

HIP: Population health work group – session 2

Discussion document

February 17th, 2016

February 17th Agenda: Population Health

Workgroup 2



Time	Session description	Session type
09:00-09:15	Welcome and update	Presentation
09:15-09:45	Advancing public health outcomes and value-based payments- national view	Facilitated discussion
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Goal of work group session 2 is to provide feedback on proposed strategies



Purpose/principles

- Collaborate with stakeholders across the Commonwealth to test preliminary strategies

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

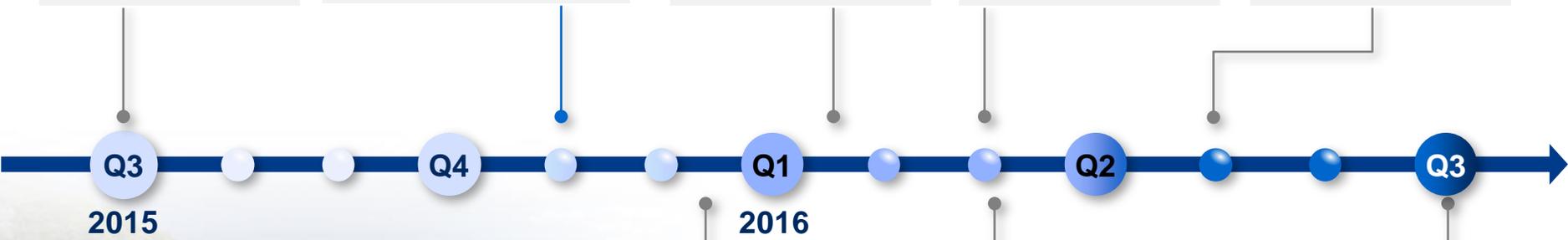
Work Groups Session 1: Input

Jan
Steering Committee webinar briefing

Catalyst for Payment Reform payer survey

March
Work Groups Session 3: Refine

May
Submit HIP plan to CMMI



Jan / Feb
Work Groups Session 2: Test

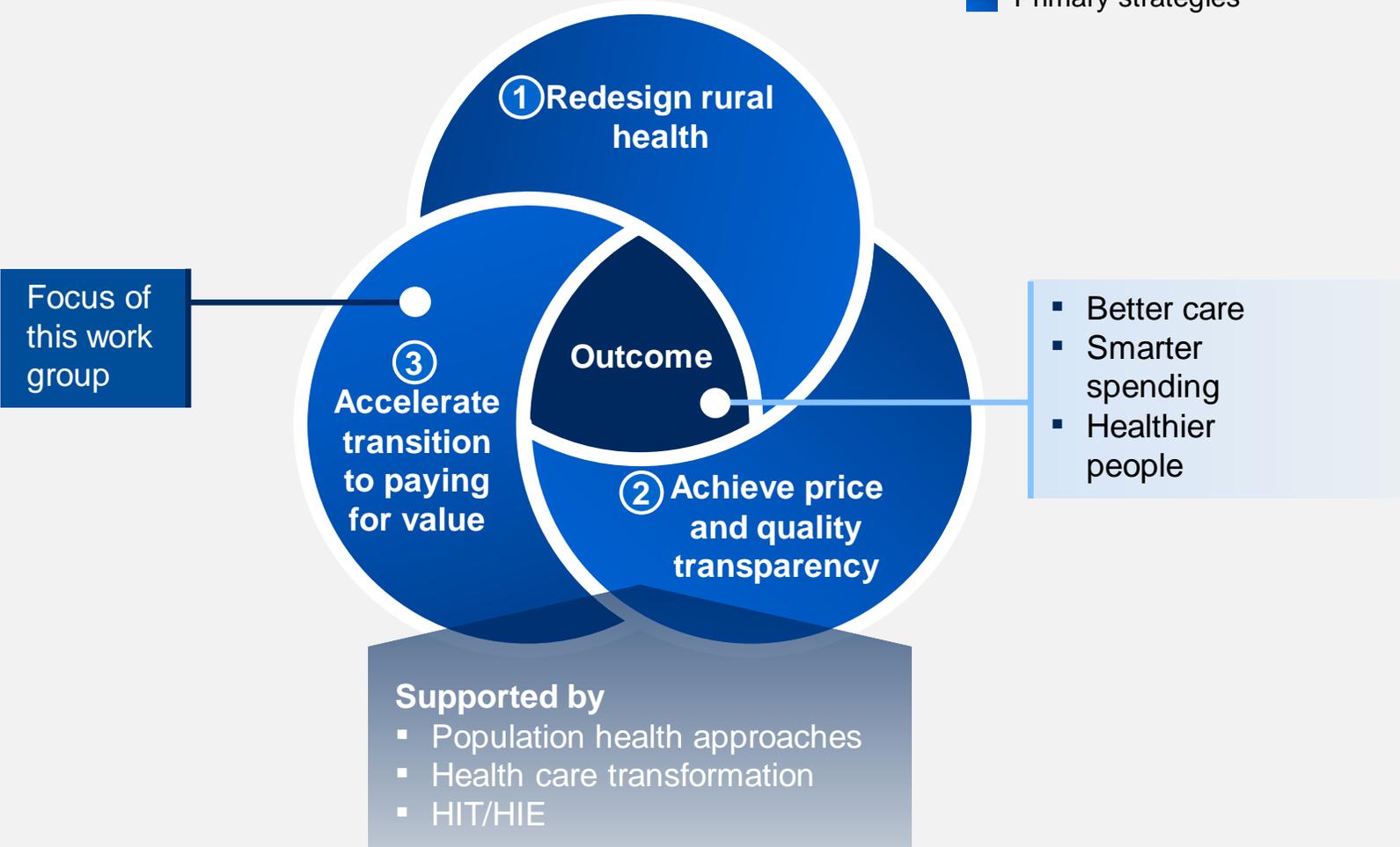
March
Draft (outline) of full HIP plan complete

Summer
Launch payment model according to implementation plan

Objectives for Health Innovation in Pennsylvania (HIP)

In-going approach to accelerate innovation in PA

■ Primary strategies



What we heard from other work groups in session 1

Payment innovation:

- The work group should build on existing payment innovation in PA
- New payment models should incorporate a ramp-up time period to allow providers time to prepare
- Payment model innovation needs to be sustainable so that providers (and payers) invest in developing the necessary capabilities to be successful, but also flexible enough so that it can adapt and improve over time
- Different types of providers (e.g., geography, size) may require different payment models

Price and quality transparency:

- Work group's main focus is on consumers and how transparency innovations impact the end consumer
- Understand consumer journey to help identify different needs for information throughout all stages of care (e.g., provider quality and cost information to help consumers select PCPs)
- Clarify and standardize definitions and formulas for cost, quality, and value metrics
- Build off existing transparency initiatives in PA and leverage ideas / concepts across other industries

What we heard from other work groups in session 1

Health Information Technology:

- Work group's main focus areas are: data extraction, data sharing, and technology
- Focus efforts on the outcome and impact for the final stakeholder (e.g. consumer, provider, payer, and policy maker)
- Strategies should build upon and leverage existing payment models
- Marry clinical data with claims data
- Identify appropriate standard cost and quality measures of data that are consistent across provider scorecards, consumer tools, and payer metrics based on evidence

Health Care Transformation:

- Embracing disruptive technologies is critical to improving care delivery
- New innovations should align with and augment existing care delivery goals
- Care collaboration must be the focus, as providers work together in teams, and should be driven by:
 - Improving technology, driving accountability, and building awareness of the full care team
 - Shifting the culture to look at care as a broad team effort (including patients)
 - Retraining for provider to work with additional types of care providers

What we heard from work group session 1: guiding principles

Guiding principles for Population Health:

- Work group's main focus was operationalizing five health priorities and defining key strategies and tactics to support them
- The group also focused on the importance of the integration of population health outcomes and value-based payment methodologies
- Identified a need to develop and report baseline data; bridge the gap between hospitals and social service agencies; and clarify protected information in regards to behavioral health.

Commonwealth should act as a leader by

- Bringing stakeholders together
- Ensuring standardization, especially around metrics
- Ensuring data available to support work across agencies

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Health Innovation: National Diabetes Prevention Program

Ann Albright, PhD, RD
Director, Division of Diabetes Translation
Centers for Disease Control and Prevention

The findings and conclusions in this presentation are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention. The presenter reports no conflict of interest related to the content of this presentation.

National Center for Chronic Disease Prevention and Health Promotion

Division of Diabetes Translation

www.cdc.gov/diabetes



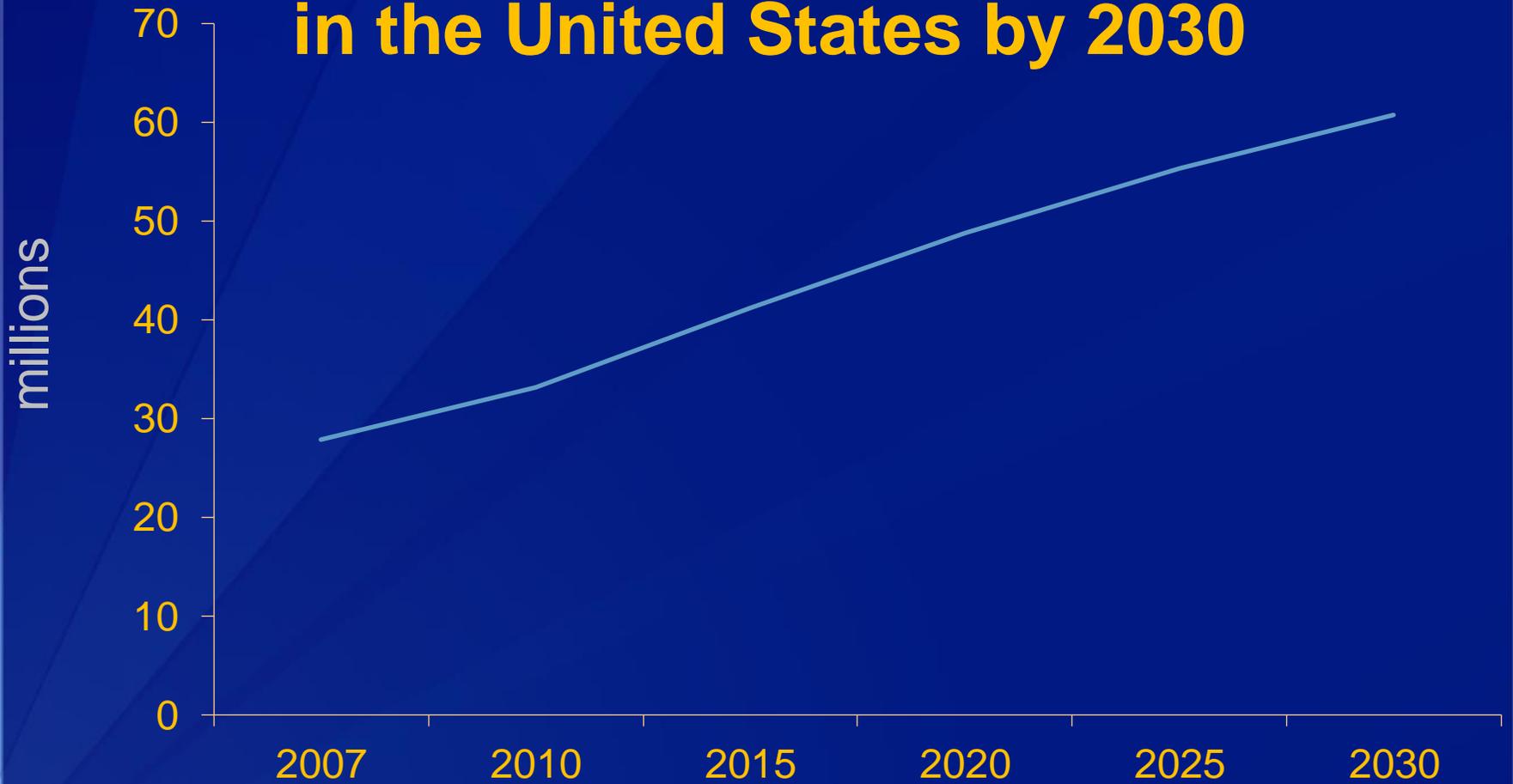


**29 million
with Diabetes**

**86 million
with Prediabetes**

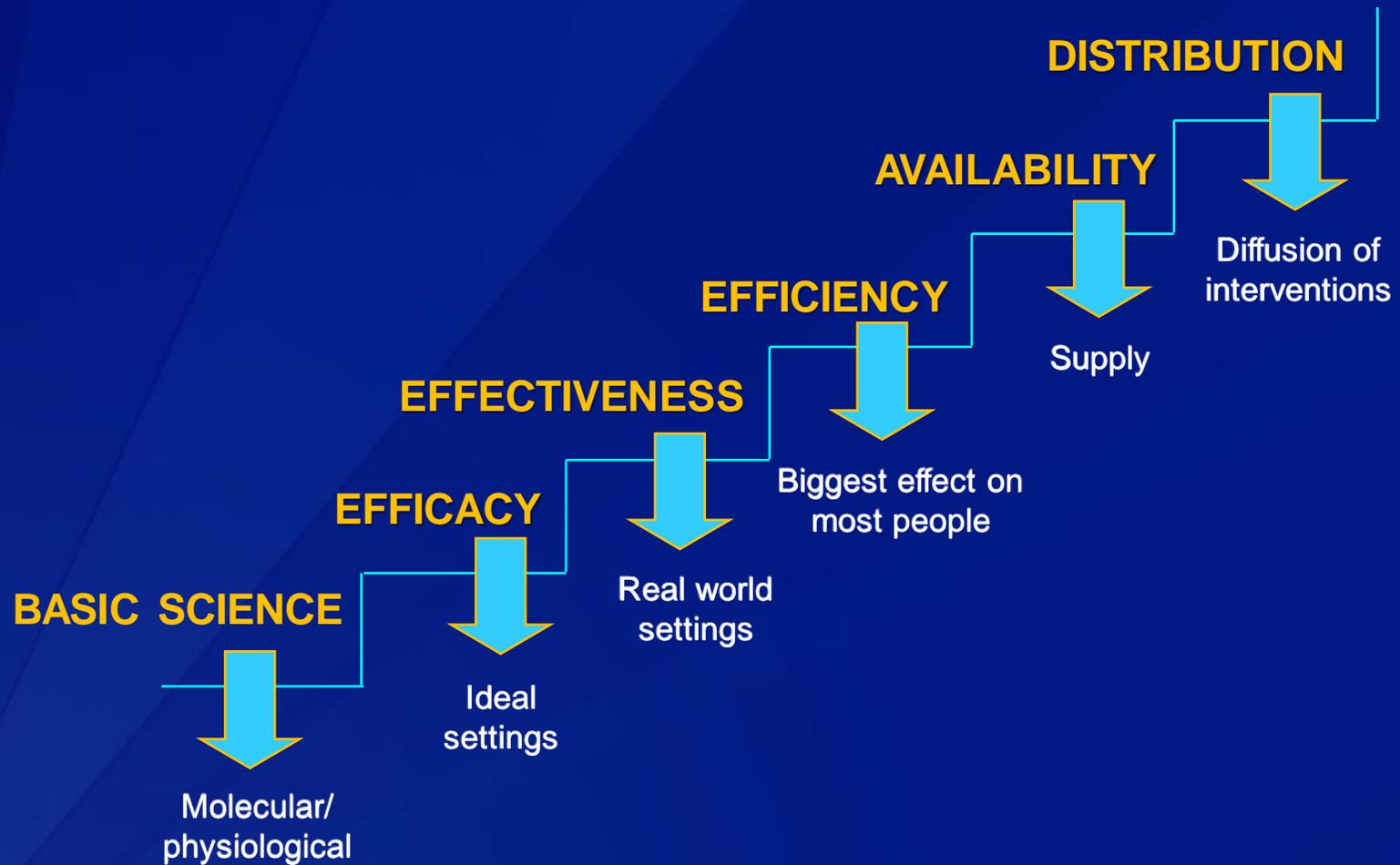
Centers for Disease Control and Prevention
National Diabetes Statistics Report, 2014

Current Projections of Cases of Diabetes in the United States by 2030



Risk Stratification Table for Diabetes Prevention Interventions

Risk Level	Adult Prevalence (%)	10 year Diabetes Risk (%)	Risk Indicators	Intervention
Very High	~ 15%	> 30	A1c > 5.7% FPG > 110	Structured Lifestyle Intervention in Community Setting
High	~ 20%	20 to 30	FPG > 100 NDPP Score 9+	
Moderate	~ 30%	10 to 20	2+ risk factors	Risk Counseling
Low	~ 35%	0 to 10	0-1 risk factor	Build Healthy Communities



Adapted from information in Sinclair JC, et al. N Engl J Med. 1981;305:489–494. and Detsky AS, et al. Ann Intern Med. 1990;113:147-154.

The largest national effort to bring diabetes prevention lifestyle programs to communities

REDUCING THE IMPACT OF DIABETES



Congress authorized CDC to establish the NATIONAL DIABETES PREVENTION PROGRAM (National DPP) —a public-private initiative to offer evidence-based, cost effective interventions in communities across the United States to prevent type 2 diabetes

It brings together:



Research shows structured lifestyle interventions can cut the risk of type 2 diabetes in

HALF

to achieve a greater combined impact on reducing type 2 diabetes



National Diabetes Prevention Program

COMPONENTS



Training: Increase Workforce

Train the workforce that can implement the program cost effectively.



Recognition Program: Assure Quality

Implement a recognition program that will:

- Assure quality.
- Lead to reimbursement.
- Allow CDC to develop a program registry.



Intervention Sites: Deliver Program

Develop intervention sites that will build infrastructure and provide the program.



Health Marketing: Support Program Uptake

Increase referrals to and use of the prevention program.

Albright A, Gregg EW. *Am J Prev Med.* 2013;44(4S4):S346-S351.

Strategies

- Goal - all payers provide coverage
 - Commercial health plans stepped up first
 - Simultaneous work with CMS
- Built National DPP from the start on a sustainable business model
 - Value-based payment used by many
 - Based on attendance and wt. loss
- National standards and CDC recognition increasingly required for reimbursement

Strategies

- Work with employers AND health plans
- Look for ways to make it work w/o moving too far from the evidence
- Stay focused

National DPP

Status of State Employee Coverage

State	Number	Individuals Covered
Colorado	178,738	State employees and dependents
Kentucky	264,000	State and education employees, retirees, and dependents
Washington	350,000	State and higher-education employees, retirees, and dependents
Minnesota	90,000	State employees and dependents
Maine	30,000	State employees and dependents
Ohio	73,703	State employees and dependents covered under United Healthcare
Louisiana	180,000	State employees and dependents covered under Blue Cross/Blue Shield of LA
New Hampshire	28,669	State employees, dependents, and retirees under 65 years old (up to \$150)
New York	TBD	State employees in the Capitol District Physicians' Health Plan
Rhode Island	~9,000	State employees

Approaches to Achieving State Employee Coverage: Minnesota



- **Approach:**

- Formed a statewide diabetes steering committee in 2012
 - Included representatives from the Minnesota State Employee Group Insurance Plan
- Used a Collective Impact (CI) model involving multiple sectors
- Goal:
 - Reduce new cases of T2 diabetes among those at highest risk
 - Ensure statewide access to the National DPP
 - Start with state employees (largest employer)

Approaches to Achieving State Employee Coverage: Minnesota



- **State Health Department Role:**

- Convener

- Assembled the diabetes steering committee to apply CI principles to the problem of diabetes prevention

- Program Promoter

- Educated state agency leadership
 - Supported program marketing/promotion across state agencies
 - Shared participant testimonials

Approaches to Achieving State Employee Coverage: Minnesota



- **Lessons Learned:**

- Collaboration is key—an emphasis on CI helped establish a common foundation
- An “all-in” payer strategy creates an even playing field

Approaches to Achieving State Employee Coverage: Minnesota



- **Outcomes:**

- The National DPP became a covered benefit for all state employees in April, 2015...3 years after the diabetes steering committee was formed
- A modified pay-for-performance model is used.
 - initial claim filed at enrollment and after 8 weeks in the program
 - final claim is based on health outcomes
- An online CDC-recognized National DPP provider was used to make the program accessible to all state employees, including those in more isolated rural areas

Approaches to Achieving State Employee Coverage: Washington



- **Approach:**

- Governor issued an executive order in Oct., 2013 mandating that all cabinet agencies establish a worksite wellness initiative
 - Executive order established a health and wellness steering committee co-chaired by the Washington State Healthcare Authority (in which the Public Employee Benefits Board [PEBB] is housed) and the Washington State Department of Health (DOH)
 - Committee's priorities included securing coverage for the National DPP for state employees
- DOH was the first to implement a program to provide onsite screening, including blood glucose testing
 - Paved the way for a worksite screening model implemented across the state

Approaches to Achieving State Employee Coverage: Washington



- **State Health Department Role:**

- Convener

- Worked across stakeholder groups to raise awareness of prediabetes and the benefits of the National DPP lifestyle change program

- Data Provider

- Reported diabetes burden data in the 2014 state *Diabetes Epidemic in Action* report
- Report recommendations made a case for National DPP coverage

Approaches to Achieving State Employee Coverage: Washington



- **Lessons Learned:**

- Long-standing relationships between PEBB and DOH facilitated collaboration across the two agencies
- National efforts supporting the National DPP helped fuel momentum at the state level
- Worksite screening events provided an opportunity to refer individuals at risk directly to a program
- Champions from various governmental/nongovernmental agencies can accelerate this effort
- Important to build trust between insurers/benefits administrators and public health

Approaches to Achieving State Employee Coverage: Washington



- **Outcomes:**

- In January 2014, the National DPP became a covered benefit for state employees through PEBB
- ~85% to 90% of eligible employees sign up and attend the first class. Of those who enroll, 70% to 75% complete the year-long lifestyle change program

Medicaid Demonstration Project

- In July 2015, CDC/DDT funded NACDD to conduct a project to test the feasibility and effectiveness of various models to obtain Medicaid coverage for the National DPP in value-based plans (MCOs, ACOs, and Medical Homes)
- NACDD, in partnership with CDC/DDT and Leavitt Partners, will competitively fund 2-3 Medicaid expansion states to design, implement, and evaluate coverage models that can be translated for use in other states

Medicaid Demonstration Project

- **Phase 1 (Oct.-Dec., 2015)**
 - NACDD established an Expert Panel to advise on the selection of states and the design of the demonstration project
 - Leavitt Partners compiled quantitative data and completed an initial assessment of state capacity for presentation to the Expert Panel
- **Phase 2 (Jan.-March, 2016)**
 - Leavitt Partners conducting interviews with:
 - State Medicaid Directors
 - organizations delivering the National DPP to Medicaid beneficiaries
 - The Expert Panel will meet on March 31 to review interview findings and a proposed RFP

Medicaid Demonstration Project

- **Phase 3 (April-June, 2016)**
 - NACDD will issue a competitive RFP and select 2-3 states
 - Leavitt Partners will develop a “business case for coverage” toolkit (i.e., ROI, benefit designs, payment and billing models, etc.)
- **Phase 4 (July, 2016-July, 2017)**
 - States will be funded and begin the project
 - NACDD will conduct the evaluation
 - The Expert Panel will meet to review study findings, including an assessment of the tools developed
 - Successful models and tools will be translated for general use

Takeaways

- Strong evidence-based intervention
- National infrastructure (National DPP) and national standards to help with implementation in communities across the country
- Governor executive order
- Include in state plan
- Hold accountable for implementation so everyone is committed to goal

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Discussion

- What are the opportunities for implementing the National DPP across PA?
- What are the barriers and who can help address them?
- What are your immediate next steps to build on what you have already done to implement the National DPP statewide?

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BREAK
10 minutes
Please return at 10:40 AM

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Framing Health Equity Throughout Population Health Priorities

Health equity ensures every person has the opportunity to attain his or her full health potential

Health inequities include differences in:

- Length of life
- Quality of life
- Rates of disease, disability, and death
- Severity of disease
- Access to treatment

How do we integrate health equity in our population health priorities?

- Work with Medicaid to ensure coverage for diabetes education
- Work with Medicaid to ensure coverage for nutrition education for children
- Promote the acceptance of MA by dental providers and support free oral health care initiatives
- Transportation, housing, other socioeconomic barriers?

Advancing Pennsylvania's Five Health Priorities: Childhood Obesity

SMART Objective: Reduce the proportion of children and adolescents who are considered obese from 17.4% to 15.7% by July 2019+

- Strategy: Collaborate with PDE to promote health and wellness within Commonwealth schools

Tactics	Metrics
1. Review feasibility of integrating 150 minutes of PE per week in elementary schools	Determine available policy and regulatory levers
2. Work with school districts to integrate activity breaks for children into elementary school curricula	Number of school districts participating
3. Promote the provision of nutrition education through school gardens in elementary schools	Number of school districts that have school gardens



Note: +obtained from the Healthy People 2020 goals

Advancing Pennsylvania's Five Health Priorities: Diabetes (Prevention and Self-Management)

SMART Objective: Reduce the annual number of new cases of diagnosed diabetes from 8.0 to 7.2 new cases per 1,000 population by July 2019+

- Strategy: Promote combined diet and physical activity programs aimed at preventing type-2 diabetes among people who are at increased risk of the disease

Tactics	Metrics
1. Promote the healthy corner store initiative across the Commonwealth	Number of corner stores participating in the initiative
2. Promote diabetes prevention programming	Percentage of referrals to the Diabetes Prevention Program Percentage of pre-diabetic adults who report increased participation in a health diet and physical activity



Note: +obtained from the Healthy People 2020 goals

Advancing Pennsylvania's Five Health Priorities: Oral Health

SMART Objective: Reduce the proportion of children who have dental caries experience in their primary or permanent teeth from 33.3% to 30% by July 2019⁺

- Strategy: Promote better oral health across the Commonwealth

Tactics	Metrics
1. Collaborate with the PA Oral Health Coalition to review the feasibility of a statewide water fluoridation policy	<p>Number of counties who provide water fluoridation</p> <p>Number of counties who do not provide water fluoridation and why</p>
2. Collaborate with family medicine physicians, pediatric dentists, and pediatric providers to provide regular oral health assessments at well child visits	Percent of providers who provide regular oral health assessments at well child visits
3. Collaborate with providers to provide dental sealant applications in children ages one to three	Percent of providers who provide dental sealant applications to children ages one to three



Note: ⁺obtained from the Healthy People 2020 goals

Advancing Pennsylvania's Five Health Priorities: Substance Abuse

SMART Objective: Reduce drug-associated deaths from 12.6 to 11.3 deaths per 100,000 population by July 2019+

- Strategy: Reduce access to prescription drugs for misuse and abuse

Tactics	Metrics
1. Develop and maintain prescribing guidelines for prescription opioids	Number of prescribing guidelines developed
2. Encourage prescribers to access and use the PDMP system	Number of dispensers and prescribers using the system
3. Support adoption of meaningful payment reform to optimize access to quality addiction treatment services	Passage of regulations or legislation that supports payment reform



Note: +obtained from the Healthy People 2020 goals

Advancing Pennsylvania’s Five Health Priorities: Tobacco Use

SMART Objective: Increase smoking cessation among women (ages 18-49) during their pregnancy from 11.3% to 30.0% by July 2019+

- Strategy: Collaborate with health care providers and health systems to increase referrals to the PA Quitline for women ages 18-44

Tactics	Metrics
1. Increase utilization of e-referral system among health care providers	Number of patients referred to the PA Quitline
2. Expand and enhance e-referral in health care systems to target women of childbearing years and pregnant women	Number of hospitals/health systems that require inpatients direct handoff to PA Quitline
3. Increase enrollment rate of e-referrals to participation in Quitline services	Percent of conversion (enrollment) rate



Note: +obtained from the Healthy People 2020 goals

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Health Priorities Feedback Discussion- Questions for the Group

Question 1: How and where do these strategies integrate at the county, local, and provider level?

Question 2: How do we establish a baseline for the proposed tactics?

- What data sources are necessary?
- Who would provide the data?
- How often should it be updated?
- Who should receive it and how?

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Next steps

- Participate in follow-up webinars / calls
- Meet in April for work group session 3 to refine strategies and finalize the plan
- Continue to provide input; plan draft to be shared prior to work group session 3

Questions

