Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

Nevada State Innovation Model (SIM) Design Project

Provider Workgroup Charter

May 7, 2015

Background

On December 16, 2014, CMS awarded the Nevada Department of Health and Human Services (DHHS) a $2M State Innovation Model (SIM) design grant. This grant provides financing and technical assistance from the Centers for Medicare and Medicaid Services (CMS) to design models that will transform health care delivery systems in states while improving population health, improving the patient experience, and lowering cost. These three goals – improving population health, improving the patient experience, and lowering cost- are known as the CMS Triple Aim.

The deliverable under this grant is a design model that will be presented to CMS in the form of a State Health System Innovation Plan (SHSIP). The SHSIP will serve as the Nevada roadmap to achieving the CMS Triple Aim. The SHSIP will be considered by CMS in the event additional grant funding is made available to implement and test the model outlined in the plan.

A successful Nevada SHSIP will require broad stakeholder input and engagement. One of the mechanisms to gain this input and engagement is through the formation of workgroups and taskforces with a specific purpose for each.

Purpose of this Charter

This Project Charter serves several purposes:

- Identifies the goals and anticipated activities of the workgroups and taskforces formulated to assist DHCFP with designing the SIM State Health System Innovation Plan
- Establishes the roles, responsibilities, and expectations of the participants who are participating on behalf of and with the executive support of their organization
- Upon signoff, provides authorization of the participant to participate in the workgroups/taskforces
- Serves as the point of reference for documentation and work product of the workgroups/taskforces
- Establishes agreement of the deliverables between the Division of Health Care Financing and Policy (DHCFP) and the workgroup/taskforce members.

Goals Statement:

The SIM Workgroups and Taskforces are vital contributors to the Nevada SIM Design Project. The mission of the NV SIM Design Project is to:

- Improve access to care for Nevadans
- Improve the health status of Nevadans
- Align healthcare delivery and payment systems
- Contain healthcare costs while increasing healthcare value

While critical, the participant role in the workgroup/taskforce forum is advisory in nature. These participants will provide input into the Nevada SIM Model Design project based on the stakeholder's experience with the Nevada health care delivery system. The workgroups and taskforces will concentrate on input that will achieve the CMS Triple Aim, align with Governor Sandoval's seven (7) health services core functions (see page 7), and achieve the goals listed above.

At a global level, participants are requested to consider:

- Successes and shortcoming of the current health care delivery system
- Opportunities for meaningful and sustainable change
- Critical design features necessary for success
- How success will be measured
- Availability and accessibility of data necessary to implement and evaluate proposed solutions
- Fiscal and operational sustainability of solutions offered

The Provider Workgroup's purpose and suggested areas for discussion are found on page 8 of this document. The list is provided as a starting point for discussion and should stimulate participants' thought process. Participants should make sure discussion remains germane to their charge, but they should not be constrained by the topics listed. A list of all workgroups and taskforces are found on pages 8-10 to give a broader perspective of where certain topics may be being discussed.

The input from this and other workgroup/taskforce forums will be utilized by DHCFP Leadership to formulate the State Health System Innovation Plan (SHSIP).

Workgroup/Taskforce Members:

To ensure a manageable forum for input, participation in the meetings will be kept to a relatively small but representative size of volunteer members. The members of the Policy & Regulatory Taskforce are:

- Larry Trilops, Renown
- Lisa Farnan, Dignity Health, St. Rose X
- Abby Burkhart, RN, CHNII X
- Richard Davis, American Lung Association x
- Lawrence Barnard, UMC X
- Brian Brannman, Dignity Health X
- Charmaane Buehrle, West Hills Hospital X
- Walter Davis, Nevada Health CentersX
- Lisa Dettling, Nevada Health CentersX
- Dan Galles, St. Mary's Regional MC X
- Nancy Hook, NV Primary Care Assn X
- Mike Johnson, MD X
- Fergus Laughridge, Humboldt General Hospital X
- Rudy Manthei, MD, NV Eye and Ear X
- Carol Reitz, NV Commission on Autism
- Todd Sklamberg, Sunrise
- Anthony Slonim, Renown
- Wilt Grayson, Nevada State Medical Assn X
- Mark Zellmer, Nevada Hand

Each member serves at the pleasure of the DHCFP Administrator.

Workgroup/Taskforce Activities

- Identify short-term and long-term strategies to improve access and address workforce capacity
- Identify network deficiencies common to all payers involved as well as drivers behind network disparities across payers
- Explore alternatives to traditional access
- Urban versus rural issues/opportunities
- Value Based Purchasing (VBP) from a provider perspective

Meeting Expectations:

All Participants shall:

- Conduct a thorough review of SIM materials provided by DHCFP in advance of the meeting
- Arrive to meetings timely and actively participate in the full meeting
- Solicit feedback from relevant peers, associates, etc. prior to the session
- Approach discussions with a fair, balanced, and professional perspective
- Provide feedback on draft documentation reflecting session outputs

Meeting Frequency:

The workgroup and taskforce meetings are envisioned to begin on or about the first week of May 2015. The sessions will be a two (2) to three (3) hour facilitated working session with in-person attendance strongly encouraged. The workgroups and taskforces are expected to reconvene approximately every three weeks through the end of August 2015. Note that the frequency of meetings may be greater or less than anticipated in order to meet the needs of the project. After the anticipated conclusion of the stakeholder input period (August 2015) and at various times afterward, workgroup and or taskforce members (in whole or individually) may be asked to assist DHCFP with the model design or other aspects of this project.

To ensure both urban and rural input, engagement, and representation, the workgroup/taskforce member selection process will take participants' location into consideration. While in-person attendance at workgroup and taskforce meetings is highly preferred, efforts will be made to utilize teleconferencing, webinars, or other technology when necessary to minimize travel and promote a balanced representation of urban and rural participants.

All attempts will be made to provide meeting notice and related meeting materials to all members by electronic mail at least five (5) business days prior to the meeting date.

Reimbursement:

Participants are not eligible for compensation or reimbursement from DHCFP for time, travel, or other expenses related to their participation in the workgroups or taskforces.

Timeframes:

Activity	Timeframe/Date	Responsibility
Notice of Meeting Issued	Approximately two weeks prior to meeting date	Myers and Stauffer, LC
Distribution of Meeting Materials	Five business days prior to meeting date	Myers and Stauffer, LC
Facilitated Meeting	Approximately every three weeks beginning the first week of May 2015 through the end of August 2015	All
Provide Draft Sessions Summary	No later than 5 business days after session	Myers and Stauffer, LC
Provide feedback on draft summary	No later than 3 business days after receipt of draft document	Workgroup/Taskforce Members
Provide DHCFP with Summary	No later than 10 business days after session	Myers and Stauffer, LC
Finalize Summary		DHCFP

Governor Sandoval's Seven (7) Health Services Core Functions:

- ***Access to Affordable Health Care*** – Improve access to quality affordable, high quality health care
- ***Prevention*** **-** Increase awareness and opportunities for Nevadans to receive preventive care and instruction to safeguard against or reduce the impact of injury, illness, and infectious disease
- ***Wellness*** **-** Educate, encourage and empower Nevadans to take responsibility for their own health by engaging in healthy lifestyle activities resources and choices
- ***Chronic Disease*** **-** Build awareness of, and provide services for, the most dangerous risk factors which cause the greatest number of deaths and highest medical costs
- ***Quality*** **-** Ensure health services are provided in a quality environment and manner which improve health outcomes
- ***Pregnancy*** **-** Increase the percentage of women who seek appropriate care during pregnancy
- ***Mental Health*****-** Provide accessible and affordable mental health services to people of all ages

Accessed from: http://budget.nv.gov/StateBudget/Priorities_and_Performance_Based_Budget/page 3, February 10, 2015

Taskforce and Workgroup Purpose and Areas for Discussion

Health Information Technology and Data Taskforce

- Data sources and availability
- Standardization of data and data elements
- Data integration and analytics tool
- Use of regional or independent Health Information Exchange data
- Explore opportunities to encourage development of a NV statewide HIE
- Promoting further adoption and meaningful use of electronic medical records
- Receive and research feasibility of obtaining and making available data that will be needed to support the Value Based Purchasing and Clinical Outcomes and Quality Workgroups

Policy and Regulatory Taskforce

- Evaluates input from other work streams to evaluate the impact of current or envisioned policies and regulations
- Identifies policy or regulatory barriers and opportunities to execute the innovation plan components
- Develops a pathway for alternative policy or regulations that may be necessary
- Ensures policy alignment with innovation plan components

Provider Workgroup

- Assess current and future provider workforce capacity
- Identify short-term and long-term strategies to improve access as well as NV health provider workforce capacity
- Identify network deficiencies common to all payers involved as well as drivers behind network disparities across payers
- Explore alternatives to traditional access modalities (ex. Telemedicine, teledentistry, telepsychiatry, paramedicine, role of Public Health Departments, etc.)
- Explore changes needed for Graduate Medical Education and academic pathways and funding sources for students to pursue health care careers
- Address issues affecting providers in rural versus urban settings
- Identify tools such as enhanced or greater penetration of health information technology needed by providers to achieve desired clinical outcomes and quality improvements
- Explore value based purchasing from the provider perspective (level of interest, concerns, minimum components of a VBP program from provider perspective, etc.)
- Identify unique provider needs and characteristics in an urban versus rural setting

Delivery System and Payment Alignment Workgroup

- Explore need/desire for Patient Centered Medical Homes and or Health Homes for certain subsets of the NV population
- Is there a role for Accountable Care Organizations (ACOs) in the NV delivery system
- Develop a model to integrate behavioral health and physical health
- Accountability of providers for health outcomes of attributed patients
- Tools needed by providers to be successful under alternative delivery system models proposed
- Identify and address opportunities to achieve greater payer alignment
- Develop a strategic vision that will define and guide the NV SIM VBP effort
- Define a patient attribution model
- Decide if payment strategies will be set at payer level or multi-payer level
- Develop value based payment approach and methodology for initiatives identified by the Clinical Outcomes and Quality Workgroup
- Identify data needs and sources
- Identify any unique differences or considerations of the model for urban versus rural settings

Clinical Outcomes and Quality Workgroup

- Define the population health objectives to be accomplished
- Identify disease states, conditions, or populations by order of priority to be addressed through specific initiatives under this project
- Decide if common clinical practice guidelines are acceptable for specified areas of intervention and are feasible across multi-payers
- Define multi-payer structure to promote uniform messaging regarding clinical practice guidelines, best practices, and standards of care
- Identify clinical outcome measures and quality markers that will be used to measure and assess improvement for each initiative
- Identify data needs, data sources, and methodologies to measure each outcome/quality measure
- Ensure measures provide timely and early feedback on interim progress or develop lead measures that do so
- Decide if measures will be at a payer or multi-payer level or both.
- Identify tools needed by providers to achieve desired clinical outcomes and quality improvements
- For areas identified for population health improvement, identify level of patient engagement including methodologies to measure and improve patient engagement

Patient Focused Workgroup

- Patient perspective on experience with the healthcare system (what works, what doesn't work, what is needed from the patient perspective, etc.)
- Issues or opportunities related to eligibility or enrollment
- Are challenges or concerns faced by patients in a rural setting different from those in an urban setting?
- Identify social determinants impacting health of Nevadans
- Identify unmet patient needs in the NV healthcare system
- Opportunities for improved patient knowledge of prevention, wellness, and health care conditions
- Identify tools and other resources that may be necessary to drive improved patient engagement in their health and health care

Workgroup/Taskforce Charter Agreement and Approval:

Workgroup/Taskforce Charter Agreement and Approval

These signatures indicate our collective understanding and the advisory capacity of this stakeholder focus group. Further, the Charter represents our agreement to the goals, activities and deliverables defined by this charter and to support it with the appropriate time and commitment required.

DHCFP Signature	Date
Participant	Date