

# HIP: Health care transformation – session 1

Discussion document

December 7<sup>th</sup>, 2015

# December 7<sup>th</sup> Agenda: Health care delivery transformation

Work group 1



<b>Time</b>	<b>Session description</b>	<b>Session type</b>
9:00-9:20	Introduction and goals of the work group	Presentation
9:20-10:00	Current state of PA	Presentation and discussion
10:00-10:40	Delivery transformation innovations across states	Gallery walk
10:40-10:50	Break	
10:50-11:30	Delivery transformation focus area exercise	Breakout exercise
11:30-11:50	Full group debrief	Full group discussion
11:50-12:00	Closing and next steps	Presentation

# Goal of work group session 1 is to provide input and align on principles



## Purpose/principles

- Gather input from multiple stakeholders with the objective of building a plan with the highest likelihood of success
- Collaborate with stakeholders across the state to align around a set of guiding principles
- Share informed view of what initiatives (led by stakeholders or the Commonwealth) are happening in PA and across the country

### Session 1

Provide input and align on principles

### Session 2

Test preliminary strategy

### Session 3

Refine strategy and identify interdependencies across broader plan

# Milestones for HIP

**July**  
*Stakeholder engagement kickoff at NGA*

- Nov**
- *Webinar briefing for work group members*
  - *Work Groups Session 1: Input*

**Jan**  
*Catalyst for Payment Reform payer survey*

**March**  
*Work Groups Session 3: Refine*

**May**  
*Submit HIP plan to CMMI*

Q3

2015

Q4

Q1

2016

Q2

Q3

**Jan**  
*Work Groups Session 2: Test*

**End of Jan / Feb**  
*Draft (outline) of full HIP plan complete*

**Summer**  
*Launch payment model according to implementation plan*

# Work group charter: Health care transformation

<b>Work group title: Health Care Transformation</b>	<b>Co-chairs: Dr. Rachel Levine and Lisa Davis</b>
<b>Problem statement:</b> <ul style="list-style-type: none"><li>▪ Payment and healthcare delivery innovation are necessary for PA to achieve better health, better care, and smarter spending but additional support and capabilities (e.g., tele-health, workforce) are needed to catalyze the transformation process</li><li>▪ In order to design successful innovation strategies, the Commonwealth needs to embrace broader health care delivery system transformation opportunities</li></ul>	
<b>Mandate for this group:</b> <ul style="list-style-type: none"><li>▪ Align stakeholders on top health care delivery system transformation opportunities to support the PA's goals</li><li>▪ Design health care delivery system transformation strategy and recommend state-led or multi-stakeholder levers to reach these goals</li></ul>	<b>Types of decisions to provide input on for HIP Plan:</b> <ul style="list-style-type: none"><li>▪ Scope of potential transformation solutions to consider</li><li>▪ Areas where state-wide, regional, and local alignment is needed</li><li>▪ Resources and funding for transformation opportunities</li><li>▪ Plan for stakeholders to track program effectiveness / health outcome impact (e.g., medical cost or quality targets for the initiatives)</li><li>▪ Best practices and current models within and outside of PA in health care delivery transformation that can be leveraged by the Commonwealth</li><li>▪ Areas where the state should play the role of “actor” vs. “catalyzer”</li></ul>
<b>Participation expectations:</b> <ul style="list-style-type: none"><li>▪ Join 3, 2-3hr work group meetings between now and HIP Plan submission (May 2016)<ul style="list-style-type: none"><li>– Webinar (Nov 5<sup>th</sup>, 2015)</li><li>– Kickoff (Dec 7<sup>th</sup>, 2015)</li><li>– Review / input on draft model design options (February 2016)</li><li>– Review / input on full draft of HIP Plan (April 2016)</li><li>– Potential ad hoc additional meetings</li></ul></li><li>▪ Communicate updates from work group within your organization &amp; collect feedback to share back with work group members</li></ul>	

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# The PA workforce: Physicians

- In 2012, 46,715 physicians responded to the licensing survey.
- Of licensed physicians in PA, 66 percent practiced direct patient care.
- Between 2004 and 2012, the percentage of female physicians increased from 25 to 32 percent. The average age was 51.4 years.
- Thirty-five percent of physicians in direct patient care practiced primary care, including family medicine, internal medicine, pediatrics, and OB/GYN.
- Of practicing physicians, Medicaid and Medicare recipients were accepted by 85 and 90 percent, respectively.

# The PA workforce: Dentists

- In 2013, 8,230 dentists responded to the licensing survey.
- Of licensed dentists in PA, approximately 80 percent practiced direct patient care. Seventy-seven percent of those practice general dentistry.
- Between 2007 and 2013, the percentage of female physicians increased from 18 to 23 percent. The average age was 52.4 years.
- Dentists providing care in rural areas increased from 19 percent in 2011 to 20 percent in 2013.
- The percentage of dentists providing direct patient care that accept Medicaid increased from 17 percent in 2003 to 24 percent in 2013.

# An overview of tele-health in PA

- Twenty-eight percent used live videoconferencing; 26 percent used recorded videos available on the Internet; 20 percent used remote monitoring for diagnostic purposes.
- No significant difference regarding tele-health use based on age, type of facility, physician specialty, or rural versus urban location.
- Fifty-eight percent reported poor infrastructure, little training, and no technical support for tele-health activities.
- Ninety-three percent reported a low patient satisfaction rate.
- According to best practices, tele-health is most effective for chronic disease management, professional collaboration, and medical education purposes.

## Health care transformation: Today's conversation is a place to start

- There are many opportunities to improve tele-health (consultation, remote monitoring, and patient wearables) in rural areas to increase access to needed services.
- Innovating payment to better support advanced primary care is a key priority of the payment work group.
- Improving oral health and access to dental services are focus areas of the population health work group and technical assistance PA is receiving through the National Governors Association.
- Exploring community health worker roles, training, certification, and financing is also a focus of the NGA TA program and a 75-member stakeholder effort currently underway by the Jewish Healthcare Foundation to create and distribute a CHW strategic plan and toolkit.

# NW PA Area Health Education Center – AHEC Learning Communities

Organization: NW PA AHEC

Start date: 2014

Number of providers: >10

Lead: Patty Stubber, PhD, MBA

Initiative status: Work in progress

Number of patients: >1,000



## Goals

- Improve Health Literacy
- Improve Health Status of Patients
- Improve Cultural Competence of Health Professions students/residents

## What we did

- Engaged primary care residents (Family Medicine & Psychiatry), health professions students to offer health education to resettled refugees in Erie (very informal with face-to-face interpretation)—enhanced understanding of health/systems/tests
- Plan to develop definitive outcomes measures with the help of a Slippery Rock student, Allegheny College, & VISTA volunteer (one of the Lost Boys of Sudan)

## Results / impact

- Physician (Kelli Wienecke, DO) comment: “I will never look at another patient in the same way again”
- ↑ requests for mammograms & pap smears; acquainted county EMS system w/population of deaf Nepalis previously unknown to them—working with LECOM med students for IDs; female circumcision discussion/recommendations; WIC recipient children learned how to brush their teeth; enabled bullied child to move to another school (Psych Resident)

## Lessons for the state

- Communicate with contractors/partners to find out what we are doing in addition to the work statement.
- Engage us in discussion for projects for which we may be of help. If you are not sure if we can be of assistance, ask us. If we can't help, we likely know who can.

# UPMC – Integrated Behavioral Health Project

**Organization: UPMC St. Margaret Family Medicine Residency Program**

**Leads: Jonathan Han, MD; Jim Mercuri, LCSW; Marianne Koenig, PharmD; Nil Das, MD**

**8 Faculty / 36 Residents / 4 LCSWs / 8 PharmDs**

**Number of patients: 20,000**

## Goals

- Integrate behavioral health (BH) within primary care, offering on-site, open access to BH services including counseling, psychiatric evaluation, case management
- Improve medical outcomes, patient/provider satisfaction, demonstrate financial sustainability

## What we did

- Embed LCSWs, psychiatrist, and PharmDs within Family Health Centers
- Establish workflow and culture emphasizing multidisciplinary, collaborative care
- Target patients with high-risk medical comorbidities, psychiatric illnesses, polypharmacy issues
- Utilize data to drive quality initiatives
- Provide counseling about opioid overdose risk and distribute naloxone to patients and families

## Results / impact

- Demonstrated continued growth in utilization and reimbursement for services in FFS model
- Demonstrated improved BH outcomes (PHQ9 and GAD7 scores), as well as improvement in diabetes metrics
- Decreased hospitalizations and ED utilization among enrolled patients
- Improved patient and provider satisfaction
- Increased provider comfort level counseling opioid-dependent patients
- Multiple naloxone reversals documented

## Lessons for the state

- Multidisciplinary team care is effective, efficient, and fun – providers enjoy working in this model.
- Reimbursement – we need to financially incentivize physicians to work with SWs and PharmDs; develop strategies to reimburse home visits not led by physicians, telemedicine.
- Improve accessibility to and communication with addiction service providers.
- Reimburse and encourage development of non-pharmacological services for pain management.

# Cole Memorial – Coordination of Care

Organization: Charles Cole Memorial Hospital

Start date: February 2013

Number of providers: 30 in Cole Memorial Primary Care Network

Lead: Janice Walters, Executive Director Revenue Systems

Initiative status (Planned, Ongoing, Complete): Ongoing

Number of patients: 23,500 in Cole Memorial Primary Care Network

## Goals

- Increase the coordination of care efforts for patients throughout the healthcare system to improve patient outcomes, reduce utilization, and reduce cost of care

## What we did

- Cole Memorial introduced the use of ambulatory network care managers to coordinate care throughout the healthcare system, not just in the inpatient setting. Typically this level of service is only found in health systems that also offer an insurance product.
- The initial focus area of this work was identifying patient populations who frequently used emergency services that could possibly receive care in a more appropriate setting. Inappropriate emergency department visits are not a unique issue to this organization. In an effort to address this problem, the new ambulatory care managers work to connect patients who frequently use emergency services with a primary care provider. This often means identifying additional care needs and facilitating the acquisition of resources in order to meet these needs.

## Results / impact

- Data that is being used to track the impact of this improvement in the care model is showing an overall decrease of 24% in frequent ED visits since the inception of this strategy two years ago. This effort has resulted in sustainable improvement.
- A comprehensive system-wide improvement strategy is the overarching goal. In addition to frequent use of emergency services, these care management services have been expanded to include care management services for re-hospitalizations, patients with chronic diseases, and/or advanced illness as well as patients identified by the primary care provider in need of additional services.

## Lessons for the state

- Reimbursement strategies need to be designed in such a way that recognizes the level of services that are being provided and rewards progressive and innovative thinking. To date, Cole has received no enhanced reimbursement from either the State or CMS for the improved coordination of care efforts as this level of service is not recognized in RHC reimbursement structures. The lack of compensation for this level of service may impact sustainability.

# Health Federation of Philadelphia – Quality Improvement



**Organization:** Health Federation of Philadelphia  
**Start date:** December 2012  
**Number of providers:** 300

**Lead:** Suzanne Cohen  
**Initiative status:** Ongoing  
**Number of patients:** 200,000

## Goals

- To support health centers with practice transformation and the ability to use data for QI
- To improve EMR use, PCMH recognition, Meaningful Use Attestation, and performance on HP 2020 key measures

## What we did

- Implementation of a population health management system that is EMR agnostic and allows health centers to view and use their data.
- Intensive coaching and support around EMR use, workflow, and practice transformation.
- Implementation of a data warehouse to allow network level data benchmarking and quality improvement work.

## Results / impact

- Greater capacity at the health center and network level to use EMRs and to use data for quality improvement.
- NCQA recognition and maintenance/ improvement of recognition status
- Meaningful use participation
- Improvement in a core set of Quality Improvement measures

## Lessons for the state

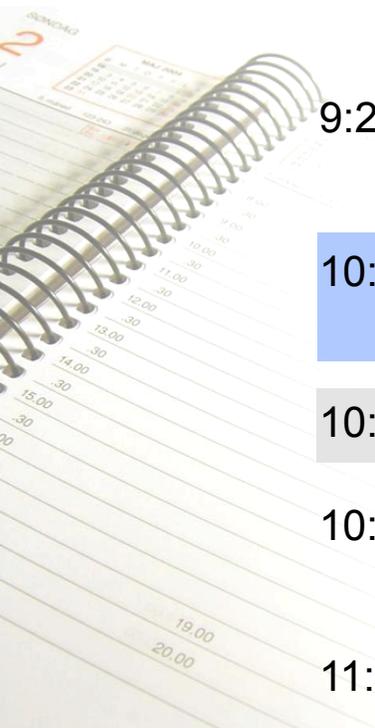
- EMRs do not give providers the tools they need to use data meaningfully. Additional technology and support around the technology is needed.
- Continued emphasis on building capacity to manage data and quality is necessary for the transition to value-based payment.

## Discussion questions

- Which health care workforce or tele-health pilots / initiatives are you currently implementing in PA?
- What are the biggest priorities for health care transformation in PA?
- Which stakeholders should be involved and why?

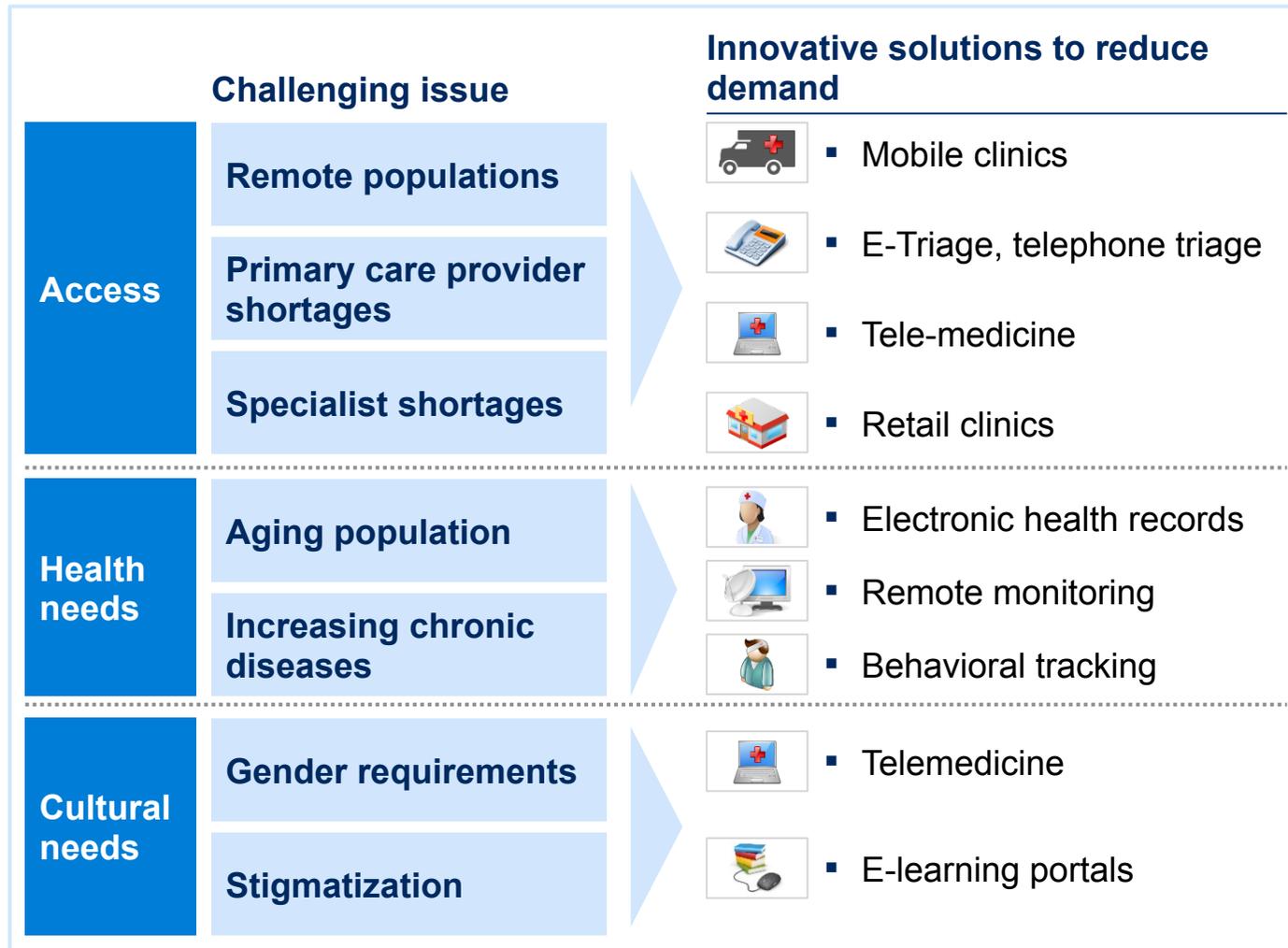
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# Innovations in care delivery can address these challenges...



# ...to enable more efficient health care provision and optimal workforce utilization

Innovation	Description	Impact on workforce
 <b>Advanced practitioners</b>	<ul style="list-style-type: none"> <li>Nurse Practitioners and Physician Assistants provide primary care services</li> </ul>	<ul style="list-style-type: none"> <li>Alleviation of PCP shortages</li> <li>Increased need for nurses</li> </ul>
 <b>Community health workers</b>	<ul style="list-style-type: none"> <li>Initial point of contact, providing advice on medical topics especially for long-term conditions; transfer to doctor if needed</li> </ul>	<ul style="list-style-type: none"> <li>AHP to educate patients, coordinates demands, may reduce physician contacts</li> </ul>
 <b>Mobile clinics</b>	<ul style="list-style-type: none"> <li>Regularly providing primary medical care by GP to patients in rural areas, incl. those that cannot travel to hospitals (e.g., older)</li> </ul>	<ul style="list-style-type: none"> <li>Higher GP share, better workforce planning per area, other HC workers needed</li> </ul>
 <b>Retail clinics</b>	<ul style="list-style-type: none"> <li>Located in popular places (e.g., malls), patients can receive basic medical care in acute cases such as flu, etc.</li> </ul>	<ul style="list-style-type: none"> <li>Use of advanced practitioners could cover a gap in physician's availability</li> </ul>
 <b>Tele-medicine</b>	<ul style="list-style-type: none"> <li>Option for patients to call in and receive medical advice; can be also used to involve specialists in other locations</li> </ul>	<ul style="list-style-type: none"> <li>More efficient utilization of workforce, especially for hardly available specialists</li> </ul>
 <b>Remote monitoring</b>	<ul style="list-style-type: none"> <li>Patient's condition is (self-)monitored and results are screened by specialist doctors via remote access</li> </ul>	<ul style="list-style-type: none"> <li>Potential to decrease redundant communication, add technicians as needed</li> </ul>
 <b>Appointment mgmt. systems</b>	<ul style="list-style-type: none"> <li>Enabling more unified and efficient access by coordinating appointments and requests between providers within one area</li> </ul>	<ul style="list-style-type: none"> <li>Enables efficient capacity allocation, may reduce idle times for physicians</li> </ul>

# Innovative health care workforce solutions can be used to address healthcare demand with different health professionals leading care



## Advanced practitioner-led

### Primary care

- Advanced nurse practitioner

### Maternity care

- Nurse specializing in ob/gyn

### Pre-hospital care

- Paramedic

### Mental health care

- Nurse specializing in psychiatry



## Allied health professional-led

- Pharmacist

- Midwife

- Emergency medicine technician

- Psychologist



## Physician-led

- Family medicine physician

- Ob/gyn physician

- Emergency medicine physician

- Psychiatrist

# ZocDoc allows patients to contact the doctors when they need it

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Search by: Specialty Name Location (Zip, City, State) Insurance  
 Primary Care Doctor 10013 I'm paying for myself Search

Reason for Visit Language Doctor Gender Only doctors that see children

Doctors in 10013

**Dr. Susie Chung MD**  
 Primary Care Doctor  
 139 Centre St  
 New York, NY 10013  
 0.54 miles  
 ★★★★★  
 Very nice office, sweet receptionist, Dr. Chung saw me right away. Appointment was ...

**Dr. Zvi Ben-Zvi MD**  
 Primary Care Doctor  
 5 Harrison Street  
 New York, NY 10013  
 0.22 miles  
 ★★★★★  
 Excellent... we still from now on come to Dr. Ben-Zvi as a family. Very satisfied, VERY

**Dr. York Sing Chan DO**  
 Internist  
 85 Bowery  
 New York, NY 10013  
 0.78 miles  
 ★★★★★  
 Very comfortable and nice.

Book Online View Profile

12:00 pm 10:00 am  
 12:15 pm 10:15 am  
 12:30 pm 10:30 am  
 12:45 pm 10:45 am  
 more... more...

No availability these days.  
 Next Mon, Dec 15 >

2:00 pm 1:00 pm 2:00 pm  
 3:00 pm 2:00 pm 3:00 pm  
 4:00 pm 3:00 pm 4:00 pm  
 5:00 pm 4:00 pm 5:00 pm  
 more...

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Who participates in  
 I'm paying for myself

Find a Doctor

## Solution

- On demand access to doctors in minutes or same day in person or via phone video call
- Easy booking of appointments
- Real-time updates of doctor's availabilities
- Patient reviews of doctors

## Impact

### Impact on

Productivity efficiency

Quality of care

### What it does

- Automate existing activities
- Improve communication with patients
- Remove the need for co-location

## Integrated impact

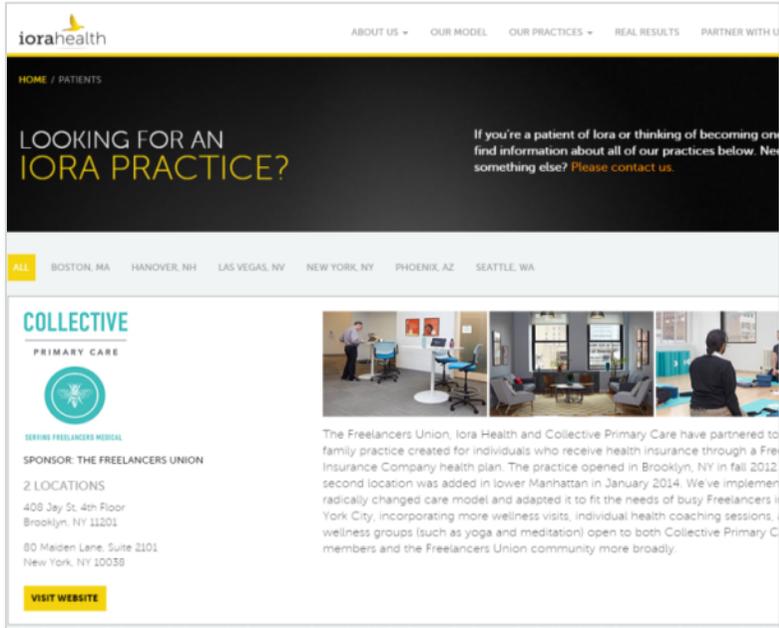
- Time saving for both patient and doctor
- Patients get access to care in just 24 – 72 hours
- Doctors get their cancelled appointment filled rather than wasting them

VIDEO: <http://www.bloomberg.com/video/zocdoc-facilitating-medical-appointments-online-NGAY9GI8SFu6fj1RP~cvgd.html>

SOURCE: <http://www.zocdoc.com/aboutus>;

<http://bits.blogs.nytimes.com/2012/01/30/lessons-from-zocdoc-a-health-tech-start-up-that-works/?php=true&type=blogs&r=0>

# Iora Health uses remote communication to provide care to small business employees



## Solution

- Primary care network that uses remote communication (e.g., text messages, e-mail, video)
- Patients receive personal primary care physician and health coach
- Customer base is self-insured employers; value based payments (fee per month)

## Impact

Impact on

Productivity efficiency

Quality of care

What it does

- Automate existing activities
- Improve communication with patients
- Remove the need for co-location



# FitBit Flex allows consumers to easily track and analyze personal activity and sleep patterns



## Solution

- FitBit Flex tracks **steps taken, calories burned, hours slept, distance traveled, active minutes, and quality of sleep**
- Automatically syncs to most computer and smart phones, giving consumers **real-time access to personal statistics via Fitbit dashboard**
- Allows consumers to see personal trends with free online tools and mobile app

## Impact

Impact on

**Demand management**

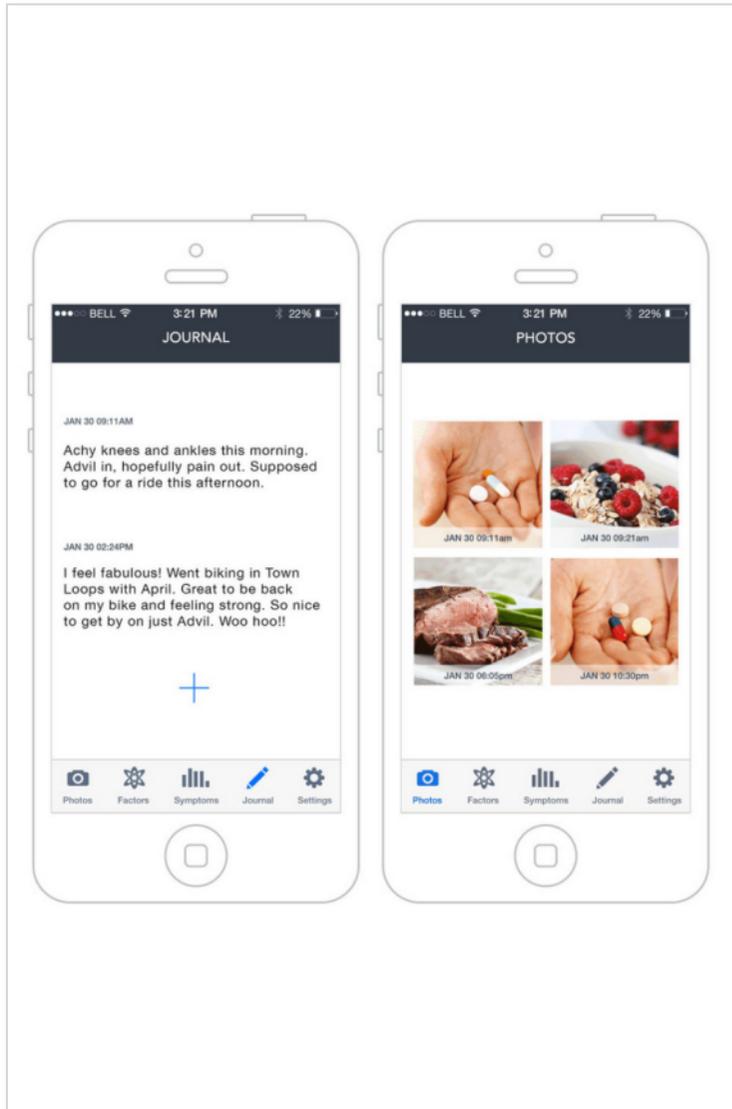
What it does

- Enable patients to take greater role in their care

## Integrated impact

- Users take **43% more steps with Fitbit**
- Fitbit is partnering with Tory Burch to promote exclusive collection of bracelets and other items that will hold Fitbit flex tracker

# Symple Health provides consumers with a simple method to track wellness



## Solution

- Provides consumers with elegant symptom journal available through mobile app
- Easy to use, and flexible enough to meet any set of symptoms, regardless of condition or disease
- Allows patients to self-advocate and communicate more effectively with physicians
- iPhone symptom tracker and health diary, enabling users to:
  - track as many as 20 symptoms at a time
  - record medications, exercise & other factors that influence your symptoms
  - keep daily notes and photos
  - easily share your history with your doctor
  - export data to your favorite spreadsheet app

## Impact

Impact on

Demand management

Quality of care

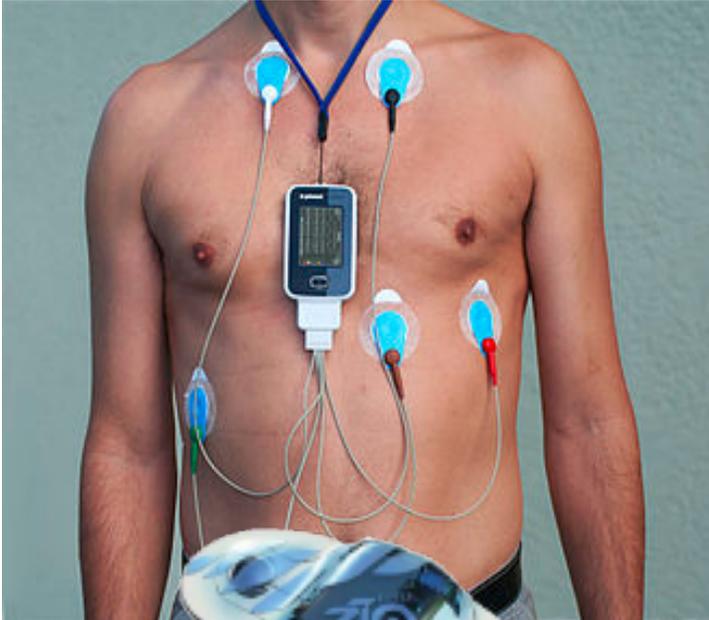
What it does

- Improve clinical decisions through better information
- Improve communication with patients
- Enable patients to take greater role in their care

## Integrated impact

- **55K user install base with 25%** using Symple App daily; 55+ age group is the largest segment of users

# iRhythm's 'Zio Patch' is a breakthrough technology in the field of devices monitoring heart activity



## Solution

- Offers a **single-use patch** that provides **continuous heart monitoring** for fourteen days, primarily for diagnosis of arrhythmias
- Zio Patch is non-invasive, water-resistant, is discrete and has no leads or wires
- Patients affix the Zio Patch to their chest for two weeks to measure their heart activity
- The patch enables continuous monitoring that and early diagnosis to **improve patient outcomes** and **reduce costs** earlier in the clinical pathway
- Data from device **is downloaded and interpreted** by the company's proprietary algorithms

## Impact

### Impact on

**Productivity efficiency**

**Demand management**

**Quality of care**

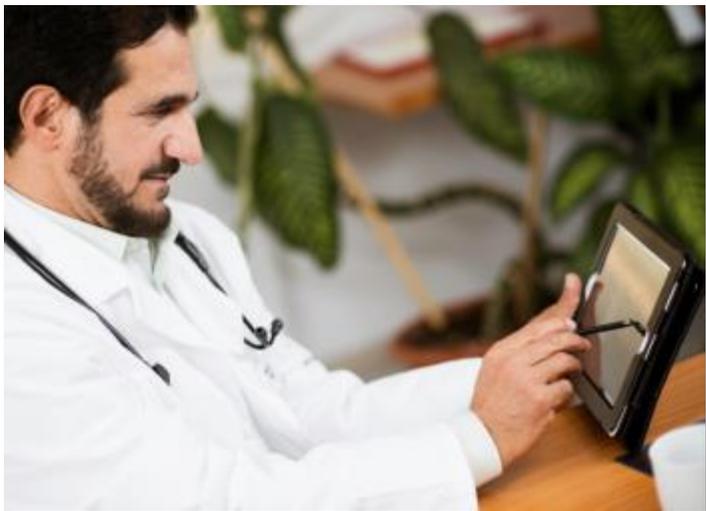
### What it does

- Improve clinical decisions through better information
- Improve communication with patients
- Automate existing activities
- Enable patients to take greater role in their care
- Remove the need for co-location

### Integrated impact

- The ZIO **Service detected 57% more arrhythmias**
- **Ninety percent of the time**, referring physicians said the ZIO Service **aided in a definitive diagnosis**
- **Eighty-one percent of patients** preferred ZIO Patch over other monitor devices, due to comfort and ease of use

# Consumers are also likely to pay for remote monitoring and access to doctors in developing countries



## Solution

- Membership program that provides access to care, including via phone and in-home
- 1mn households subscribe and:
  - Price ranges from \$15-\$100 per year
  - Consumers can purchase directly
- 90,000 calls per month

## Impact

Impact on

Productivity efficiency

Demand management

Quality of care

What it does

- Improve clinical decisions through better information
- Improve communication with patients
- Automate existing activities
- Remove the need for co-location
- Enable patients to take greater role in their care

## Integrated impact

- 62% avoid need to see doctor – a call is resolved without need of face-to-face consultations



# Managed care company uses tele-monitoring to lower cost and improve care quality for LTCs

## Solution

- The Montefiore Health System (integrated care network with >150 locations across the region) uses telemonitoring solution for patients with chronic conditions
- The Telehealth device is a small machine, which connects to your phone. Monitor your heart rate, blood pressure, weight, blood sugar, peak flow and oxygen levels on a daily basis. It will also ask "yes" and "no" questions related to symptoms
- Patients' daily health information is automatically and securely sent over the telephone line, and reaches our Telehealth nurse in less than 30 seconds.
- The health data is reviewed and patients are contacted if there is an alert. Telehealth also alerts your physician should you require a change in medication or in the treatment plan



## Impact

Impact on	Productivity efficiency	Demand management	Quality of care
<b>What it does</b>	<ul style="list-style-type: none"> <li>▪ Improve clinical decisions through better information</li> <li>▪ Improve communication with patients</li> <li>▪ Automate existing activities</li> <li>▪ Remove the need for co-location</li> <li>▪ Enable patients to take greater role in their care</li> </ul>		

## Integrated impact

- Telemonitoring enjoyed 50% participation and a 25% reduction in hospital utilization of participating members
- Hospital is in general highly ranked



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# Group A: Health care workforce – community health workers

Core elements of strategy	<u>Barriers / challenges</u>	<u>Assets to leverage</u>	<u>Critical stakeholders</u>	<u>Role of the Commonwealth</u>	<u>Strategies to operationalize</u>
Financing					
Access					
Integration into delivery system					
Data requirements					
Other					

# Group B: Health care workforce – behavioral health and primary care integration

Core elements of strategy	Barriers / challenges	Assets to leverage	Critical stakeholders	Role of the Commonwealth	Strategies to operationalize
<p><b>Financing</b></p>					
<p><b>Access</b></p>					
<p><b>Integration into delivery system</b></p>					
<p><b>Data requirements</b></p>					
<p><b>Other</b></p>					

# Group C: Health care workforce – oral health / dental health access

Core elements of strategy	<u>Barriers / challenges</u>	<u>Assets to leverage</u>	<u>Critical stakeholders</u>	<u>Role of the Commonwealth</u>	<u>Strategies to operationalize</u>
<p><b>Financing</b></p>					
<p><b>Access</b></p>					
<p><b>Integration into delivery system</b></p>					
<p><b>Data requirements</b></p>					
<p><b>Other</b></p>					

# Group D: Tele-health

Core elements of strategy	Barriers / challenges	Assets to leverage	Critical stakeholders	Role of the Commonwealth	Strategies to operationalize
<p><b>Tele-consults (PCP/ specialist, dentistry, mental health)</b></p>					
<p><b>Remote imaging / monitoring</b></p>					
<p><b>Consumer wearables</b></p>					
<p><b>Other</b></p>					

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## Breakout exercise questions

- What are the most significant **barriers** to implementation?
- What **assets** should be leveraged to successfully implement health care transformation?
- Which **stakeholders** will need to be engaged?
- What is the **role of the Commonwealth** in ensuring successful implementation of various strategies?
- What **strategies can be used to operationalize** specific innovations?

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9:20-10:00	Current state of PA	Presentation and discussion
10:00-10:40	Delivery transformation innovations across states	Gallery walk
10:40-10:50	Break	
10:50-11:30	Delivery transformation focus area exercise	Breakout exercise
11:30-11:50	Full group debrief	Full group discussion
11:50-12:00	Closing and next steps	Presentation

## Next steps

- Participate in follow-up webinars / calls
- Meet in February for work group session 2 to test preliminary strategic plan
- Continue to provide input on HCT strategic plan; preliminary draft to be shared prior to work group session 2

Questions

