



# Specialty Care Visioning Session 2016

## Redwood Community Health Coalition

Synthesis of Regional Opportunities | November 7, 2016



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## ▶ Introduction

Redwood Community Health Coalition (RCHC) has been working with member health centers, Partnership Health Plan, local multispecialty groups, community-based organizations, medical societies and others to address the **challenging issues and disruptive market forces impacting access to specialty care for 153,559** vulnerable patients in Marin, Napa, Sonoma and Yolo counties facing challenges in obtaining specialty care.

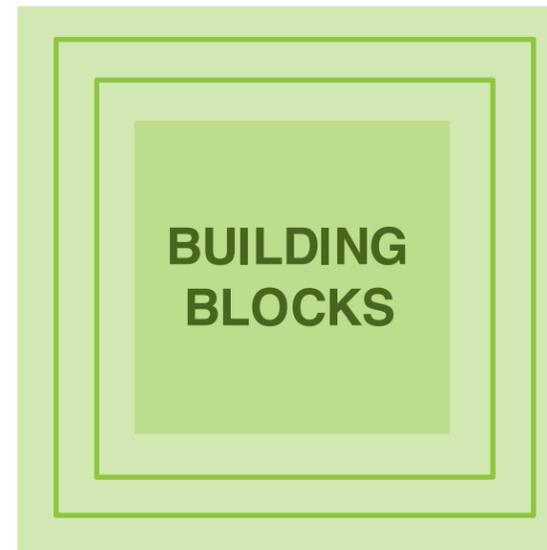
While there have been many attempts from dedicated local health care organizations and individual physicians to improve access to specialty care, it is imperative to thread these *individual attempts* together and **collectively stretch cross-county thinking to define an innovative systems-based** specialty care vision for vulnerable populations served by these multi-county health centers.

**Achieving a future vision of specialty care for vulnerable populations** requires a shared will and commitment from all regional stakeholders to define and prototype a systems-level specialty care delivery model that delivers care beyond the clinic walls with a rejuvenated workforce, agile technology platform and key stakeholders who rally around shared goals and incentives.

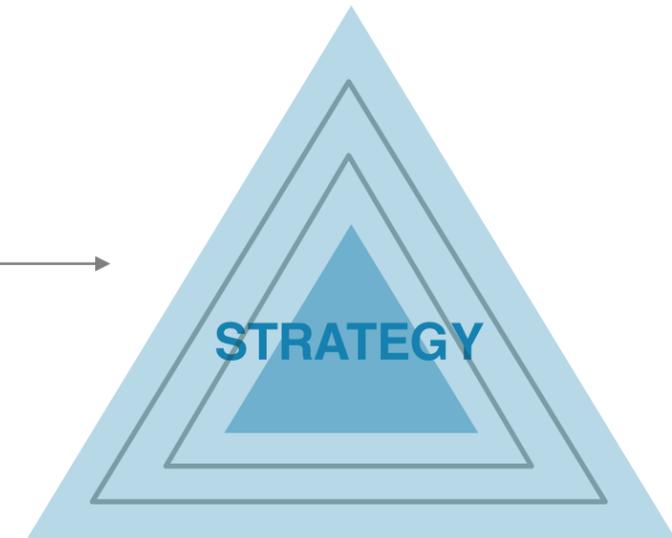
Organized as three key components to define and build the future of specialty care at a systems-level approach.



Compass to navigate health centers and stakeholders toward the 'future end-states' of specialty care.



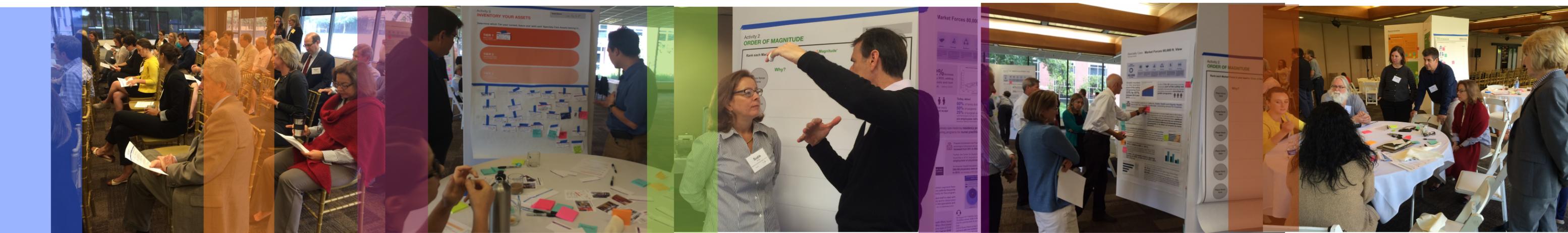
Essential foundational assets put in place across health centers to reframe specialty care.



Master plan of concrete opportunity areas to drive a systems-level approach with strategic cohesion.

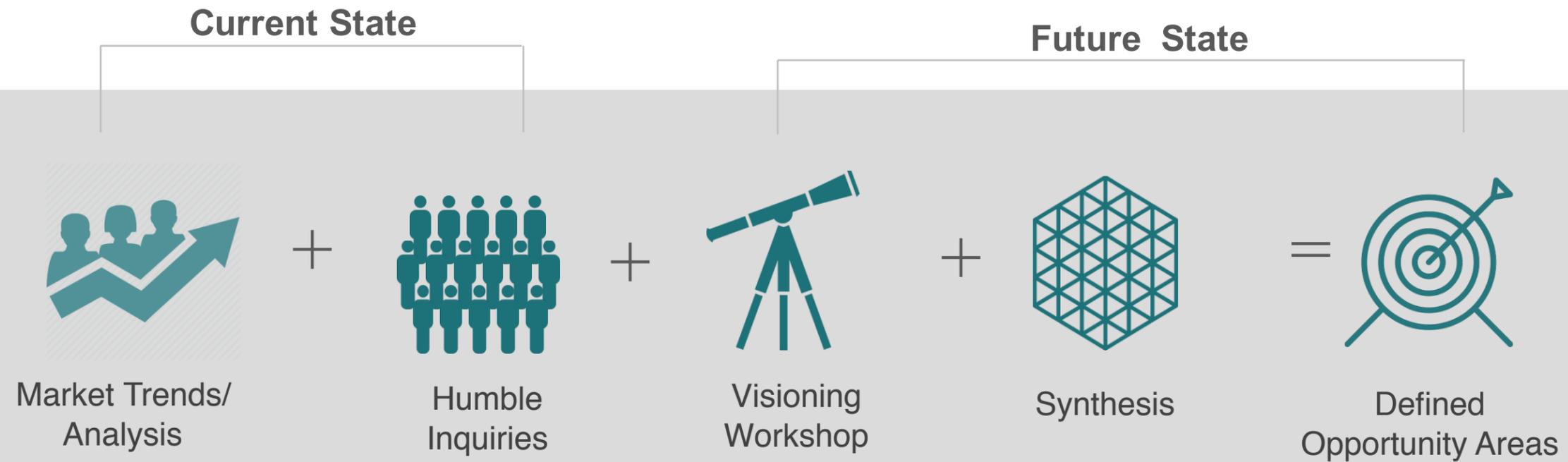
## ► Project Overview

To gain deep insight and understanding into what RCHC specialty care leadership, health plans, clinical and ancillary care teams, and patients **envision the future of specialty care to be, then translate that vision into actionable opportunities.**



# Approach

This collection of current and future state specialty care insights and ideas from over **60 regional stakeholders** has been synthesized into a cohesive, actionable vision of Specialty Care of the future.



47 CA healthcare innovators from across four counties engaged in a day long visioning session to imagine what Specialty Care of the future could look like at the regional level.

## Purpose

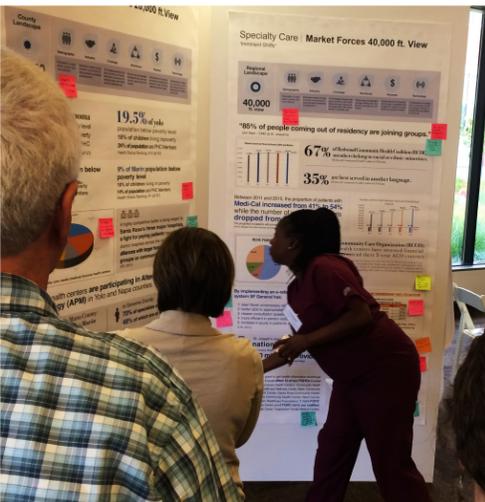
- Excite and engage multi-county stakeholders in cross-functional conversations
- Light up current regional transformative models and pilots
- Define a vision of what specialty care of the future might look like in this region

# Visioning Session

Designed as a space for stakeholders to freely explore, make bold statements and have 'aha' moments about what specialty care of the future for vulnerable populations might look like.

8 teams engaged in a sequence of immersive and expansive 'thinking and making' activities to produce emerging visions.

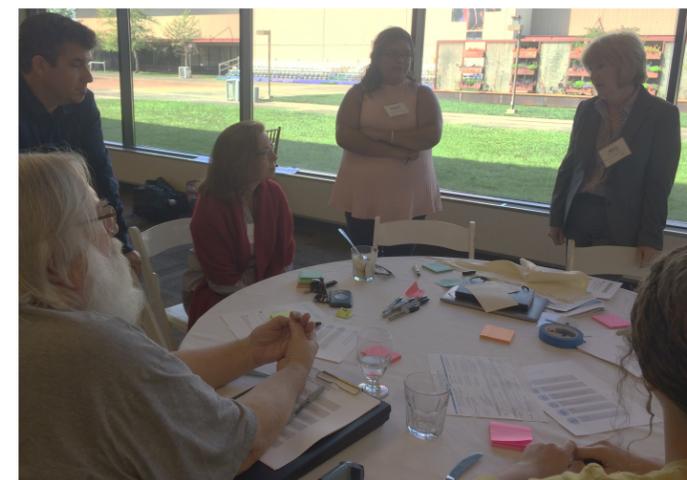
## VISIONING SESSION ACTIVITIES + OUTPUT



## immersive activities

Immerse and get smart on current state:

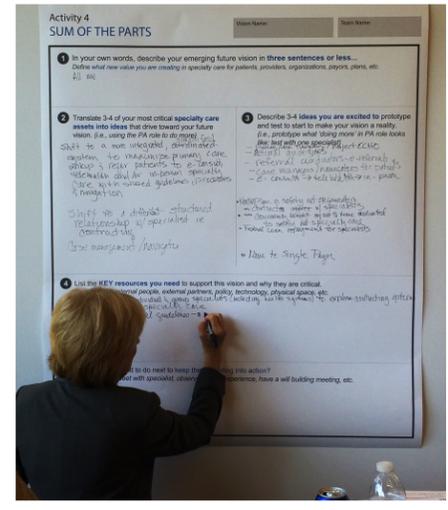
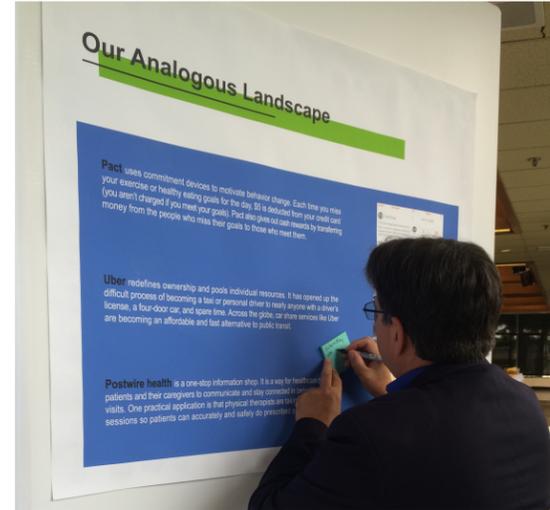
- Market trends/forces on the national, state, regional, local levels
- Innovative regional pilots/models
- Organizational challenges / opportunities



## expansive activities

Expansive toward the future state:

- Analogous industry models as thought starters
- Inventory of most valuable future state assets
- 'Sum of the Parts' Emerging Visions; assets, resources prototypes, action steps

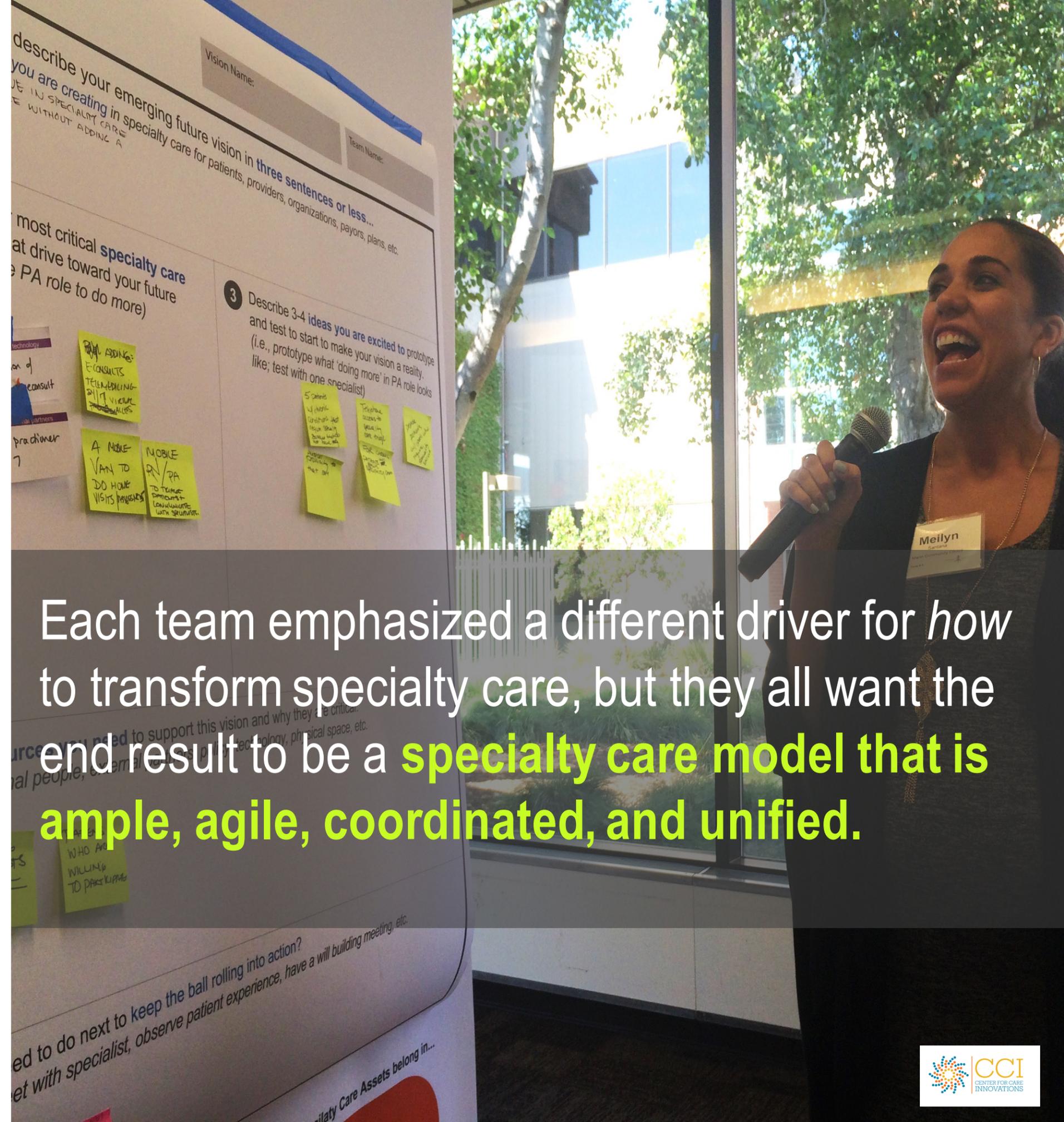


## ▶ Guiding Principles

## Guiding Principles

Visioning session participants were tightly aligned around the imperative to **remove old ways** of thinking and practicing...

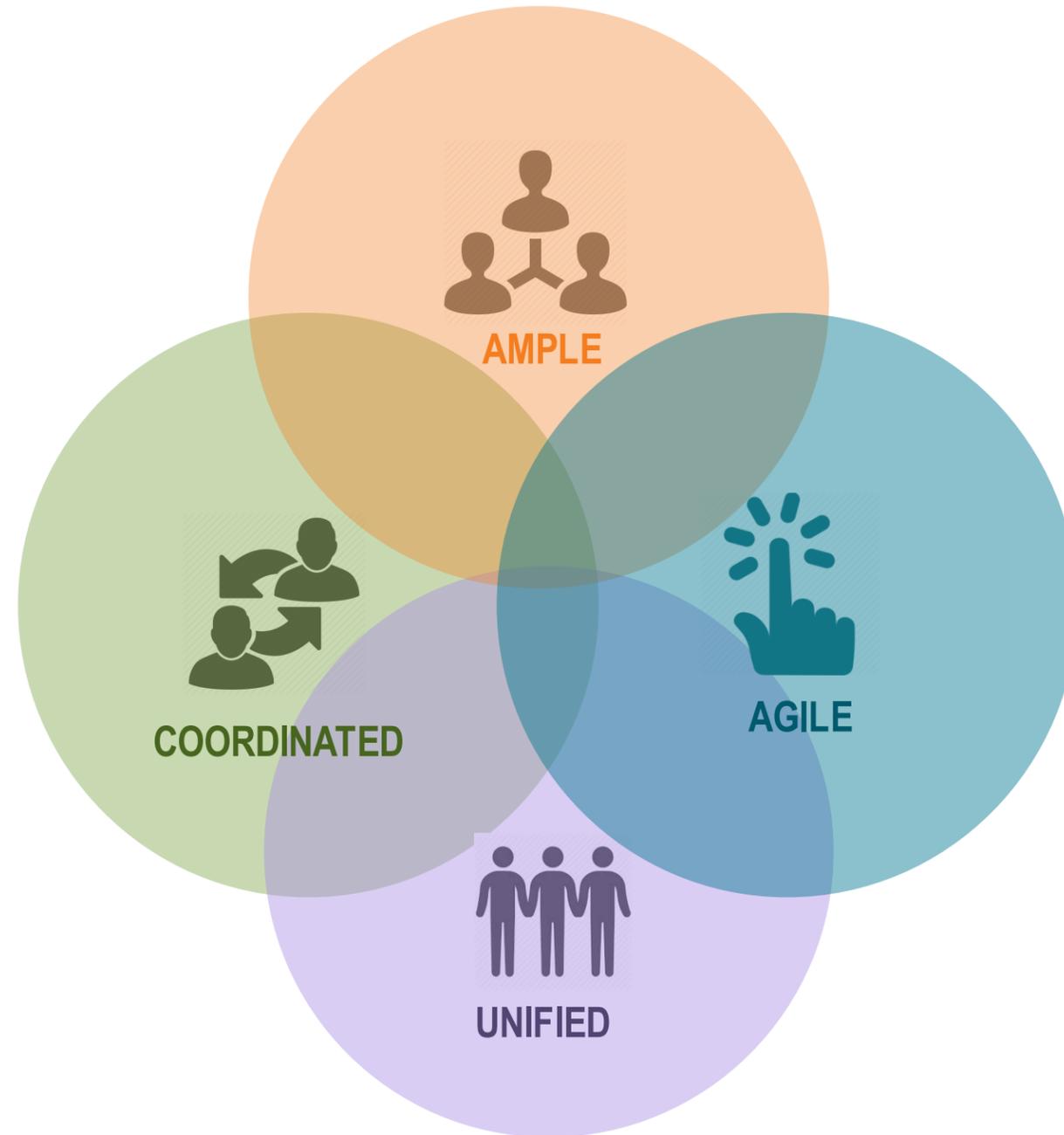
... and **replace them with new ways** of thinking and practicing to transform specialty care for vulnerable populations.



Each team emphasized a different driver for *how* to transform specialty care, but they all want the end result to be a **specialty care model that is ample, agile, coordinated, and unified.**

## Tap into new and existing supply of providers

Deepening roles and responsibilities of providers to rejuvenate and replenish the 'supply pipeline'.



## Leverage current and emergent technology for fluid information exchange.

Real-time, convenient data sharing among all key care delivery stakeholders.

## Culturally-minded care delivery in close proximity

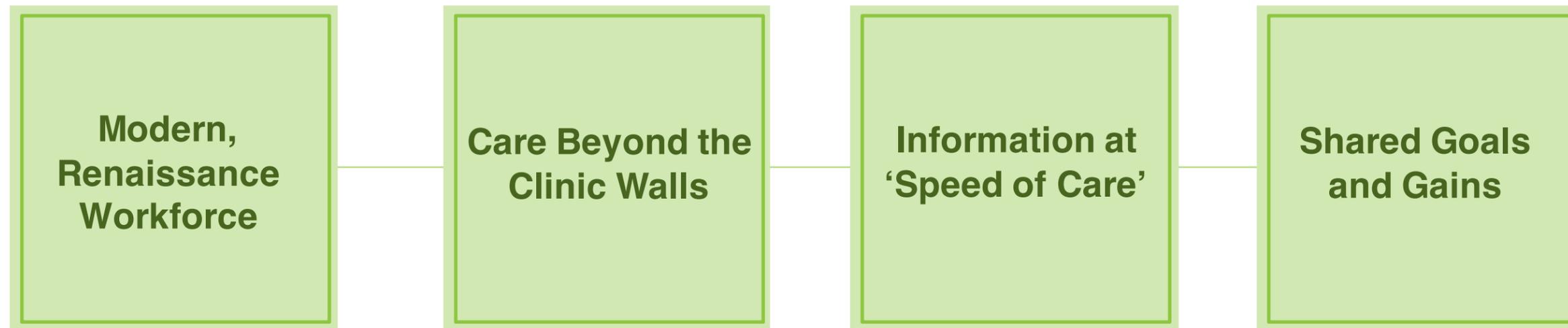
More care delivery services to more people in more places; near where vulnerable patients are.

## Stakeholders participate in shared value creation.

Providers, payers, policy makers and patients have common expectations, goals and gains for healthcare delivery.

## ► Building Blocks

4 building blocks serve as **essential foundational assets** that must be in place at an organizational level across health centers to reframe specialty care for vulnerable populations.





## Modern, Renaissance Workforce

Extends traditional roles, scopes and participation of care team to maximize supply and services for the growing demands of vulnerable populations.

### Themes expressed from stakeholders

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- Rejuvenated workforce strategy
- Robust, sustainable provider supply pipeline
- 'Not your traditional' role/scope of primary and specialty care
- A culture of participation; set expectations to give back



AMPLE



## Care Beyond the Clinic Walls

Alternative, flexible, ‘culturally minded’ virtual care delivery that serves vulnerable patients beyond the clinical environment.

### Themes expressed from regional stakeholders

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- Complimentary new care delivery models that wrap-around current models
- Care where you are; virtual modes of specialty care access, services, and providers
- Responsive to range of social determinants and cultural diversity



AGILE



## Information at the 'Speed of Care'

Information '*super highway*' to keep pace with the demand of care; all stakeholders document, get, give, and share data using agile technology.

### Themes expressed from stakeholders

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- Core medical information shared by and accessible by 'all'
- Continuous loop of direct, real-time communication between primary and specialty care and patient
- Decision making tools without barriers
- Real-time relevant data /analytics



COORDINATED



## Shared Goals and Gains

Shared congruence of interests to support the growing needs and expectations of patients, providers, payers and policy makers serving vulnerable populations.

### Themes expressed from stakeholders

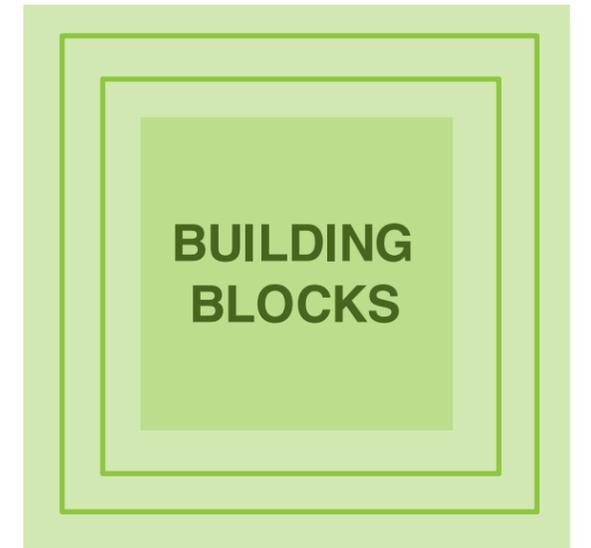
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- One vision, one goal, shared gains
- Behavior and mindset of co-opertition vs. competition
- Aligned financial model across payers, providers and patients
- Structured partnerships at scale



UNIFIED

## REFLECTION QUESTIONS

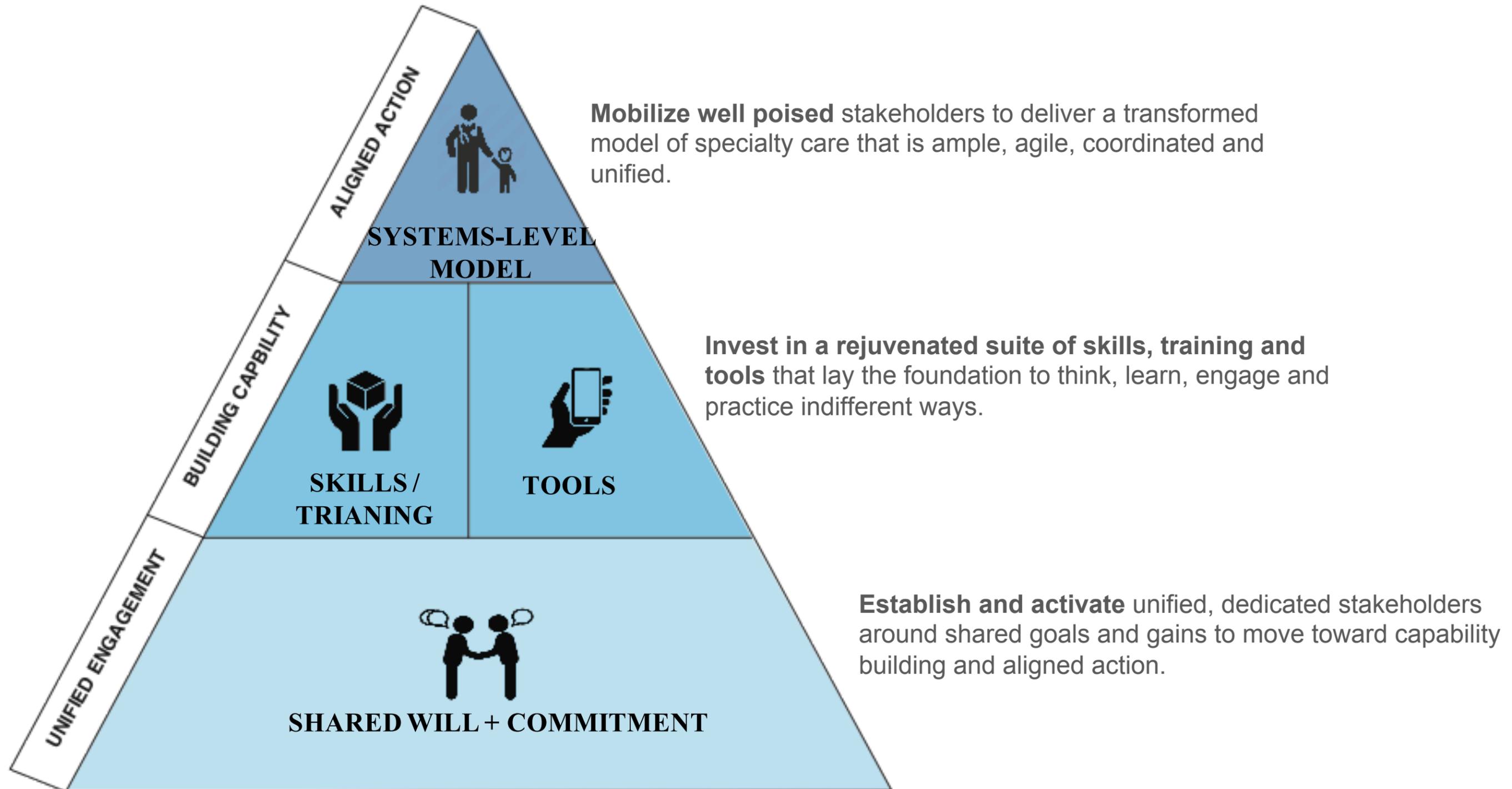


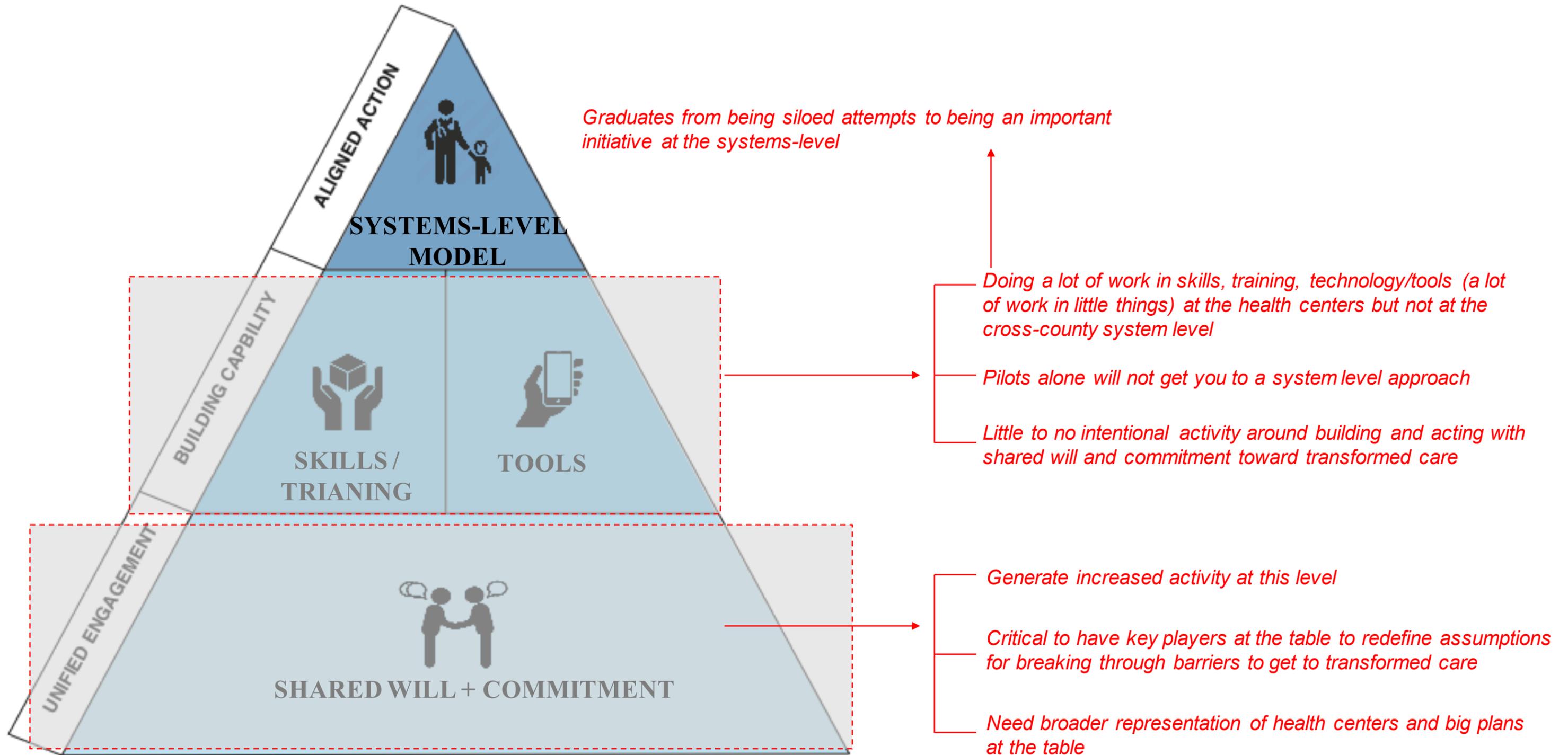
### Refining Your Building Blocks

- Are there any building blocks missing?
- Which stakeholders need to be aligned and mobilized to put these in place?
- How might we prioritize and act on the building blocks tomorrow?

► **Strategy**

Master plan of concrete opportunity areas to organize, prototype and drive a systems-level approach with strategic cohesion.





# SHARED WILL + COMMITMENT

**Establish and activate** unified, dedicated stakeholders around shared goals and gains to move toward capability building and aligned action.

## Make a Game Plan

- ▶ Determine where specialty care is positioned in RCHC's priorities
- ▶ Define what role RCHC will play moving forward
- ▶ Address the end of grant and ongoing funding need
- ▶ Organize RCHC steering committee to make 'game plan' and execute on 'big picture'

## Partner Up

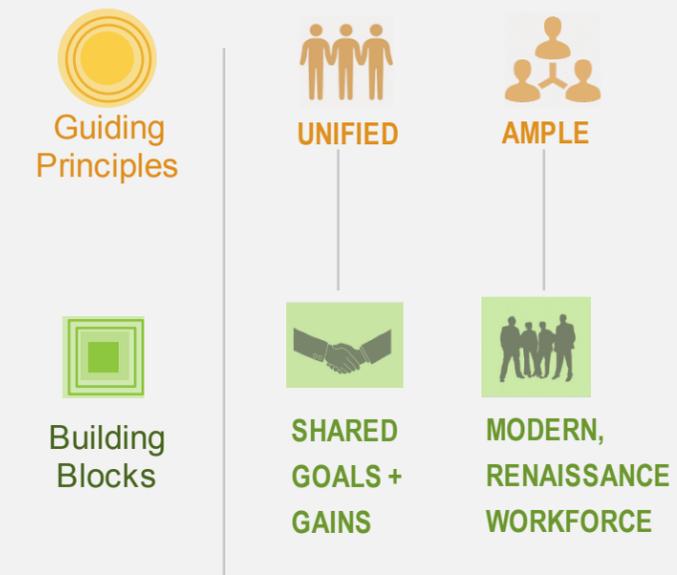
- ▶ Secure health center leadership c-suites that can make this a priority with dedicated time and resources.
- ▶ "What's in it for me" (WIIFM); create clear, concrete value proposition for health center stakeholders

## Take Inventory

- ▶ Identify health plans with 'excess access' to buy and set up visits with leadership to introduce the idea
- ▶ Catalogue active pilots across health centers; then determine which live on, which ones phase out, additional new ones
- ▶ Seek out 'early adopter' team of stakeholders willing to work and get paid in a new way
- ▶ Develop road map to test a model of sequenced prototypes



## MAPPING BACK TO FRAMEWORK



# SKILLS + TRAINING

Invest in a rejuvenated suite of skills, training and tools that lay the foundation to think, learn, engage and practice in different ways at ‘speed of care’.

## Learn from the Locals

- ▶ Schedule site visits to see + learn about current models/pilots\*
- ▶ Meet with local ‘willing’ specialists to build relationships and discuss expanding their contracts to serve vulnerable populations in their area

## Reimagine Your Care Team

- ▶ ‘Buy excess access’ from pieces of specialists’ time and knowledge to use in health centers.
- ▶ Train practicing PCPs to be ‘skilled up’ on ‘reasonable scope’ of specialty care.
- ▶ Expand PCP training and scope by educating resident PCPs with specialists
- ▶ A ‘supply pipeline’ of retired specialty providers who wish to keep practicing
- ▶ Re-define roles of referral coordinators, care managers/ navigators, RNs from primary care to best support a primary care continuum



## MAPPING BACK TO FRAMEWORK



# TOOLS

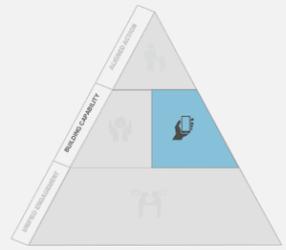
Invest in a rejuvenated suite of skills, training and tools that lay the foundation to think, learn, engage and practice in different ways.

## Get Coordinated

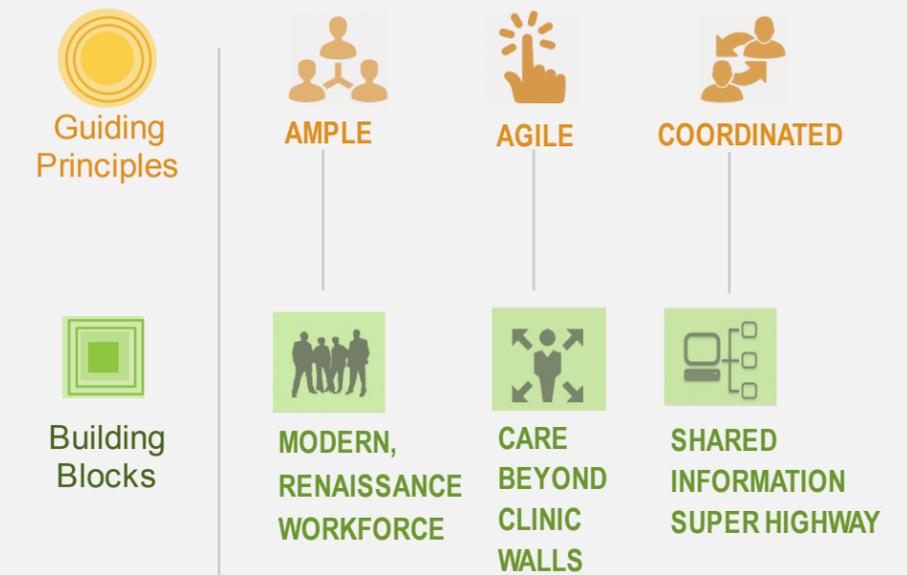
- ▶ Convene IT, operational and clinical experts to frame out a 'big picture approach' for fluid information exchange across health centers
- ▶ Establish an agile, integrated technology platform

## Go Virtual

- ▶ Shared EHR across all multi-stakeholders
- ▶ Virtual consults, referrals and visits for providers and patients
- ▶ Specialty care decision support tools
- ▶ Identify dedicated people to develop guidelines / protocols



## MAPPING BACK TO FRAMEWORK



# SYSTEMS-LEVEL MODEL

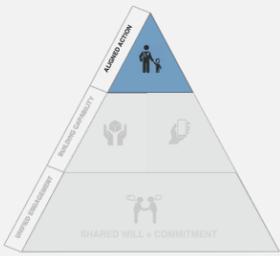
Mobilize well poised stakeholders to deliver a transformed model of specialty care that is ample, agile, coordinated and unified.

## Determine Success

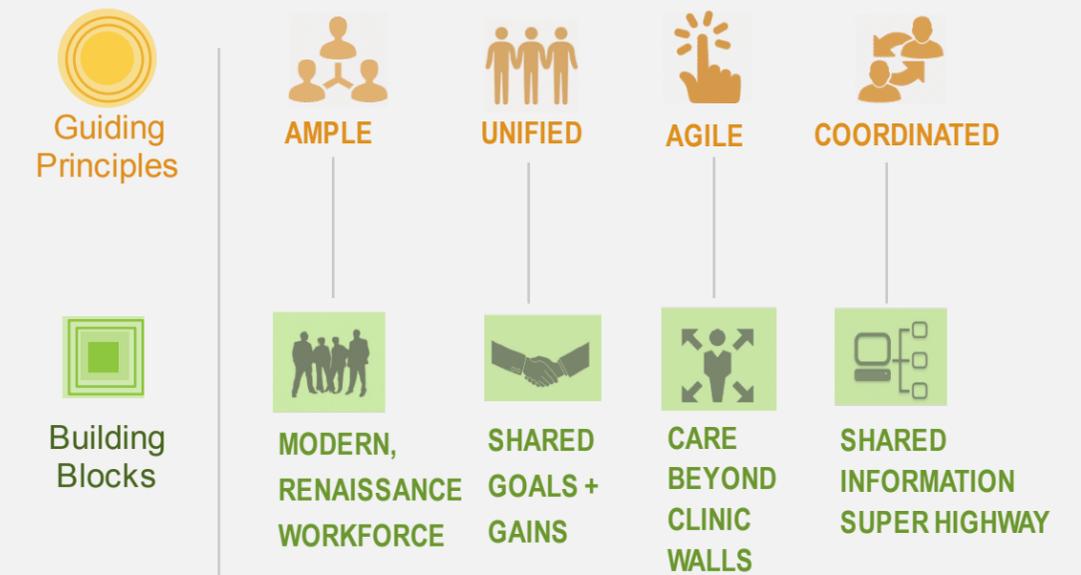
- ▶ Convene cross-county operational and clinical leaders core team to synthesize learnings from opportunity areas and prototypes that were tested.
- ▶ Share synthesis at the health center level of which prototypes/ models showed impact or success across the strategy tiers.

## Build End to End Model

- ▶ Dedicate a cross-disciplinary team to design, test and project manage piloting the systems-level model
- ▶ Use synthesized learnings to design a systems-level approach for an end to end care delivery model with road map to execute.



## MAPPING BACK TO FRAMEWORK



Starter set of 'prototypes' to move forward with in 2016 and beyond.

 **SHARED WILL + COMMITMENT**

 **SKILLS**

 **TOOLS**

 **SYSTEMS-LEVEL MODEL**

**Prototypes**

- RCHC clinical directors meet to prioritize prototypes to test.
- Agreement from health center c-suite decision makers; FQHC, PHP, Medical Foundation, Medical Groups, finance leaders
- Define process for launching prototypes with stakeholders: selection criteria, site visits, testing change, scaling change that works
- Learning collaborative; define, prototype and test change concepts led by dedicated innovation team for trying/testing of prototypes
- Establish accountability check-ins; track and share monthly progress of the work to keep it 'connected to bigger picture'
- Schedule 'coffee chats' for specialists and leadership of CHCs together to outline benefits and explore contracting options to provide care to safety net.

**Prototypes**

- Schedule site visits/ field trips to selected current pilots/ models
- Test a network/ model of retired specialty providers who wish to keep practicing; program including 'credentialing maintenance'
- Buy and test 'excess access from plans; use them at sites for half days during the week
- Design and test database of retired specialists partnering with an FQHC to request and fulfill their need for specialists; once a month, twice weekly, etc.
- Test a few small scale specialty hubs staffed by specialists / residents in primary clinics to:
  - Live patient consults in current payer model
  - Side by side curbside consults w/ PCPs in same 'place'
- Test mini-specialty fellowships to 'skill up' PCPs on 'reasonable' specialty care scope'; track referral impact (*less unnecessary referrals, more accurate referrals*)
- Design and test new care path for referral coordinators /care managers/ navigators/RNs
- Mobile Van for care delivery to patients' homes; 1 RN, 10 patients rent a van for 1-2 days to visit willing patients in their homes for RN triage

**Prototypes**

- Cross-organizational technology infrastructure for agile information sharing functionality
  - Test set of tools for decision support; guidelines, technology, protocols
- Design and test Virtual Care bundle:**
- Using HIE for making referrals
  - E-consult embedded in EHR; use existing technology standards
  - Virtual warm-hand off with pcp and sp 'in the room'; during pc visit, pcp initiates virtual warm-hand off to specialist via phone/ video, patient introduced to specialist (pcp is bridge to specialist)
  - Telemedicine consult/visits with 5 patients who require specialty care using ipads/computers to communicate with their specialist; virtual consults between specialists and patients (phone/video)
  - Guidelines/ Protocols for referrals, appointments, visits, etc. with referral coordinators, providers to; measure timely, accurate referrals, appointments, visits to learn if it is a better process / experience
  - Create electronic 'match list' of safety net patients with specialists who are willing to serve them

**Prototypes**

- Assess alternative payment models and select one to test; not just talk about testing it.
- A systematic approach for contracting with specialists willing to dedicate % of their time to giving back by providing care in the safety net.
- Test standard contracting between FQHC and foundations for specialty care access supported by Partnership Health Plan
- Test Integrated technology platform that maximizes HIE infrastructure with embedded inter- and cross-organizational EHR for convenient information access, sharing and communication for multi-stakeholders.

**Prototypes** (+others)

**Prototypes** (+others)

**Prototypes** (+others)

**Prototypes** (+others)

## REFLECTION QUESTIONS



### Evaluating Your **Strategy**

- How will you integrate it with your patients, organizational culture, capabilities, communities, and stakeholders?
- How will you assess which could be the most impactful and cost effective parts of this strategy?

### Prioritizing **Prototypes**

- What other prototypes might you need to develop and test that did not come out of the visioning session?
- Which have the most potential for change?
- Which can we start working toward tomorrow to show short term impact?

**Specialty Care Visioning session multi-stakeholders clearly outlined a cohesive plan to move forward into action including:**

- Clear, common guiding principles
- Essential building blocks needed in place at health centers to achieve foundational success
- Concrete opportunity areas and prototyping of a future model now, *not ten years from now*

### Next Steps

- Share synthesis with extended group of stakeholders
- Convene with key stakeholders to determine how to begin executing on the strategy (*opportunity areas + prototypes*)
- Identify approaches for connecting activities to on-the-ground efforts in health centers