

# Arkansas Health System Reform & Medicaid Transformation

## “Transforming Arkansas Health Care”

### Draft Work plan—May 2011

#### WORKPLAN SUMMARY

This work plan sets forth the objectives, strategies and pace of work for the Arkansas Health System Reform & Medicaid Transformation initiative.

#### Goals and Strategies

It has been suggested that between 5% and 30% of the cost of health care services is:

- Medically unnecessary; and/or
- Could be avoided by better primary, secondary or tertiary prevention; and/or
- Could be provided more efficiently by the system – i.e. at a lower unit cost; and
- Is not aligned with nationally and locally recognized quality standards.

The key to improving the system is the identification and evaluation of (1) system inefficiencies, (2) ineffective services, (3) service gaps and (4) quality gaps (or chasms) in Arkansas.

Critical to identification and evaluation are:

- Structured patient and provider engagement in efforts to identify areas where duplication and/or inefficiencies are most suspected; and
- Data driven analyses varying from rudimentary case definition and aggregation to much more elegant regression strategies using existing analytical tools and models; and
- A prioritized literature review.

These three activities will be informed by an administrative data set from Medicaid, Medicare, the State Employee Health Benefit Plan, ACHI and private insurers. (The data set will be assembled as quickly as possible – but work can begin immediately with Medicaid claims data for SFY 2006 through SFY 2010.)

The activities will be organized and supported by a Project Team at the direction of a Leadership Team.

The identification and evaluation process will involve both open-ended questions and inquiries focused specifically on:

- **Handoffs in care between providers (Transitions in Care)**– Ineffective transfer of patients to the next health care professional or clinical setting (hospital to home, nursing home to hospital, ICU to general ward) can result in avoidable re-hospitalizations, trips to the emergency room, or setbacks in a patient’s recovery. One example is incomplete coordination of medications between sites of care which results in a patient receiving too many or too few drugs for their condition.
- **Inefficient care provided by individual providers**– Avoidable care within a facility that occurs because of poorly organized clinical information, untimely or absent communication between health professionals, and ineffective use of technology. These deficits can result in repetitive diagnostic testing, unnecessarily long lengths of stay, and overuse of expensive equipment.
- **Ineffective diagnostic decisions** – Patients can undergo excessive diagnostic testing avoidable by a careful history, physical, and review of past medical records. Other patients receive unnecessary therapy for conditions that were

either misdiagnosed or incorrectly attributed to their presentation. Examples include prescription of multiple drugs for poorly documented mental health disorders or brain scans for patients with simple headaches.

- **Ineffective clinical decision making** Failure to use clinical guidelines can result in treatment plans that miss diagnoses, over use resources, and fail to create optimal clinical outcomes. Examples include advanced antibiotics for routine community acquired infections, ordering an MRI of joints for vague musculoskeletal problems, or premature referral to a specialist instead of a brief assessment in primary care.
- **Missed health promotion opportunities** – Examples of such opportunities include immunizations, smoking cessation counseling, cancer screening, or diagnostic testing to avoid new complications from previous heart disease or lung conditions.
- **Better patient support and engagement** –We need to build into our system mechanisms to educate and engage patients and their families regarding appropriate care seeking behavior, regimen adherence, and personal health maintenance. An improved system would answer patient questions and reinforce important clinical advice.
- **Reducing health care acquired conditions**—Examples include wrong-side surgery, pressure ulcers, falls resulting in injuries, hospital acquired infections, dosing errors, etc.

**The first step in the process must be the identification of priority areas for exploration through data analyses, literature review of best practices and evidence, stakeholder input and other resource reviews.**

**Assuming** the system problems are identified using Arkansas administrative claims data, and the analysis of that data includes meaningful input from patients and providers, and the project draws on the experience, expertise and tools which currently exist to identify and evaluate the scope, cost and quality of episodes of care, wellness protocols and individual ADL care needs, **then** estimating the cost of the problems listed in the first paragraph of this plan, and the value of this transformation initiative is achievable.

# DRAFT Work plan

Objectives Strategies	Tasks	Timeline and Deadline	Associated Deliverable Items
<b>Objective 1: Establish project management team</b>			
	<b>Establish project management team to conduct analyses, review literature, standards of care and best practices</b>		
	Identify project management team staff	Mid-June 2011	Project management team established
<b>Objective 2: Identification of promising areas for exploration</b>			
	<b>Conduct stakeholder interviews</b>		
	Continue stakeholder discussions, collate Medicare, Medicaid and commercial payor promising areas	May 2011	Summarized list of promising areas for exploration
	<b>Field electronic survey for stakeholder suggestions</b>		
	Design & field electronic survey	May 26 <sup>th</sup> (Stakeholder meeting) Responses due: June 30, 2011	Summarized list of promising areas for exploration
	Summarize results for publish by mid-July		
	<b>Data Analysis</b>		
	Begin preliminary data analysis using available data	June 1	Summarized list of promising areas for exploration
	<ul style="list-style-type: none"> <li>Evaluation of top promising areas as determined through stakeholder groups, payors and literature review</li> </ul>		
	<b>Literature Review</b>		
	50% literature review completed (1/2 of promising areas)	Summer 2011	Summarized list of promising areas for exploration
	100% literature review completed (all promising areas)		
<b>Objective 3: Conduct stakeholder meetings</b>			
	<b>Initial stakeholder meeting May 26th</b>		
	Presentation of process to date, promising area examples, opportunity for stakeholder input via survey, work plan hand-out	Public stakeholder meeting: May 26 <sup>th</sup> , 1pm	Stakeholder Meeting conducted; current work plan and survey distributed

Objectives Strategies	Tasks	Timeline and Deadline	Associated Deliverable Items
<b>Stakeholder meeting #2</b>			
	Re-circulate the summary promising areas list submitted by stakeholder groups; discuss survey responses	Mid-July	
	Finalize promising areas list for further exploration	Mid-July	Final promising areas list
	Creation of workgroups for promising areas <ul style="list-style-type: none"> <li>o Workgroups to meet periodically</li> </ul>	Mid-July	Workgroups formed, 1 <sup>st</sup> meeting scheduled
<b>Objective 4: Summarize &amp; publish list of promising areas for exploration</b>			
<b>List with a justification has been compiled based on responses to survey, informant interviews, payor suggestions and literature review.</b>			
	Create promising list and justification using the following: <ul style="list-style-type: none"> <li>o Patient population affected</li> <li>o Area of system (health, acute/chronic condition / support services)</li> <li>o Primary provider type responsible (if one)</li> <li>o Providers involved / affected</li> <li>o Description of inefficiency and/or quality gap</li> <li>o Impact assessment: number of patients / risk of bad outcome / cumulative cost estimates</li> <li>o Suggested improvement / path for change</li> <li>o Estimated impact of improvement -- # of individuals affected / savings to system</li> </ul>	Summer 2011	Promising areas list and justification document created
<b>Publish final list of priority items for advancement</b>			
	Project management team has set of priority items for recommendation given data analyses, literature review of best practices and evidence, stakeholder input and other resource reviews	October 1	
	Publish and solicit comment for above list; "Round 1" - items are those to be priced by July 1, 2012	Publish: October 1 Comment received by: November 15	
	Project team expands recommendation to include but is not limited to the following:	December 31	

Objectives Strategies	Tasks	Timeline and Deadline	Associated Deliverable Items
	<ul style="list-style-type: none"> <li>○ Recommendation on what to price</li> <li>○ Recommendation on what to bundle</li> <li>○ Recommendation on quality or outcome measure required</li> <li>○ Others as identified</li> </ul>		
	Publish and solicit comment on the expanded recommendation by November 15; “Round 1” agreed list of items pricing recommendations	Publish: December 31 Comment received by: February 15, 2012	

#### Objective 5: Complete ‘Care Partnerships’ white paper

##### Creation of white paper on ‘Care Partnerships’ to share with stakeholder community as guidance for forming and sustaining the necessary partnerships for potential reimbursement restructuring

Publish and solicit comments on a “White Paper on Round 1 Care Partnerships”, which address the specific partnership resources that would be required for each priced item, and how those resources might be assembled in various parts of the State.	December 31, 2011	White Paper for dissemination to interested stakeholders
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#### Objective 6: Finalize implementation strategy

##### Detail the timeline for implementation of the recommendations

Gather input from stakeholders regarding realistic and practical phase-in strategy	March-May 2012	
Provide guidelines and resources for stakeholders to implement phase-in strategy	May-July 2012	

Objectives Strategies	Tasks	Timeline and Deadline	Associated Deliverable Items
<b>Objective 7: Final scope, pricing and implementation recommendations to Governor for approval</b>			
<b>Receive CMS approval for proposed strategy</b>			
	Final recommendations to Governor on “Round 1”, and then Governor requests CMS approvals for “Round 1”	March 2012	
	<ul style="list-style-type: none"> <li>○ Based on data analyses, literature review of best practices and evidence, stakeholder input and other resource reviews</li> </ul>	May 2012	
	Governor receives CMS approval, and then DHS publishes State Medicaid Regulations for “Round 1”	July 2012 to January 2013	
	Implementation of “Round 1” Regulations by Medicaid - Medicare and private insurers tentatively identify when and, if so, to what extent each will align its policies with “Round 1”		
<b>Objective 8: Project Team Starts Work on Round 2 Recommendations</b>			
<b>Continuous and ongoing process to identify, bundle and price areas of necessity</b>			