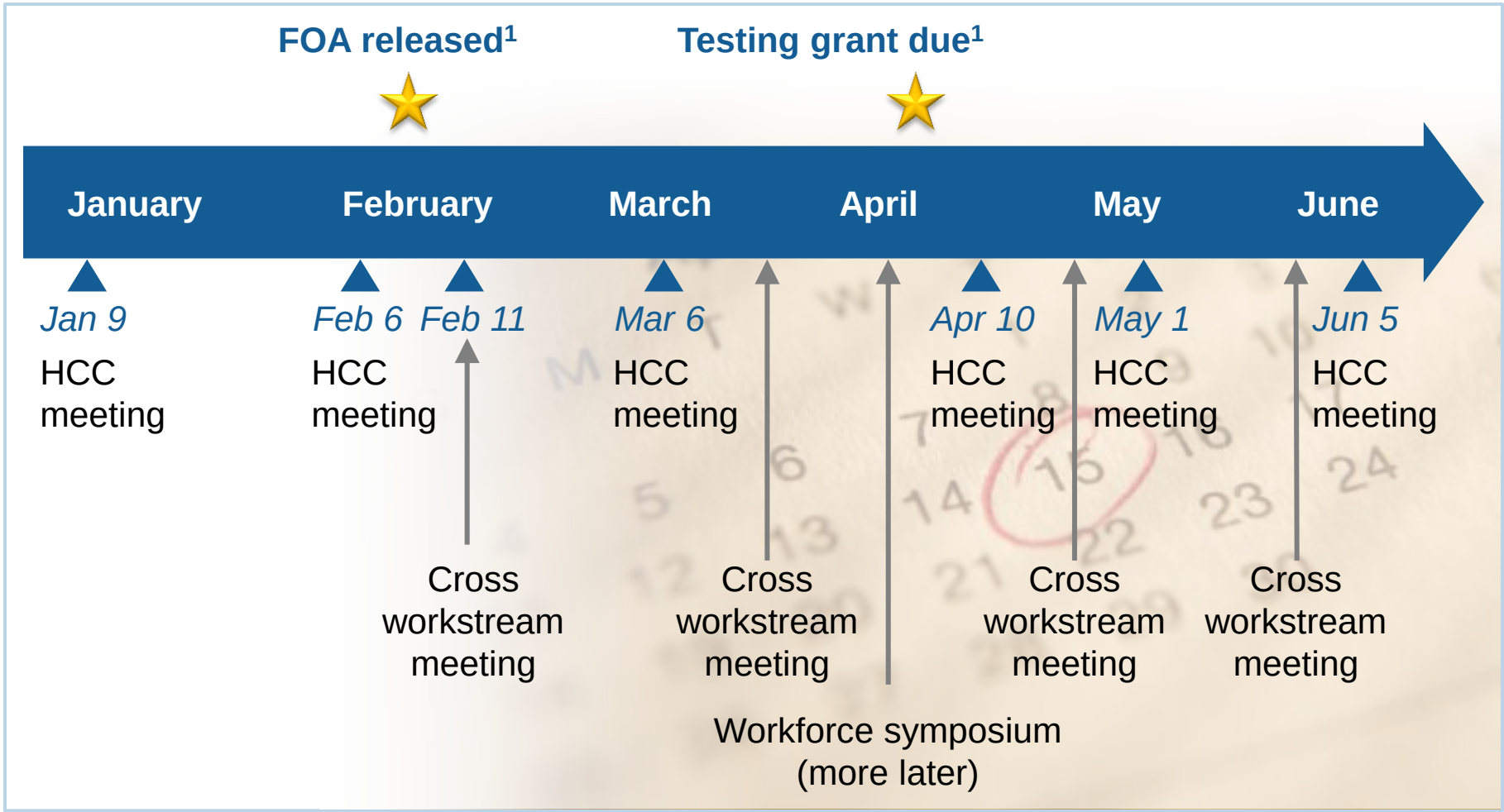
## 4 Meetings

- Implement the Innovation Plan, provide feedback on current initiatives

## 5 Briefing documents

- To share updates from key meetings with your organizations

# Program timeline




1 Expected

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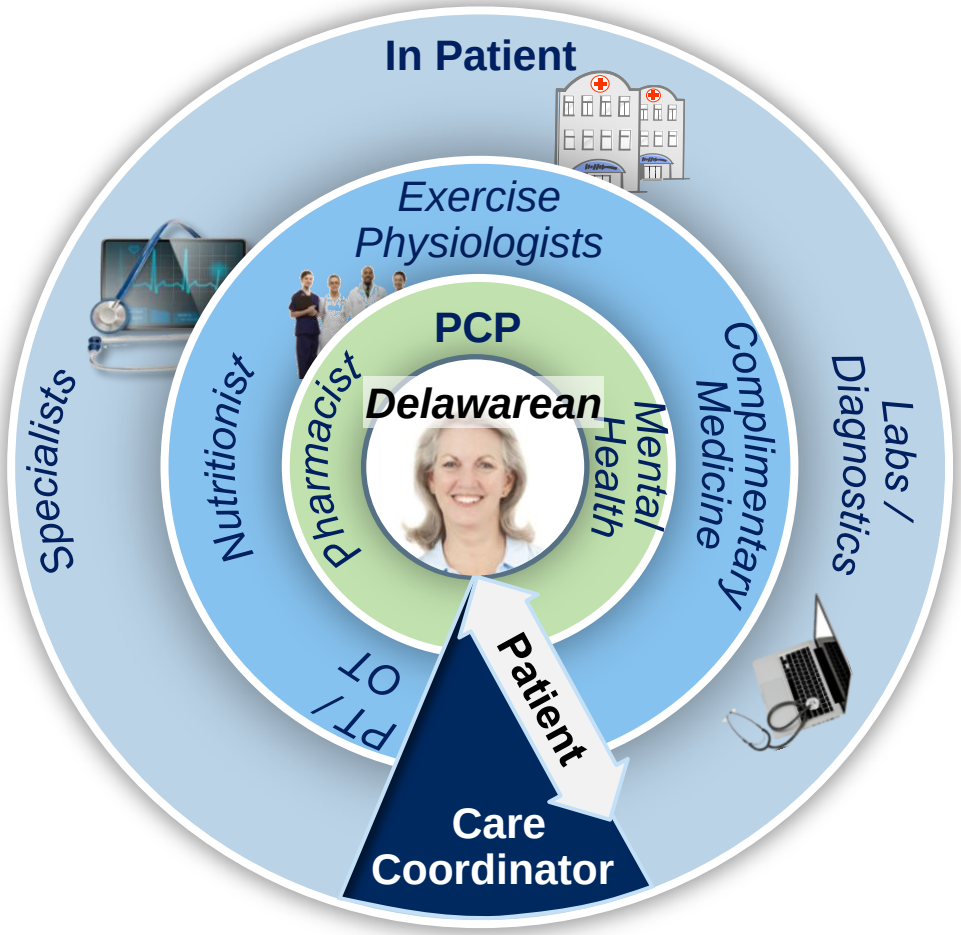
# Goals for workforce discussion

1. **Recap where we are today, including current opportunities and challenges**

2. **Discuss proposed approach going forward, for addressing capacity and new skills/ capabilities**

3. **Conduct breakouts to identify specific needs and current innovative ideas**

# Aspiration: DE as a "learning state"




- Delaware has a strong workforce, including innovative learning programs!
- However, Delaware requires additional capacity and new skills/capabilities to support improved health care delivery
- Existing programs are working to address many of these (e.g., by extending work of GME consortium to all health professions)

# Many institutions and programs are working to address needs

NOT EXHAUSTIVE

Delaware Academy of Medicine

Delaware Health Care Commission

Delaware Health and Social Services

University of Delaware

Bayhealth
Kent General · Milford Memorial

Delaware Tech

Nanticoke Health Services
Always Caring. Always Here.

Nemours

St. Francis Hospital

Beebe Medical Center

Jefferson
Thomas Jefferson University

Christiana Care Health System

Division of Public Health

MSD
Medical Society of Delaware

Delaware Health Sciences Alliance
HEALTHCARE EDUCATION, RESEARCH & SERVICES

# Some examples of Delaware's needs

***Existing needs*** There are Health Professional Shortage Areas (HPSA) in every county

***New roles*** Estimated to require ***~500*** care coordinators

***New skills*** Many practices do not currently have co-located teams

SOURCE: Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services. <http://hpsafind.hrsa.gov/HPSASearch.aspx>.

# Approach for workforce

**Workforce planning**

- Project workforce capacity and capabilities in key roles
- Set out workforce infrastructure for long-term tracking and planning
- Review HCC requirements for workforce intelligence

**Addressing capacity constraints**

- Map existing programs to strategic needs and identify gaps
- Conduct care coordination survey
- Define recruit, train, retrain, retain strategy
- Develop and pilot 1-2 year formal learning and development program with early adopters, kickoff with symposium

# Refining the role of the care coordinator

DRAFT – NOT EXHAUSTIVE

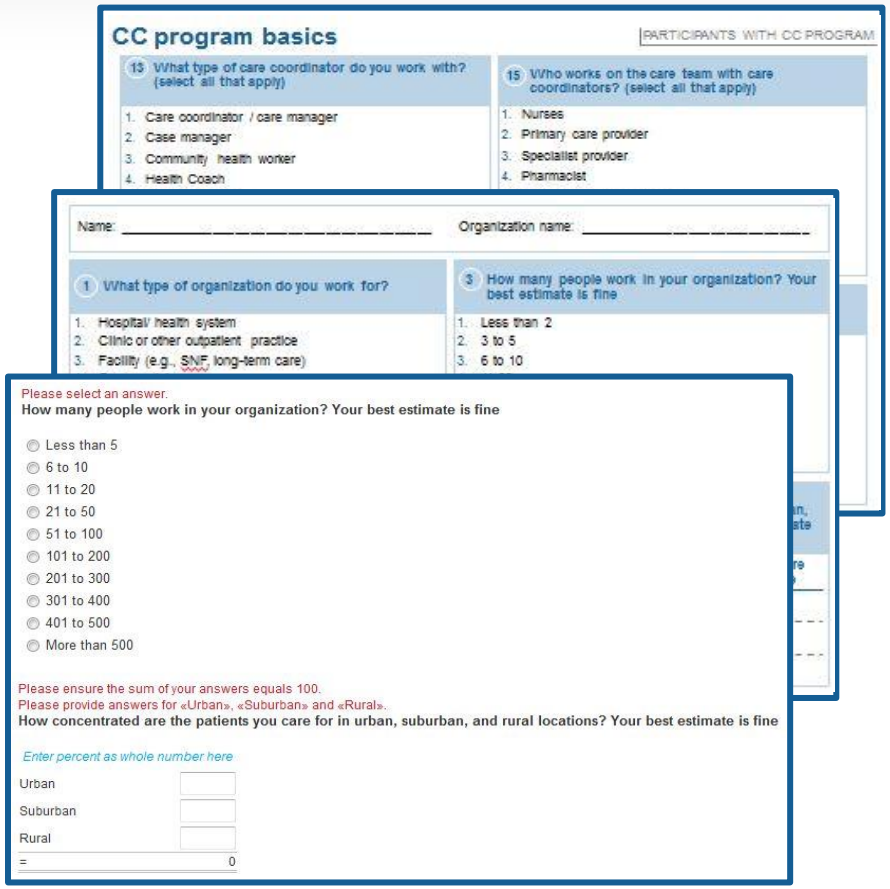

**Currently includes**:

- Care manager
- Care coordinator
- Case manager
- Health educator
- Health manager
- Health coach

1 Roles are not exhaustive - many other versions also to be considered, e.g., healthcare ambassador, nurse navigator, etc.

SOURCE:40 job descriptions from program websites from Montefiore, Intermountain, Kaiser Permanente, Mayo Clinic, Cleveland Clinic, St. John's Health System, Geisinger Health System, Inova Health System

# Care coordination survey




## CC survey will be…

***Used to determine prevalence, design, and success of care coordination programs in DE***

***Administered over a period of 2-4 weeks***

**Who should take survey? Can you help reach members within your organizations?**

# Agenda for first workforce symposium

| OBJECTIVES | APPROACH |
| --- | --- |
| Discuss new roles and capabilities | ***Presentation*** |
| Discuss what this means for organizations and individuals | ***Breakout discussions*** |
| Share examples of other workforce innovation best practices | ***Keynote speaker(s)*** |
| Prioritize capabilities and design of their own “syllabus” | ***Facilitated breakouts discussions*** |

**To be held April 8th!**

# Breakout discussions

## Approach

### Breakout Discussion (15 min):

In groups of ~5 people sitting near you discuss the following questions

- What are 1-3 outcomes and programs you hope result from this learning and development program?
- Please list the most innovative workforce programs or initiatives that you know.
- What are 1-3 challenges to implementing these types of programs?

### Report back and reflect (15 min)

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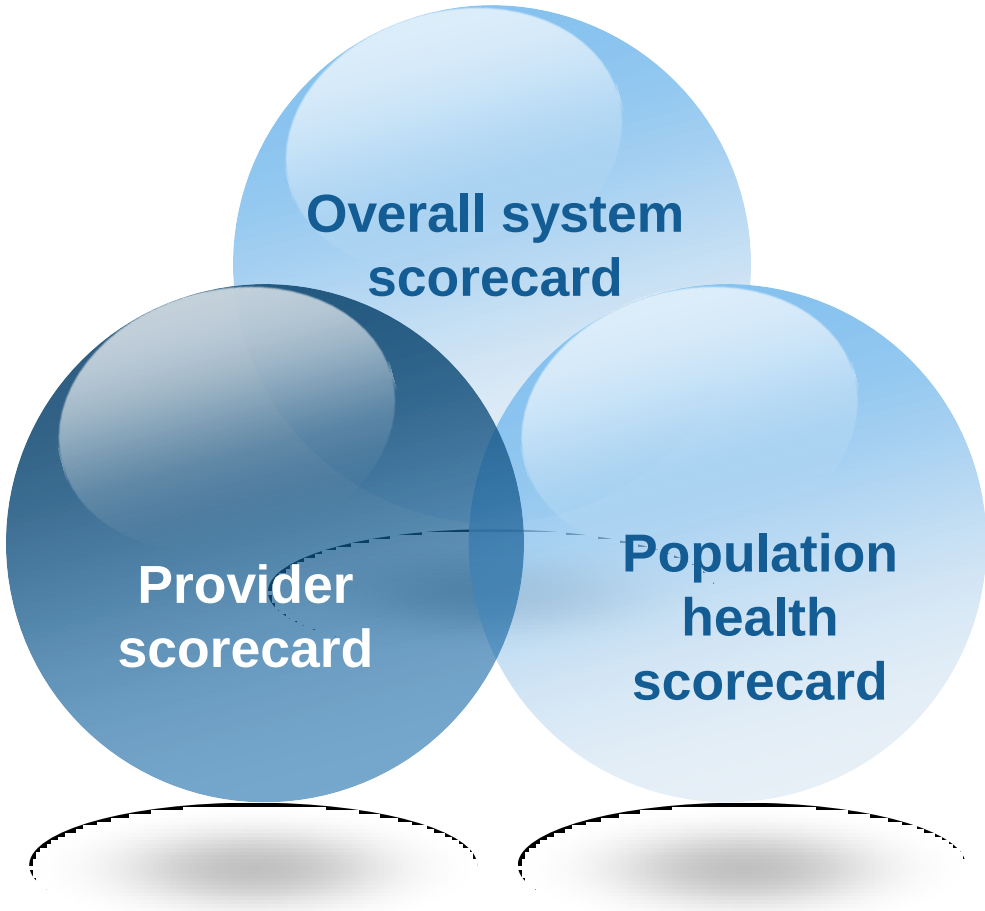
# Three scorecards for Delaware

Focus for today



# Proposed approach to finalize scorecard

1. Understand **current landscape** of data, metrics, and best practices

2. Agree on principles for scorecard design and **criteria to prioritize metrics**

3. Build an **initial data set** based on design principles

4. Analyze metrics against prioritization criteria to arrive at draft list

5. Present draft list of metrics to stakeholder workgroup and incorporate group feedback

# 1 External guidance on metric selection

## Sources

- *Common-wealth fund*
- *R.W. Johnson Foundation*
- *Institute of Medicine*
- *University of Washington*

## Synthesis of key recommendations

- Devise a **simple, manageable approach**
- Select metrics that are:
  - **standardized, validated**, national endorsed
  - Independent of each other and **collectively comprehensive**
  - Able to be **adjusted for different populations**.
- **Task a single entity with defining standards** for measuring and reporting quality and cost data
- Consider **how metric will be measured and who will use it**
- **Aim for the measure to be actionable** for the intended user

SOURCE: Robert Wood Johnson Foundation, Achieving the Potential of Health Care Performance Measures, May 2013; The Commonwealth Fund, Recommended Core Measures for Evaluating the Patient-Centered Medical Home, May 2010.; University of Washington , Guidebook for Performance measurement.

# 1 Four sources metrics…

NOT EXHAUSTIVE

| Standard Type | Examples |
|---|---|
| Medical Home Recognition or Certification | NCQA Patient-Centered Medical Home Recognized Practice 2011; The Joint Commission Disease-Specific Care Certification; URAC Patient Centered Health Care Home (PCHCH) Programs Achieving Medical Home Quality; Accredited by the Accreditation Association for Ambulatory Health Care, Inc. |
| National Standards | NCQA Measuring quality. Improving health care. HEDIS; The Joint Commission National Patient Safety Goals; National Quality Forum; cahps Surveys and Tools to Advance Patient-Centered Care |
| CMS / CMMI | CMS Centers for Medicare & Medicaid Services; Center for Medicare & Medicaid Innovation; EHR Incentive Programs A program of the Centers for Medicare & Medicaid Services; Comprehensive Primary Care Initiative |
| Other Quality Measurement Programs | Community Care of North Carolina; Blue Cross Blue Shield of Michigan; Minnesota MDH Department of Health |

# 1 …across nine categories

PRELIMINARY

| | Category | Example metrics |
|---|---|---|
| Health improvement | Health outcomes | ▪ Mortality of selected conditions (e.g. stroke) |
| | Risk factors | ▪ Tobacco use across attributed patients |
| | Prevalence of disease | ▪ Incidence of chronic conditions (e.g. diabetes) across attributed patients |
| Care improvement | Quality/ effectiveness of care | ▪ **Outcomes:** Hypertension: Controlling High BP<br>▪ **Structure:** Wait time to schedule appts. (days)<br>▪ **Process:** Adult weight screening and follow-up |
| | Patient experience of care | ▪ CAHPS: How well your providers communicate<br>▪ CAHPS: Patients' Rating of Provider |
| Cost reduction | Total cost of care | ▪ Average total cost per patient per year |
| | Utilization | ▪ Number of ED admissions per 1000 patients |
| Transformation | Health IT | ▪ Ability to receive lab data into EHR system as discrete searchable data |
| | Clinical integration | ▪ Integration of other types of care (e.g., mental/behavioral health, specialty) |

SOURCE: IOM, CMMI core measures, Meaningful use core recommended metrics, NQF, CAHPS, HEDIS

# 2 Potential prioritization criteria

PRELIMINARY

## Metrics should be…

- **Commonly used** for reporting by national programs and Delaware payers/providers
- Reliable indicators of **significant improvement**
- Those for which **Delaware has a known need to improve overall** vs. a national average or recognized benchmark
- **A known source of variation among providers**

**Goal: a small list of metrics that are also comprehensive (i.e., by category, disease)**

# 3 Four nationally representative data sets

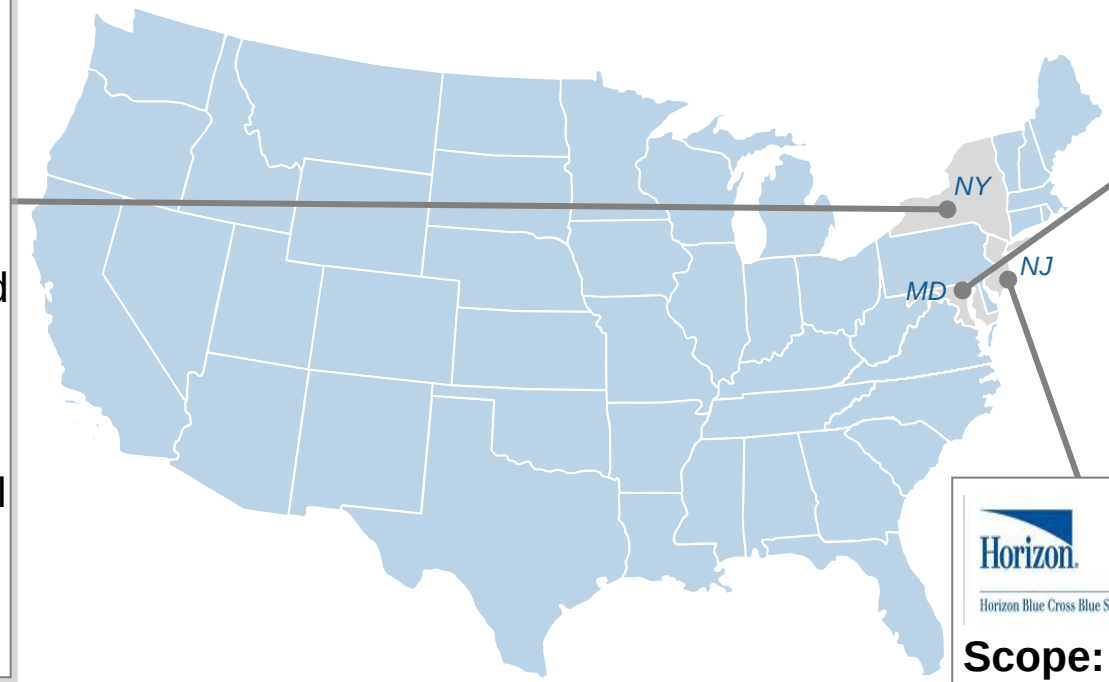
| | Description | No. of measures |
|---|---|---|
| CPCI[1] measures | A multi-payer initiative offering bonus payments to PCPs who deliver more coordinated care | 14 |
| MSSP ACO[2] | Ties provider payment to quality and cost metrics for an assigned population | 33 |
| CMMI core measures | Effort to measure overall impact of CMMI's programs on population health, quality, and efficiency of care | 65 |
| Meaningful use[1] | Effort to measure quality of healthcare services provided by eligible physicians and hospitals | 44 |

1 Includes meaningful use clinical quality measures (additional set), eligible professionals alternate core set, and eligible professionals – core set clinical quality measures

# 3 Metrics from three private payer programs

**Scope:**
- Statewide PCMH demonstration with ~250K patient enrolled

**Outcomes:**
- 15% lower medical and pharmaceutical costs than control practices




**Scope:** Statewide PCMH demonstration with 1M patients

**Outcomes:**
- 2.7% (~$98M) savings on total system costs
- 9.3% improvement in quality of care scores

**Scope:** 8 practices across the state adopted PCMH model

**Outcome:**
- Drop in utilization and cost
- Significant increase in screenings

# 3 Example scorecard: CareFirst



| PCMH Report Card: Sample of Composite Scoring | | Points | Metrics |
|---|---|---|---|
| Degree of PCP Engagement | | 4.5 | Schedule Appointments |
| | | 12.0 | Patients Receive Appointments |
| | | 4.5 | Care Plan Clear |
| | | 4.5 | Care Coordination Accomplished |
| | | 4.5 | Active Follow-ups |
| | | 30.0 | ENGAGEMENT COMPOSITE |
| Appropriate Use of Services | Admissions | 8.0 | Preventable Admissions (AHRQ)[1] |
| | | | Potentially Preventable Readmissions[2] |
| | | | Rate of Use of Recognized Hospitals of Distinction[3] |
| | | | ADMISSIONS COMPOSITE |
| | Potentially Preventable Emergency Room Use[4] | 4.0 | POTENTIALLY PREVENTABLE EMERGENCY ROOM USE[4] |
| | Ambulatory Diagnosis, Imaging, and Antibiotics | 8.0 | Colonoscopy |
| | | | CT Scans |
| | | | MRI |
| | | | Patients with Low Back Pain[5] |
| | | | Patients with Viral Upper Respiratory Infections[5] |
| | | | Patients with Pharyngitis[5] |
| | | | DIAGNOSTIC, IMAGING AND ANTIBIOTICS COMPOSITE |
| Effectiveness of Care[a] | Chronic Care Measures | 10.0 | Diabetes[5] |
| | | | Asthma[5] |
| | | | Congestive Heart Failure[6] |
| | | | Coronary Artery Disease[6] |
| | | | Coronary Artery Disease - Myocardial Infarction[6] |
| | | | Major Depressive Disorder[5] |
| | | | CHRONIC CARE COMPOSITE |
| | Population Health Measures | 10.0 | Colon Cancer Screening[5] |
| | | | Chlamydia Screening[5] |
| | | | Cervical Cancer Screening[5] |
| | | | Breast Cancer Screening[5] |
| | | | Childhood Immunizations[5] |
| | | | POPULATION HEALTH COMPOSITE |
| Patient Access | | 5.0 | Use of E-scheduling |
| | | 5.0 | Use of E-visits |
| | | 5.0 | Extended Office Hours |
| | | 5.0 | Patient Office Experience, such as wait times |
| | | 20.0 | ACCESS COMPOSITE |
| Structural Capabilities | | 2.5 | Use of E-prescribing |
| | | 2.5 | Electronic Medical Records Meaningful Use |
| | | 2.5 | Use of E-mail |
| | | 2.5 | External Certification[7] |
| | | 10.0 | STRUCTURAL COMPOSITE |
| | | 100.0 | Overall Practice Composite |

SOURCE: CareFirst BCBS

Further detail to follow



# 4 National and private payer comparison

| Categories | Number of unique metrics[1] | Number of metrics common across all sets that have at least one metric in the category |
|---|---|---|
| Health outcomes | 0 | N/A |
| Risk factors | 0 | N/A |
| Prevalence of disease | 0 | N/A |
| Quality – process | 69 | 6[2] |
| Quality – structure | 6 | 1 |
| Quality – outcomes | 18 | 2 |
| Patient experience of care | 13 | 8[3] |
| Total cost of care | 2 | 2 |
| Utilization | 10 | 1 |
| Health IT | 1 | 0 |
| Clinical integration | 0 | N/A |

**20 metrics (~15% of total unique metrics) are common across all sets for each category**

1 Comparison across 4 national sets and 3 private payer sets 2 Includes metrics common across at least 5 out of 7 sets
3 Common metrics are all part of CAHPS SOURCE: CMMI, CPCI, Meaningful Use, CareFirst, Horizon, and Anthem PCMH demonstrations

# 4 National and private payer comparison: Quality of care – process

PRELIMINARY

| Metric | CPCI | CMS SS ACO | CMMI core | Meaningful use | Care-First | Horizon | Anthem |
|---|---|---|---|---|---|---|---|
| Breast Cancer Screening | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Colorectal Cancer Screening | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| HF[1]: Beta-Blocker Therapy for LVSD[2] | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ |
| Diabetes: LDL[3] Control | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Tobacco use screening and cessation | ✓ | ✓ | ✓ | ✓ | | ✓ | |
| IVD[4]: Complete Lipid Profile and LDL Control < 100 | ✓ | ✓ | ✓ | ✓ | | | ✓ |

1 Heart failure 2 Left ventricular systolic dysfunction 3 Low density lipoprotein 4 Ischemic vascular disease

SOURCE: CMMI, CPCI, CMS Shared Savings ACO, Meaningful Use, CareFirst, Horizon, and Anthem PCMH demonstrations

# 4 National and private payer comparison: Total cost of care

PRELIMINARY

| Metric | CPCI | CMS SS ACO | CMMI core | Meaningful use | Care-First | Horizon | Anthem |
|---|---|---|---|---|---|---|---|
| Medicare Spending Per Beneficiary, Risk-adjusted and Price Standardized | ✓ | ✓ | ✓ | | | | |
| Total Medicare Part A and B Cost Calculation Recommendations9 (allowed amounts) | ✓ | ✓ | ✓ | | | | |

1 Heart failure 2 Left ventricular systolic dysfunction 3 Low density lipoprotein 4 Ischemic vascular disease

SOURCE: CMMI, CPCI, CMS Shared Savings ACO, Meaningful Use, CareFirst, Horizon, and Anthem PCMH demonstrations

# Discussion and feedback

TO GENERATE DISCUSSION ONLY – NOT FOR DECISION-MAKING

Do you agree with these prioritization criteria for metrics? (select all that you agree should be included)

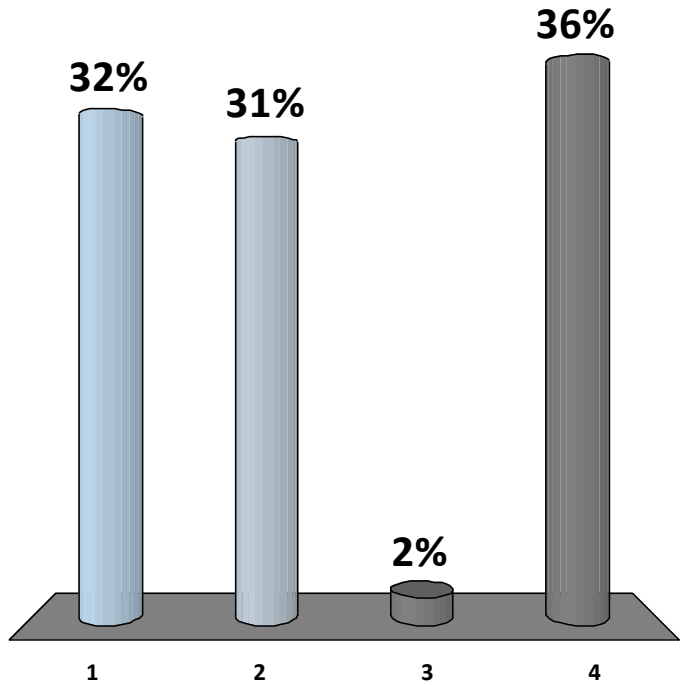
1. Metrics should be commonly used for reporting by national programs and Delaware payors/providers
2. Metrics should be reliable indicators of significant improvement
3. Metrics should be those for which Delaware has a known need to improve overall vs. a national average or recognized benchmark
4. Metrics should be a known source of variation among providers

# Discussion and feedback

TO GENERATE DISCUSSION ONLY – NOT FOR DECISION-MAKING

## What is the appropriate level of scorecard transparency?

1. All data should be made available for the public
2. Aggregate data should be public, with provider-specific data reported only to providers
3. Data should be reported only to providers directly
4. Data should be fully transparent over time, but initially reported directly to providers

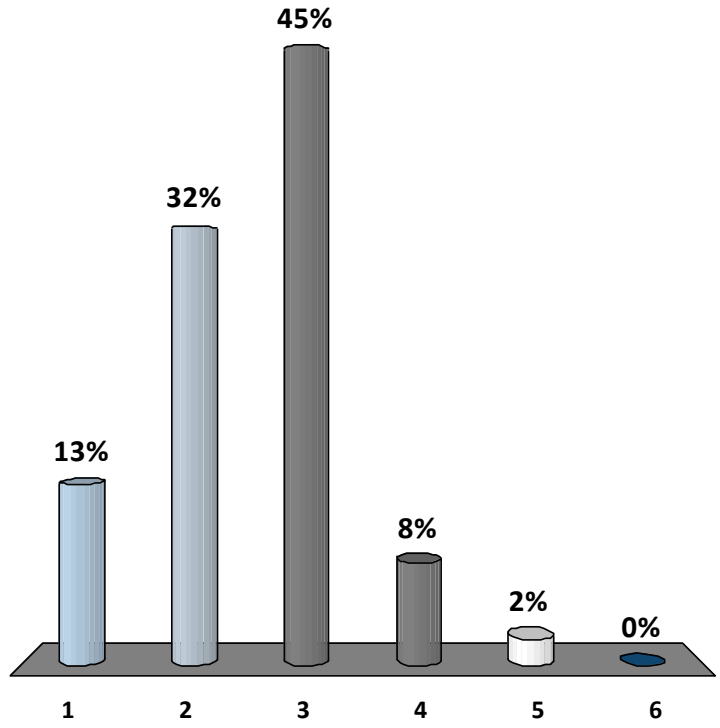


# Discussion and feedback

TO GENERATE DISCUSSION ONLY –
NOT FOR DECISION-MAKING

## How often should the scorecard be updated?

1. Annually
2. Semi-annually
3. Quarterly
4. Monthly
5. Weekly
6. Daily

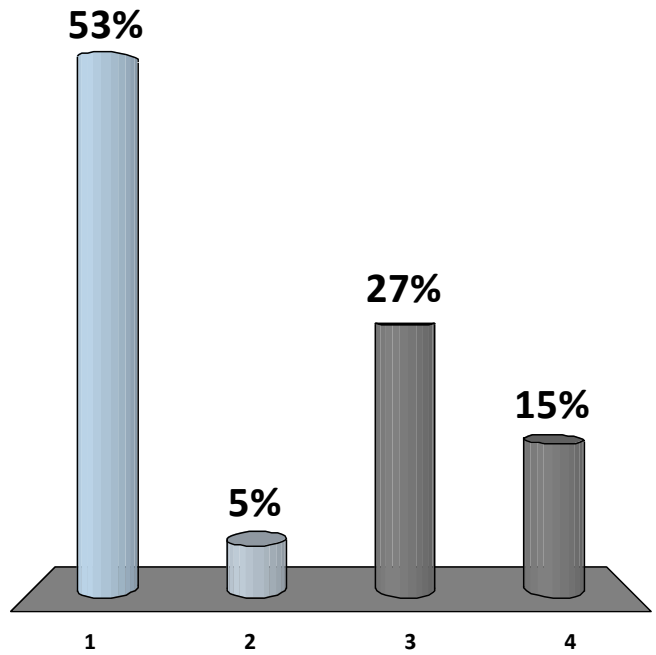


# Discussion and feedback

TO GENERATE DISCUSSION ONLY – NOT FOR DECISION-MAKING

## How should quality metrics in the provider scorecard link to payment incentives?

1. Yes, linked to care coordination and shared savings
2. Yes, linked to funding for care coordination only
3. Yes, linked to shared savings only
4. No



# Agenda

| Time | Topic |
|---|---|
| 8:30-9:30 | Recap and where we are today |
| 9:30-10:00 | Timeline and approach going forward |
| *10:00-10:15* | *Break* |
| 10:15-11:00 | Workforce discussion |
| 11:00-11:45 | Provider scorecard discussion |
| **11:45-12:00** | **Wrap up and next steps** |

# Wrap up

- Care coordination survey will be available this week
- If you are able, please share currently used scorecards
- Key dates
  - March 6: HCC meeting
  - March 18: Cross-workstream meeting
  - April 8: Workforce symposium
  - April 10: HCC meeting