Comagine Health

Breaking barriers with innovation throughout the healthcare landscape

Marc Bennett

October 4, 2019

Presentation to the UAHQ

Qualis Health & HealthInsight
have joined forces to do great things.

Comagine Health

Together, we're reimagining health care.

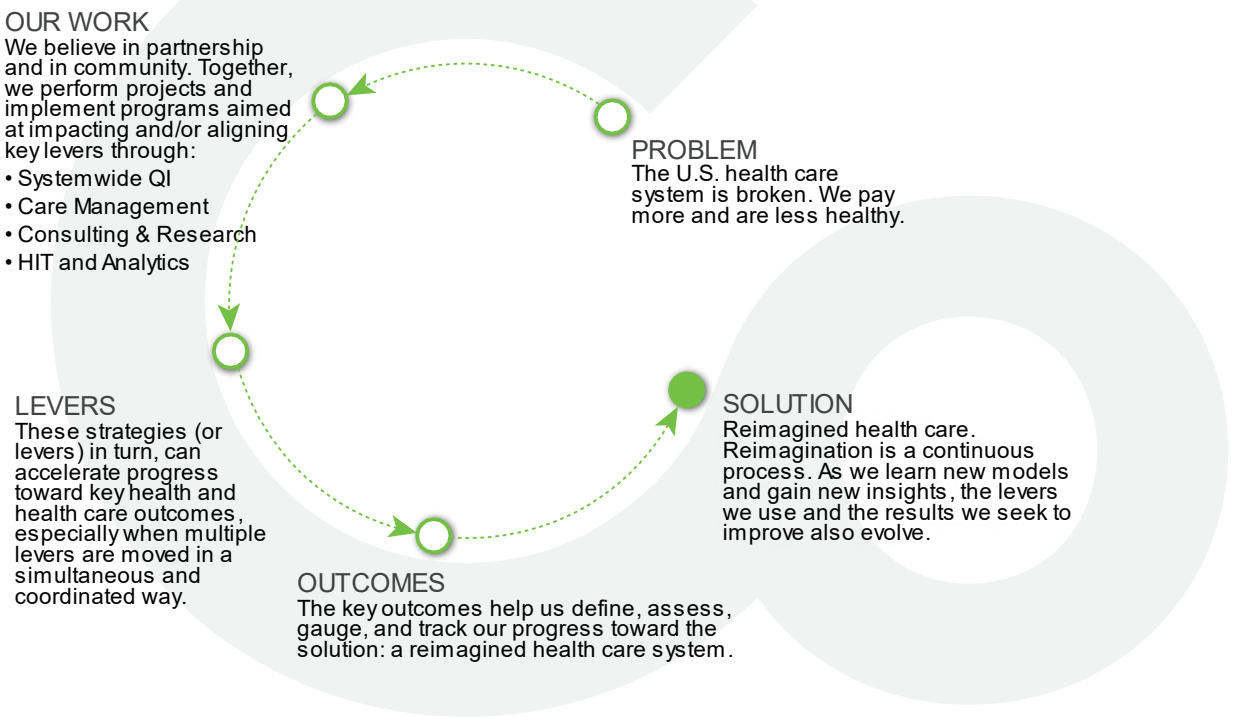
Who We Are

A national, nonprofit, health care consulting firm working collaboratively with patients, providers, payers and other stakeholders to reimagine, redesign and implement sustainable improvements in the health care system.

Comagine Health

Our Mission

Together with our partners, we work to improve health and create a better health care system so that people and communities will flourish.



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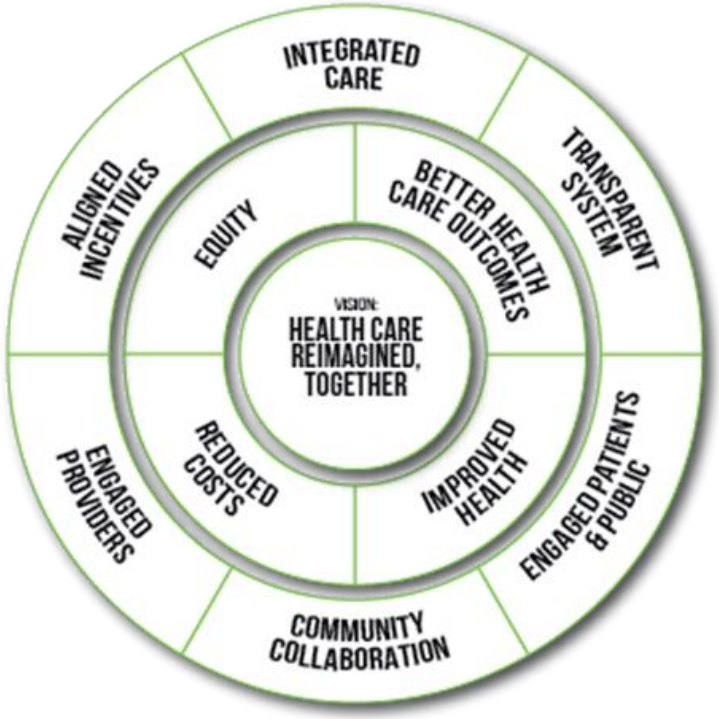
Our Vision

At Comagine Health, we believe in partnership and in community.

Together, we work on initiatives and implement programs aimed at impacting and aligning key levers or strategies to produce outcomes that improve health and create a better health care system.



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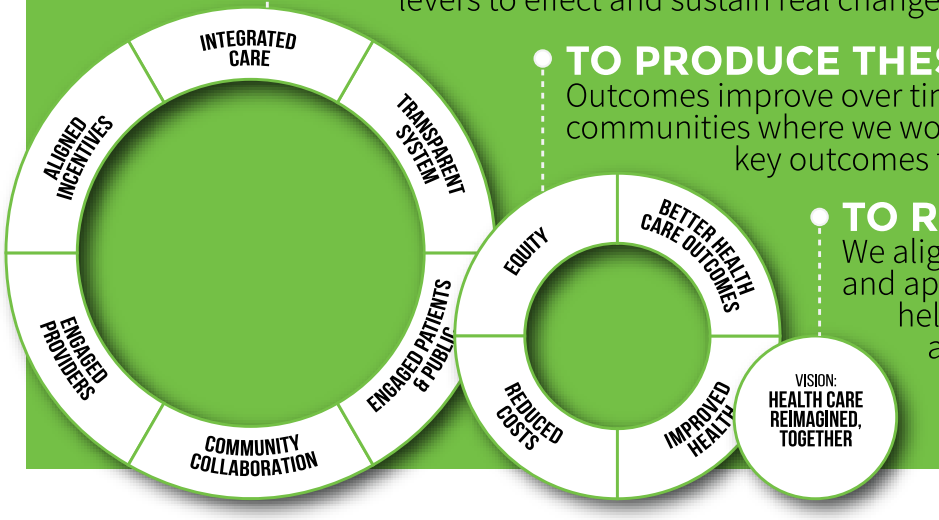
Building Our Vision



WE START WITH THESE LEVERS

We understand and engage the key strategies, or levers, that drive transformation. Together with clients and community partners, we serve as catalysts to align and synchronize the levers to effect and sustain real change.

TO PRODUCE THESE OUTCOMES

Outcomes improve over time as the system transforms nationally and in the communities where we work and for the populations we serve. We track the key outcomes to help us realize and sustain progress and results.

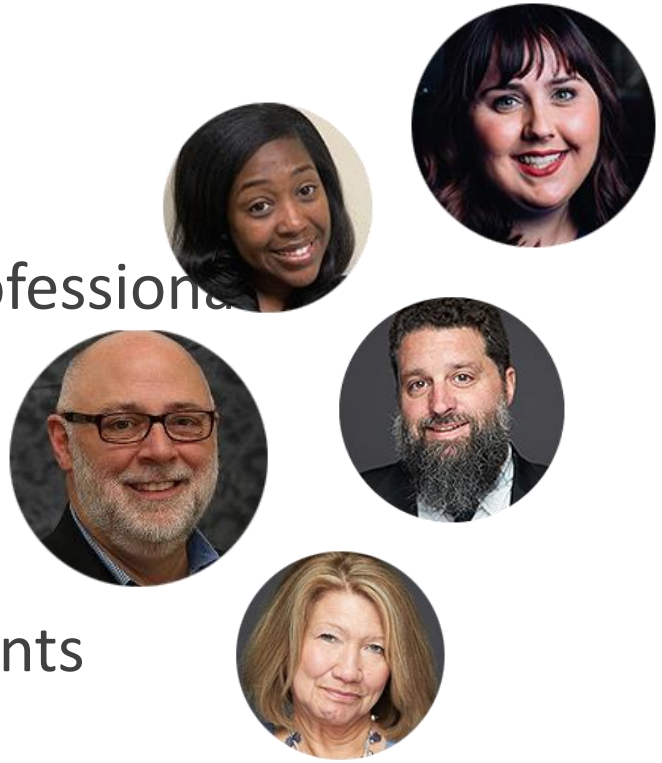
TO REALIZE OUR VISION

We align community interests, promote collaboration, and apply objectivity, experience and innovation—helping to solve the most difficult problems in health and health care. We are always evolving.

Our Staff

Approximately 550 professional staff

- Quality improvement consultants
- HIT professionals / management professiona
- Data analysts
- Medical directors and nurses
- Case managers, clinical reviewers
- 300+ physician practitioner consultants



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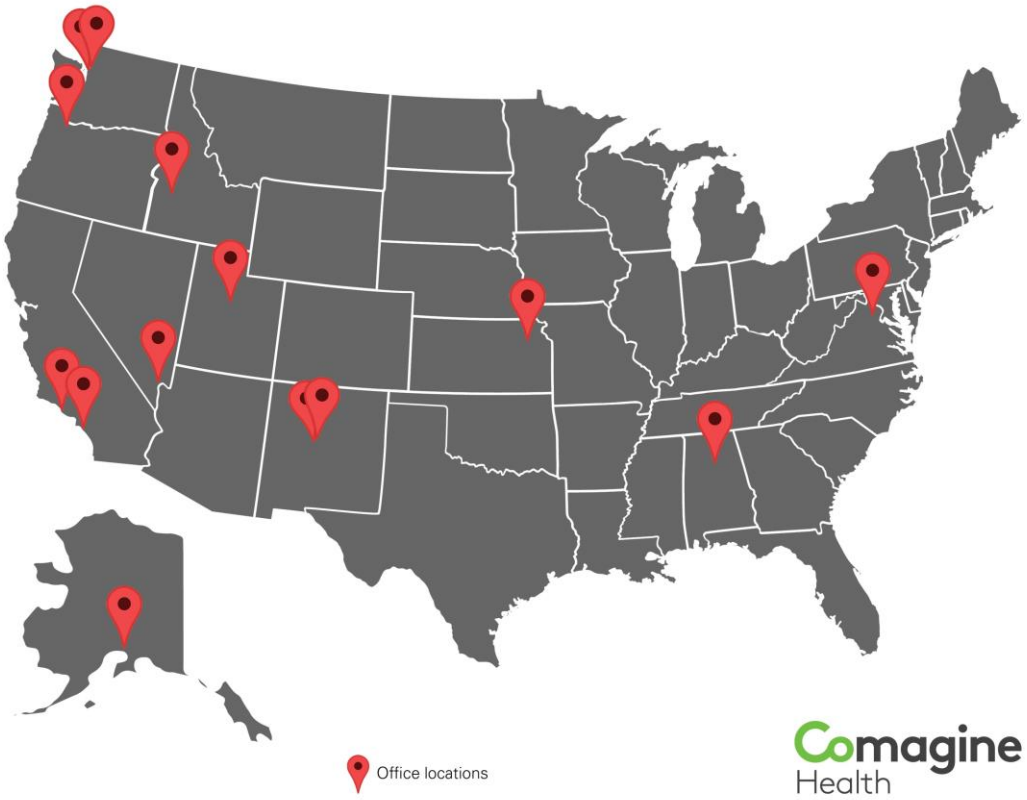
Where We Are

Office locations

- Alabama
- Alaska
- California
- District of Columbia
- Idaho
- Mississippi
- Nevada
- New Mexico
- Oregon
- Utah
- Washington



Our Services

We provide expertise in the following areas:

- Systemwide Quality Improvement
- Care Management
- Consulting and Research
- Health IT and Analytics

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Systemwide Quality Improvement

Selected projects:

- Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO)
- Hospital Improvement Innovation Network (HIIN)
- ESRD Alliance
- Quality Payment Program Rural and Underserved

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Care Management

- Better clinical outcomes, higher patient satisfaction, increased savings
- Customized for each client and patient
- URAC accreditation

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Consulting and Research

Areas of expertise:

- Payment reform
- Opioid research
- Practice redesign
- Learning systems support

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Health IT and Analytics

Areas of expertise:

- Medicaid enterprise systems
- Electronic health records
- Analytics
- Public reporting
- Health information exchange

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Our Clients

Client organizations include:

- Centers for Medicare & Medicaid Services
- Agency for Healthcare Research and Quality
- Centers for Disease Control and Prevention
- U.S. Bureau of Justice Assistance
- National Institute on Drug Abuse
- Pew Charitable Trusts
- Medicaid agencies throughout the U.S.

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Our Customers

We work collaboratively in our communities to address key, complex health and health care delivery challenges.

- Health care providers
- Payers, purchasers, policymakers
- Public/consumers
- Patients and families

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Systemwide Quality Improvement Impact and ROI, CMS Contracts, 2014-2019

Project Number and Type of Providers	Description of Main Outcome
HIIN ***85 Hospitals***	**$17,820,573 saved** via improved patient safety efforts; **1,697 patient harms avoided**
ESRD, Reducing Blood Stream Infections ***322 Dialysis Facilities***	514 fewer bloodstream-related infection reported in NHSN; **saved $12,336,000** (2018)
ESRD, Moving Patient to Home Dialysis ***192 Dialysis Facilities***	Moved 785 patients to a home modality (Medicare savings **$16K per patient** per year) Data Source: CrownWeb (2019)
ESRD, Increasing the Transplant Waitlist ***192 Dialysis Facilities***	Added 490 patients to transplant waitlist. Future savings once transplanted: **$47K per patient**. Data Source: UNOS (2019)
ESRD, Increasing Facility Access to Hospital eMR/HIE ***289 Dialysis Facilities***	47% of Comagine ESRD Network facilities have established eMR/HIE access. Collected and Verified Data (2019)
ESRD, Population Health (Hospitalization Reduction) ***22 Dialysis Facilities***	**768 fewer hospitalizations** among dialysis patients; **saved $16,402,944** in hospital costs (2017)

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Systemwide Quality Improvement Impact and ROI, CMS Contracts, 2014-2019

Project Number and Type of Providers	Description of Main Outcome
11SOW, Task C3 ***306 Hospitals***	**$9,096,058 saved** through reduction in hospital readmissions
11SOW, Task C2 ***659 Nursing Homes***	20,071 fewer residents prescribed antipsychotics; **$87,308,850 saved in avoided prescription costs**
11SOW, Task C.3.6 ***306 Hospitals***	**58,808 patients** using high-risk medication **received screenings** for appropriate use of medications
11SOW, Task C.3.6 ***47 Hospitals / 68 Nursing Homes***	**2,208 fewer patients** subjected to potential adverse drug events upon transfer from hospital to nursing facilities
11SOW, Task F.1 ***219 Home Health Agencies***	**465,882 pneumonia vaccinations** given to patients in home health agencies
11SOW, Task D.1 and QPP-SURS combined ***33,817 Outpatient Clinicians***	Offered technical assistance to **33,817 clinicians** eligible for the QPP (**100% of target**); of those eligible, **91.2% reported** QPP in 2017 in the states we serve

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Systemwide Quality Improvement Impact and ROI, CMS Contracts, 2014-2019

Project Number and Type of Providers	Description of Main Outcome
11SOW, Task D.1 ***302 Hospitals***	**51,300 hours saved per year** in burden for reporting quality measures by hospitals
11SOW, Multiple Tasks ***52,474 Clinicians***	**28,860 hours saved per year** in burden for reporting quality measures by clinicians
11SOW, Task B.2 ***3,547 Individual Patients***	**3,547 Medicare patients** completed DSME classes provided by QHI or partners, **saved $1,241,450**

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We invite partners and communities to work with us to improve health and redesign the health care delivery system.

Learn more at **comagine.org**

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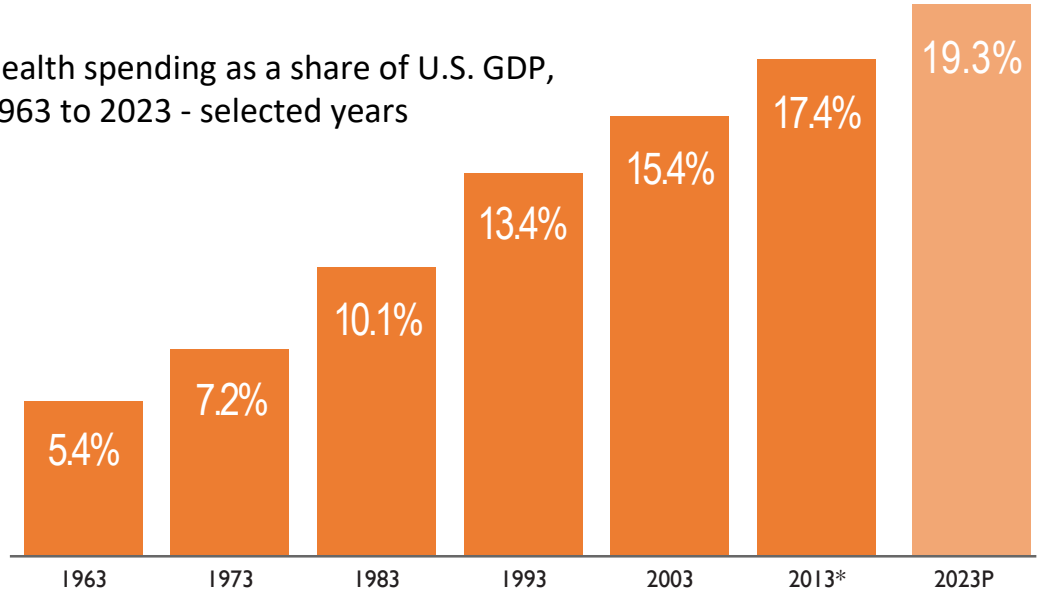
The Future
NEXT EXIT

We have an unsustainable problem. Harder choices are coming.

Health spending as a share of U.S. GDP, 1963 to 2023 - selected years



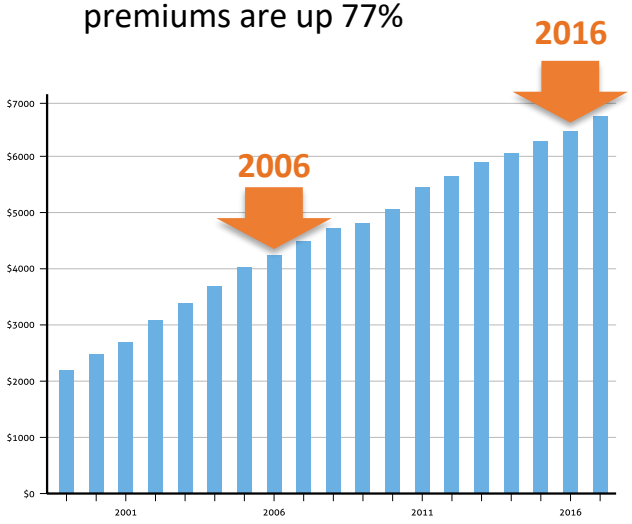
*2013 figure reflects a 3.1% increase in gross domestic product (GDP) and a 3.6% increase in national health spending over the prior year. See page 27 for a comparison of economic growth and health spending growth.

Notes: *Health spending* refers to national health expenditures. Projections shown as *P*.

Source: "National Health Expenditure Data," Centers for Medicare & Medicaid Services (CMS), 2014 (historical) and 2015 (projections), www.cms.gov.

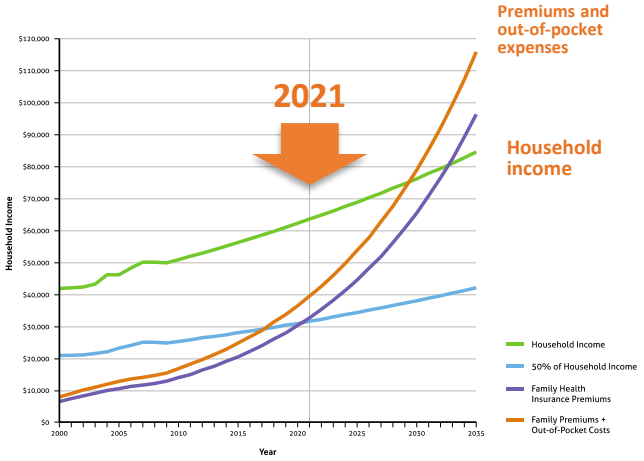
We have an unsustainable problem. Harder choices are coming.

Between 2006 to 2016 premiums are up 77%



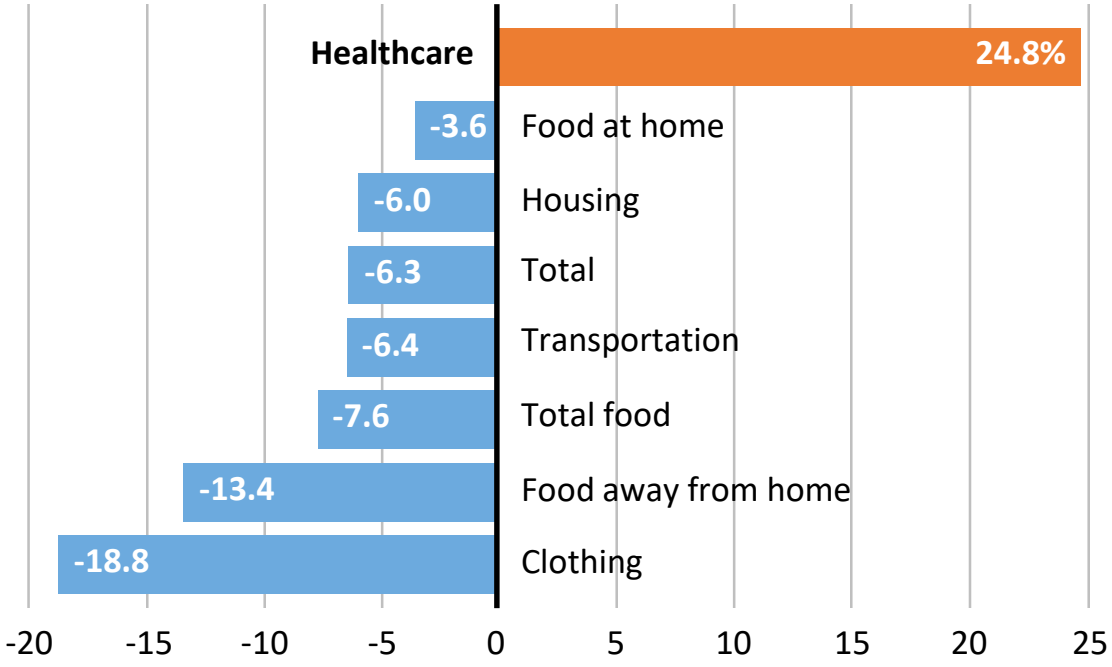
Source: Henry J Kaiser Family Foundation, September 19, 2017. Premiums and Worker Contributions Among Workers Covered by Employer Sponsored Coverage. https://www.kff.org/interactive/premiums-and-worker-contributions/

Healthcare costs will consume half of household income by 2021



Source: Young RA, DeVoe JE. Who Will Have Health Insurance in the Future? An Updated Projection. Am Fam Med 2012; 10(2): 156-162. PMCID: PMC3315130.

Percent change in middle income households' spending on basic needs (2007-2014).



Source: Brookings Institution, Wall Street Journal

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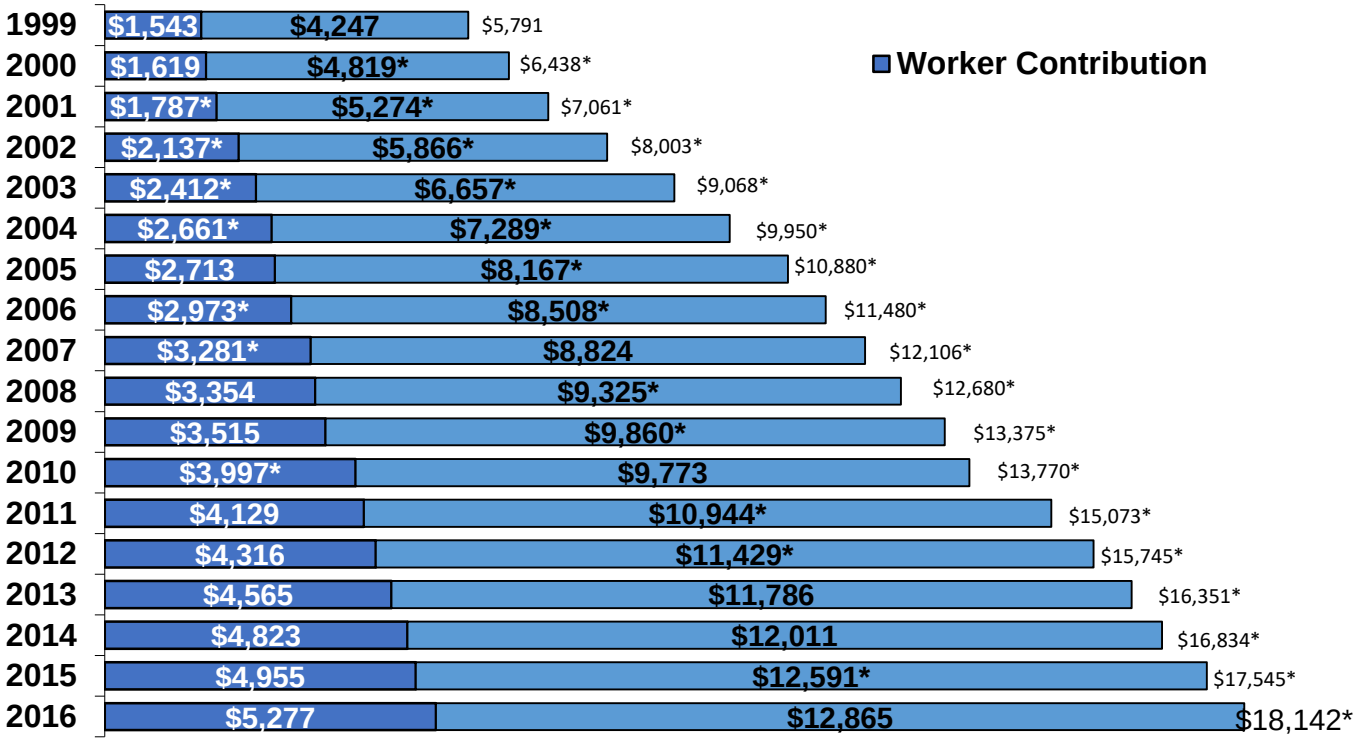
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2016



*Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2016.

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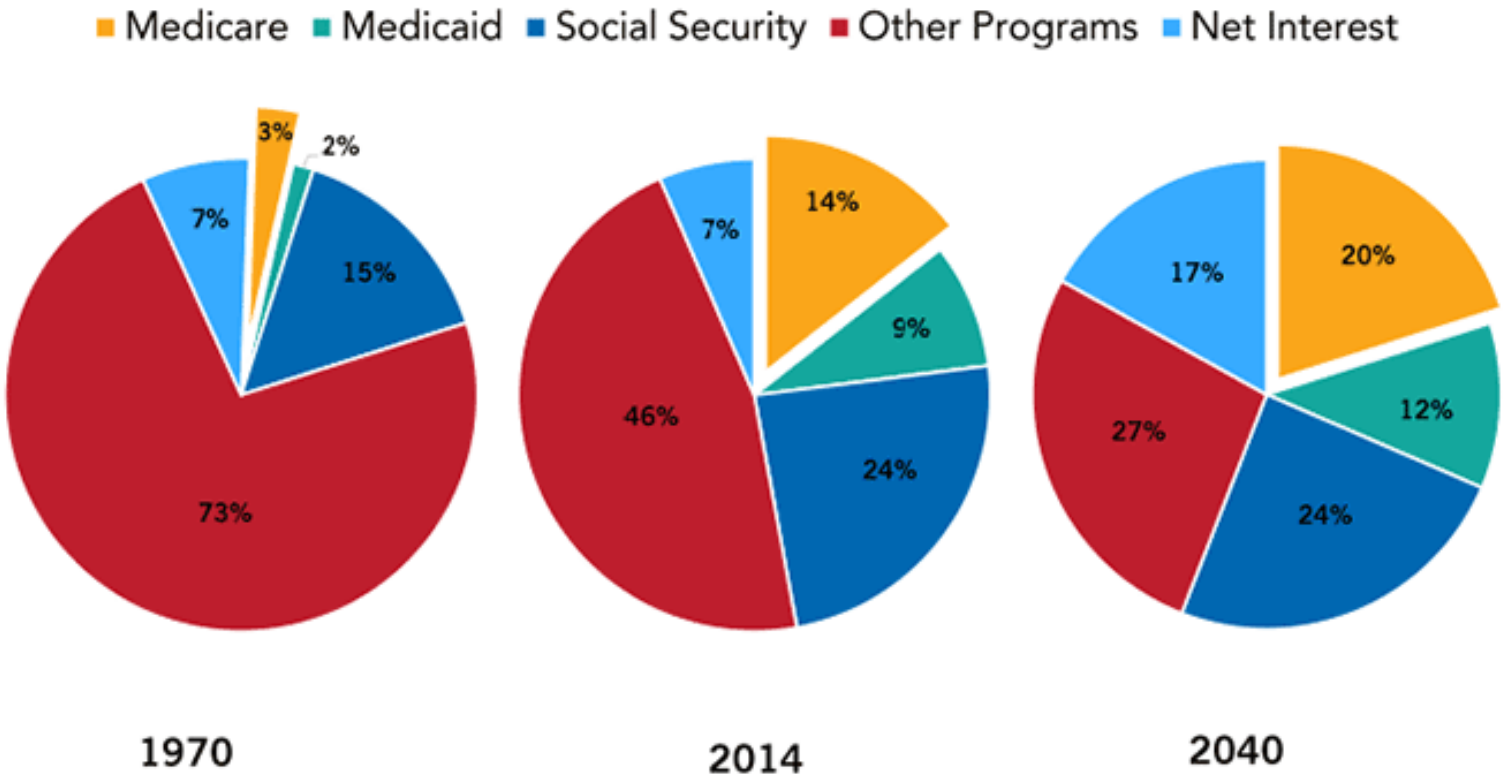
Medicare spending is a growing share of the federal budget



SOURCE: Office of Management and Budget, *Budget of the United States Government*, Fiscal Year 2015, February 2015 and Congressional Budget Office, *The 2015 Long-Term Budget Outlook*, June 2015. Compiled by PGPF.

Breaking down silos and barriers

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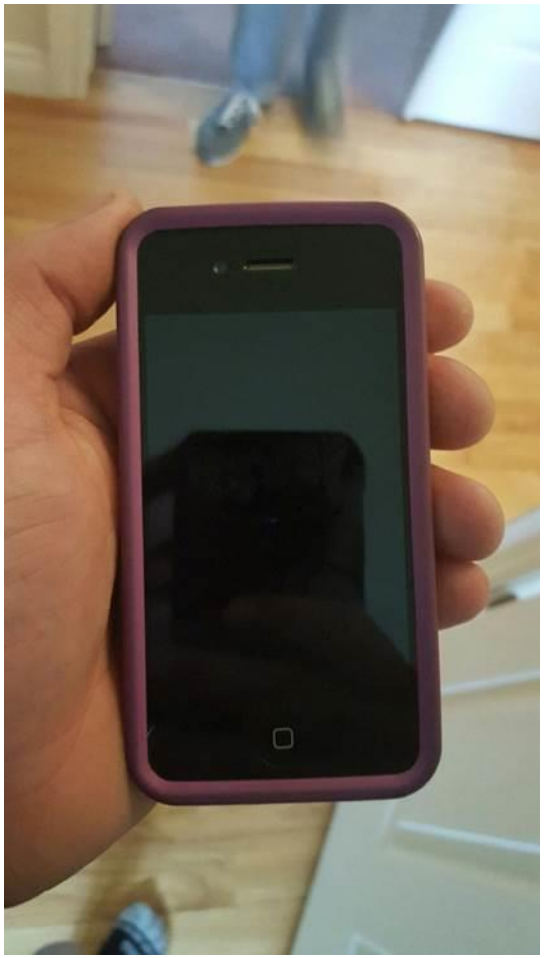
A Small Analogy



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Developing a Transformational Culture

Single and siloed, independent and uncoordinated

Team-based, integrated (with shared rewards system), coordinated and adaptive

Credit: Tom Evans, MD; Iowa Healthcare Collaborative

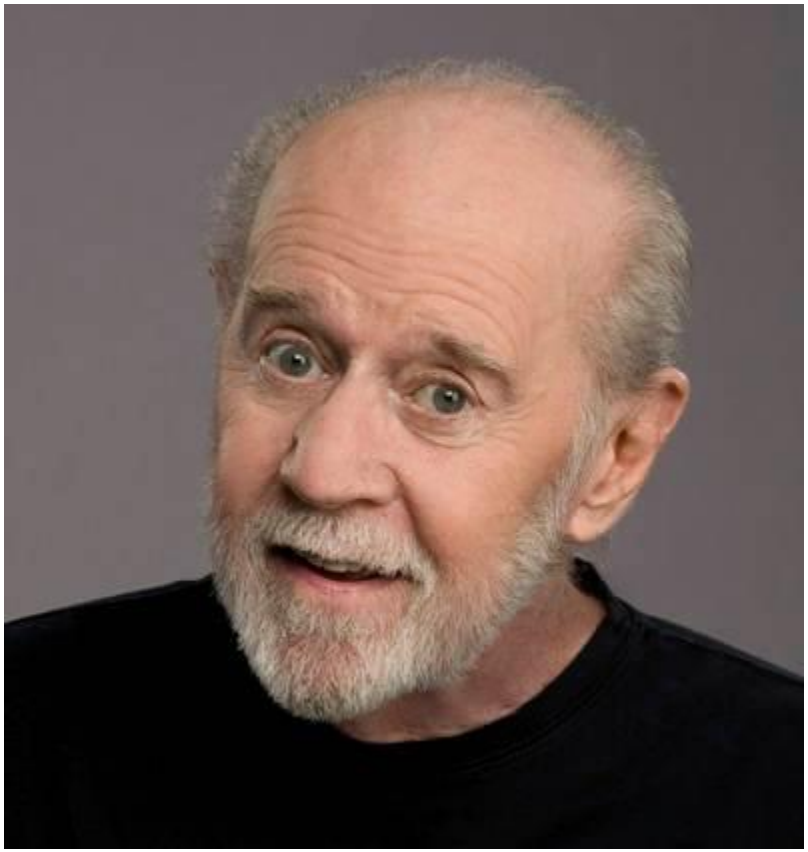
Delivery System Reform

Pay Providers

Deliver Care

Distribute Information

Credit: Tom Evans, MD; Iowa Healthcare Collaborative



“I don’t believe there’s any problem in this country, no matter how tough it is, that Americans, when they roll up their sleeves, can’t completely ignore.”

The Late Comedian George Carlin

“The Americans always do the right thing…after they’ve exhausted all the other alternatives.”

Sir Winston Churchill

“Somebody has to do something, and it’s just incredibly pathetic that it has to be us”

the late Jerry Garcia of the Grateful Dead

Why We Do What We Do

- We believe we really can change the world around us.
- "**Never doubt** that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has." —Margaret Meade

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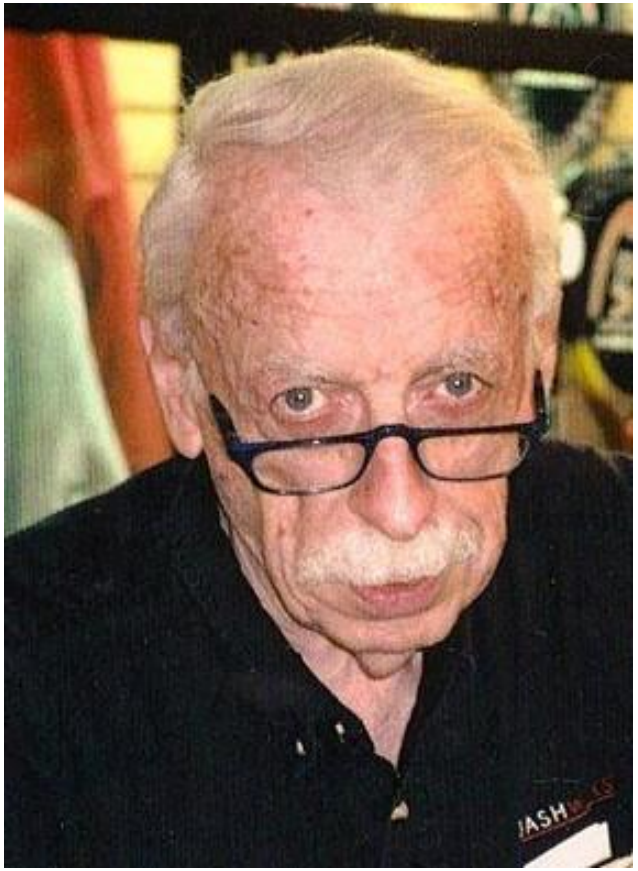
John H. Bennett

March 12, 1926 to September 24, 2016



- Father, Grandfather, Great Grandfather
- Athlete
- Independent, Determined, Private Soul
- Philosopher, Humorist, Optimist, Wanderer

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John H. Bennett

- Arthritis
- Prostatitis
- High Blood Pressure
- Kidney Failure
- Aneurysmal Disease
- Amputee
- Ulcers
- Antibiotic Resistant Infections
- Depression & Anxiety
- A-fib
- Heart Attack
- Angina

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What I've Learned

- Dad's insistence on avoiding the healthcare system didn't always serve him well.
  - And it's hard to know that for sure, or to influence it when you do
- Not everyone views death, and life, through the same lens

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What I Learned

- Our system isn't well-designed to serve the needs of the chronically ill.
  - There was generally no coordination among the 5 specialists who had an active role in caring for him (except when it was provided by our family).
  - Medication errors, overlaps, and adverse interactions were common and confusing
  - Contradictory, or misaligned messaging among providers was common
  - Even his primary care providers (and we tried two different ones) didn't see it as their job to provide this kind of coordination and active management of his care

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What I Learned

- Many providers made heroic efforts on his behalf. The problems we encountered rarely felt like a motivation or skill failures.
- When it worked, it worked masterfully (so I believe better is possible)
  - Physical Rehabilitation Medical Director
  - Nephrologist
  - Hospice Support

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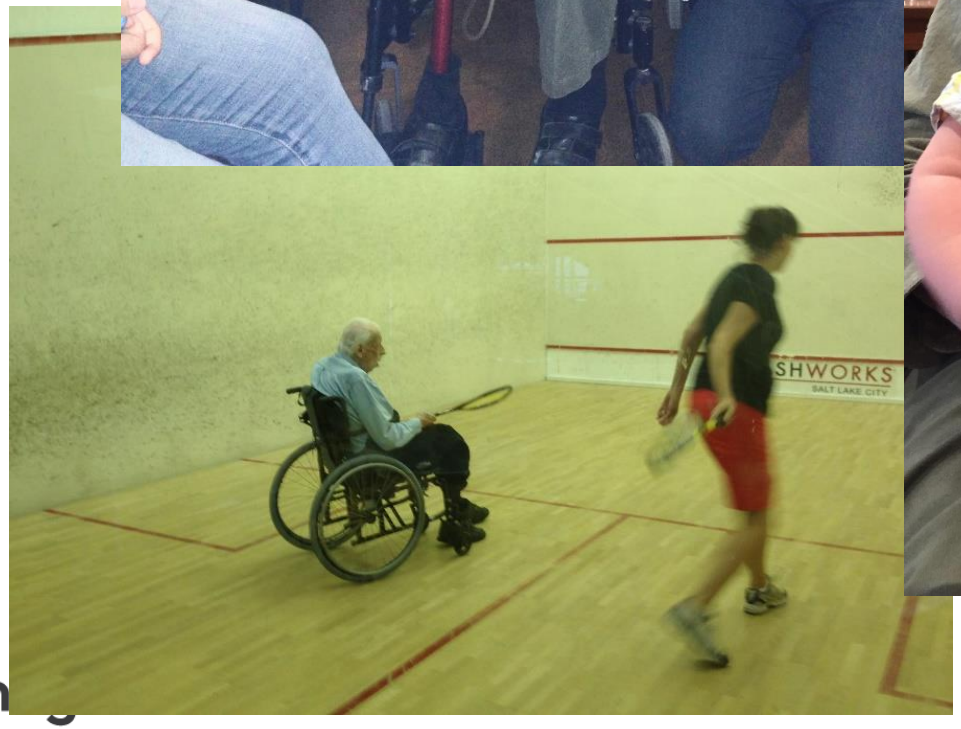

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Reflection and Discussion

- In your work environment, what are the biggest barriers and silos you must break down to reach your improvement and transformation aims?

Encouraging innovation

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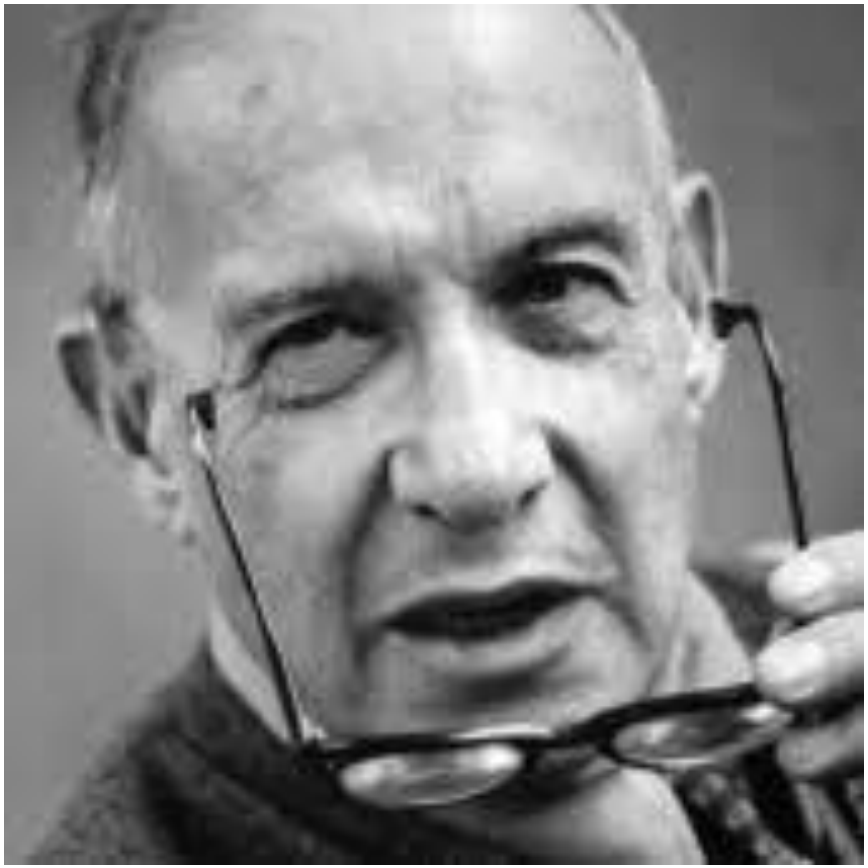

“The best way to predict your future is to create it.”

Peter Drucker

Choosing to Change

Where we were?
(our nostalgia)

Where we are?
(our stress)

Where we are going?
(our potential)

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Be the Change We Seek

- What does that mean?
- Why do we need to transform, anyway?
- How do I begin?

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Principles Needed to "Be the Change"

1. **It's all about the patient**

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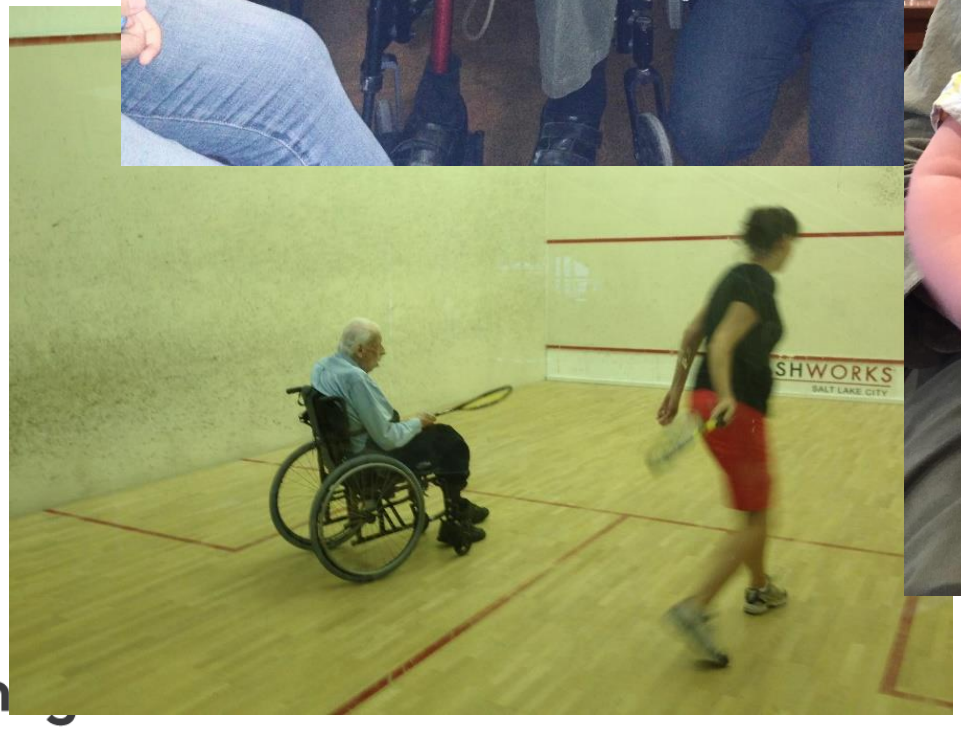

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Principles Needed to "Be the Change"

1. It's all about the patient
2. **Bad processes beat good people every time**

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Delivery System Reform

Pay Providers

Deliver Care

Distribute Information

Credit: Tom Evans, MD; Iowa Healthcare Collaborative

Principles Needed to "Be the Change"

1. It's all about the patient
2. Bad processes beat good people every time
3. **Eliminate waste**

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EXHIBIT 1

Estimates of Waste in US Health Care Spending in 2011, by Category

	Cost to Medicare and Medicaid[a]			Total cost to US health care[b]		
	Low	Midpoint	High	Low	Midpoint	High
Failures of care delivery	$26	$36	$45	$102	$128	$154
Failures of care coordination	21	30	39	25	35	45
Overtreatment	67	77	87	158	192	226
Administrative complexity	16	36	56	107	248	389
Pricing failures	36	56	77	84	131	178
Subtotal (excluding fraud and abuse)	166	235	304	476	734	992
Percentage of total health care spending	6%	9%	11%	18%	27%	37%
Fraud and abuse	30	64	98	82	177	272
Total (including fraud and abuse)	197	300	402	558	910	1,263
Percentage of total health care spending				21%	34%	47%

SOURCE Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," *JAMA* 307, no. 14 (April 11, 2012):1513–6. Copyright © 2012 American Medical Association. All rights reserved.
NOTES Dollars in billions. Totals may not match the sum of components due to rounding. [a]Includes state portion of Medicaid. [b]Total US health care spending estimated at $2.687 trillion.

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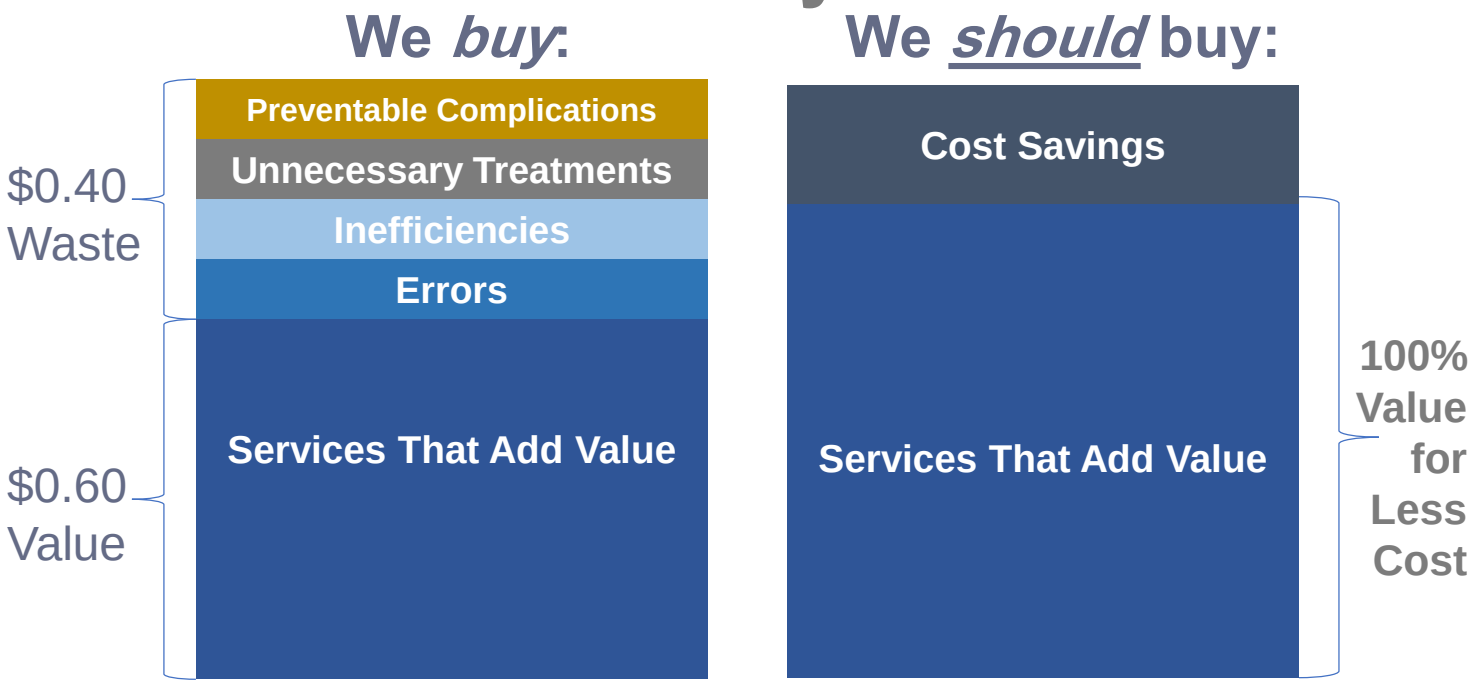
""Health Policy Brief: Reducing Waste in Health Care," *Health Affairs*, December 13, 2012. http://www.healthaffairs.org/healthpolicybriefs/

“Value” Reform: The Vision

For every $1:



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Credit: Pacific Business Group on Health (PBGH)

Principles Needed to "Be the Change"

1. It's all about the patient
2. Bad processes beat good people every time
3. Eliminate waste
4. **“Run to space”**

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The Art of Seeing the Future

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“We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten.”

Bill Gates Jr.

Principles Needed to "Be the Change"

1. It's all about the patient
2. Bad processes beat good people every time
3. Eliminate waste
4. “Run to space”
5. **Don't fear failure**

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Characteristic	Failing	Failing Forward
Motto	Get it Right the First Time	Test hypothesis, fail (quickly) and improve
World View	Solving Problems is liking baking bread	Solving Problems is like raising a child
Beginning Premise	If we plan enough, we can get it right	We can figure it out over time if we have a way to test hypothesis and improve
Implementation Protocol	Follow implementation Plan	Test hypothesis, iterate as needed, chart new course if called for
Use of Data	Data used to report on past activities	Data used to test assumptions, guide current activities and inform decisions
When things go wrong…	Hide mistakes and/or apportion blame	Share mistakes, analyze and refine hypothesis and/or form new ones
Follow-up from mistakes	Increase intensity, continue doing exact same thing or stop doing it	Next step is dependent on lessons learned

Lessons from the 100,000 Homes Campaign

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Principles Needed to "Be the Change"

1. It's all about the patient
2. Bad processes beat good people every time
3. Eliminate waste
4. “Run to space”
5. Don't fear failure
6. **Respect the limits of rules and incentives**

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“Rational common interests and rational individual interests are in conflict. Our failure as a nation to pursue the Triple Aim meets the criteria for what Garrett Harden called a “tragedy of the commons.” As in all tragedies of the commons, the great task in policy is not to claim that stakeholders are acting irrationally, but rather to change what is rational for them to do.”

- Don Berwick, Health Affairs, May/June 2008

Principles Needed to "Be the Change"

1. It's all about the patient
2. Bad processes beat good people every time
3. Eliminate waste
4. “Run to space”
5. Don't fear failure
6. Respect the limits of rules and incentives
7. **Restore joy in work**

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“Management’s overall aim should be to create a system in which everybody may take joy in his work.”

Dr. W. Edwards Deming

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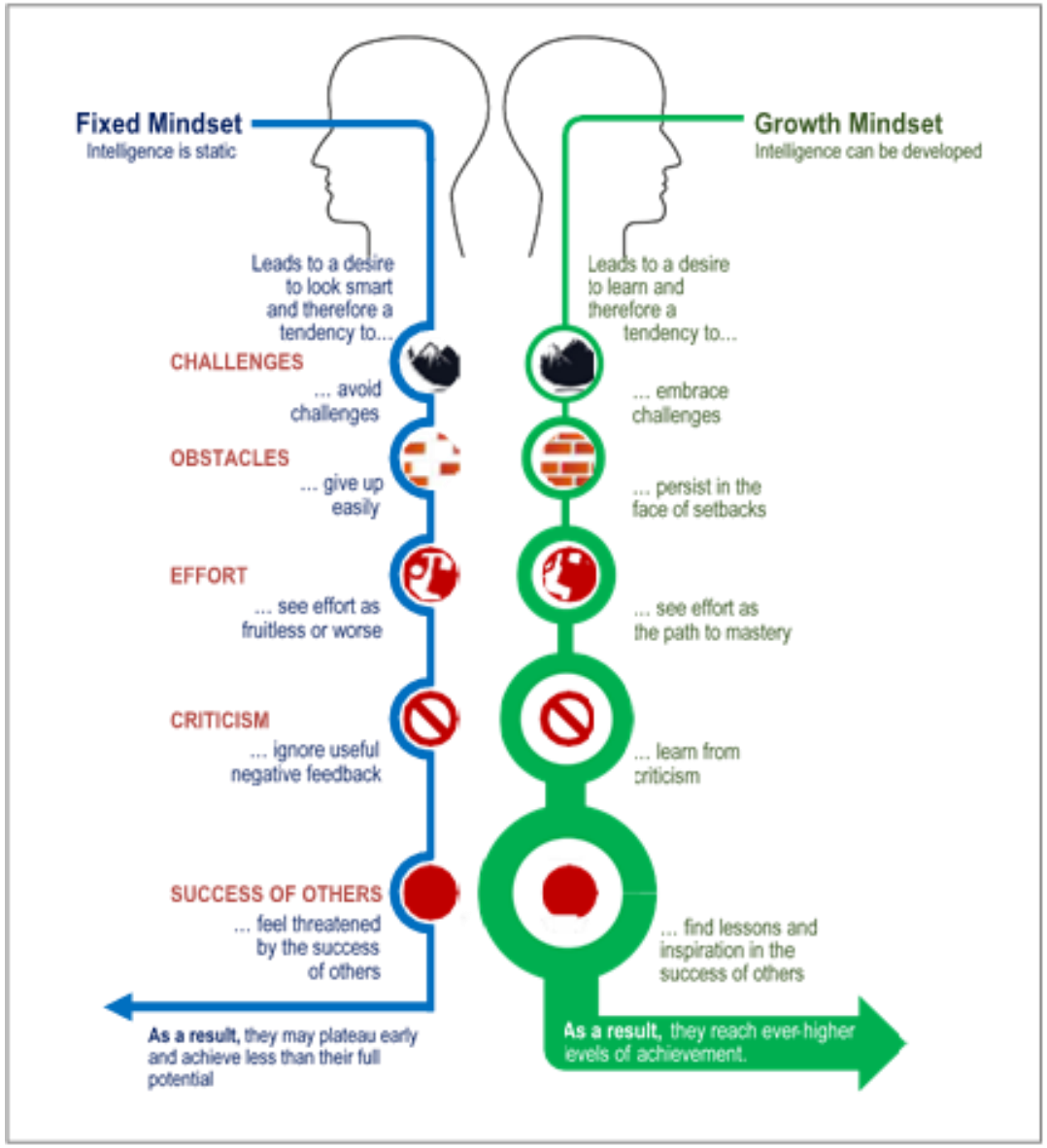
Build Resiliency: Fixed & "Growth" Mindsets

QUESTION: **How can I address one Fixed Mindset on my Team to improve the rapid adaptation to change?**



RESOURCES:

Mindset, Carol Dweck, Ballantine Books (2007) Carol Dweck

TEDTalk http://bit.ly/1sGo5Q0 Carol Dweck Podcast http://bit.ly/2wsnTcR

Mindset Online Self-Assessment (*free*) http://bit.ly/2jIABQu

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Credit: Paul McGann, MD; CMS

Principles Needed to "Be the Change"

1. It's all about the patient
2. Bad processes beat good people every time
3. Eliminate waste
4. “Run to space”
5. Don't fear failure
6. Respect the limits of rules and incentives
7. Restore joy in work
8. **Culture eats strategy for breakfast**

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“Culture eats strategy for breakfast.”

Peter Drucker

"At Zappos, our belief is that if you get the culture right, most of the other stuff—like great customer service, or building a great long-term brand, or passionate employees and customers— will happen naturally on its own."

Tony Hsieh

“The thing I have learned at IBM is that culture is everything.”

Louis Gerstner

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To Truly Lead Transformation: We Must Be the Change We Seek

It Starts with Our Culture

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Data to Drive Change

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"Big Data"

Data sets that are too large and complex to manipulate or interrogate with standard methods or tools

Source: Google, 2014

Extremely large data sets that may be analyzed computationally to reveal patterns, trends, and associations, especially relating to human behavior and interactions

Source: Google, 2018

Often defined by "The 3 Vs"
Variety, Volume, Velocity

Credit: Tim Ho, MD, MPH
Southern California Permanente Medical Group

Evolve From Data as a Deliverable to Using QI Data for Learning, Understanding & Action

Support national level improvement. Understand and act on variations; spread best practices	Level 3 CMS & National
Support network level improvement. Understand and act on variation; spread best practices	Level 2 Networks (QIN, HIIN, ESRD, more)
Support provider improvement through their use of their own data. Optimize EHRs at provider level. Support real time access to performance information	Level 1 Providers Organizations

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Credit: Dennis Wagner; CMS

Some Key Uses of Data

- Performance Reporting
- Equitable Care
- Decision Support
- Patient-facing Decision Support
- Clinical Improvement
- Panel Management
- Policymaking
- Regional Outreach and Engagement

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UHIN

We are UHIN.

For over 25 years, Utah has known UHIN as a steadfast solution for electronic data exchange in the healthcare community.

UHIN provides a standards-based, interoperable approach to exchanging information. Today UHIN handles approximately one billion transactions every year, while also operating a health information exchange. We are a national leader in healthcare technology, interoperability and data exchange.

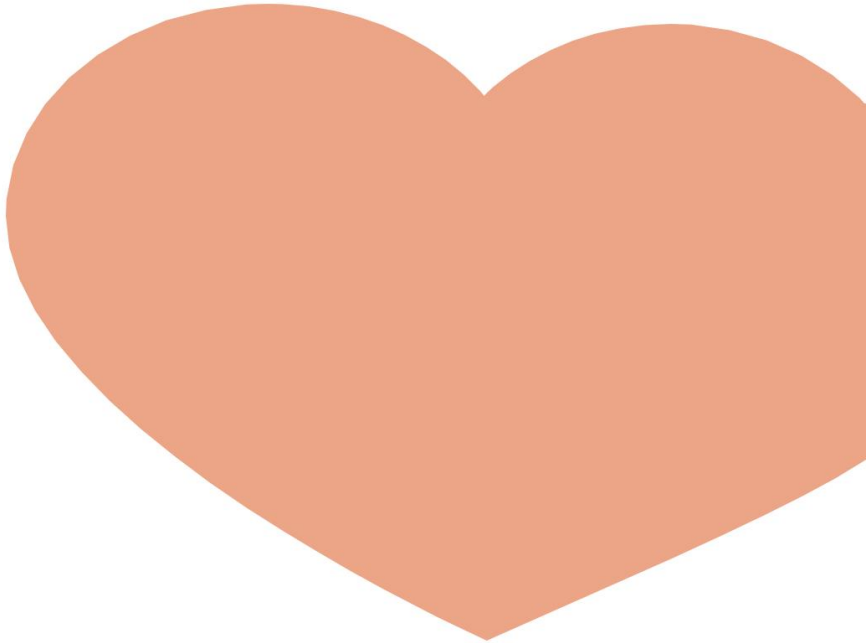
Our Purpose.

We are clinical and claims data experts. We built Utah's Health Information Exchange, the CHIE, and provide a low-cost solution for administrative data exchange for providers and payers. We build solutions with our members' needs in mind.

UHIN

Our Scope.

We securely harness healthcare data and create innovative software solutions for the healthcare community. We seek to assist our members in increasing the quality of healthcare, while reducing the cost.



UHIN

Our Impact.

We work for healthcare providers, payers, ACOs, billing services, the Utah state government and other healthcare partners who need reduced data transmission costs, better access to their data, and the tools/expertise to use their data effectively.

Additionally, we work with practice management systems, other clearinghouses and HIEs to support our members in integration and interoperability of their IT systems across the broader healthcare system.

UHIN

Systems and Processes to Accelerate Change

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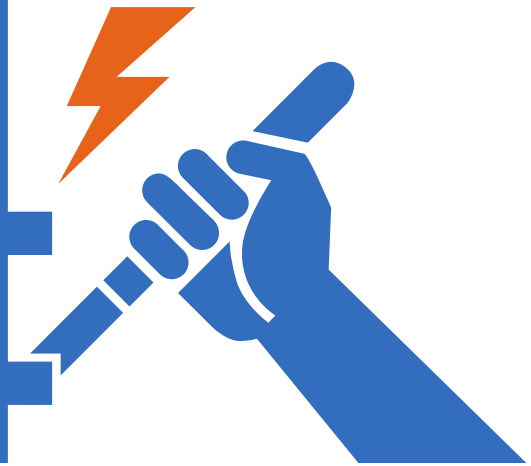
What would it take to fix all this?

Transparency
Data & Information
Aligning Incentives
Community Engagement
Collaboration Across Sectors
New Payment Models
Informed Consumers

Who could do all this?



Principle:

“All models are wrong, some models are useful.”

—George E.P. Box

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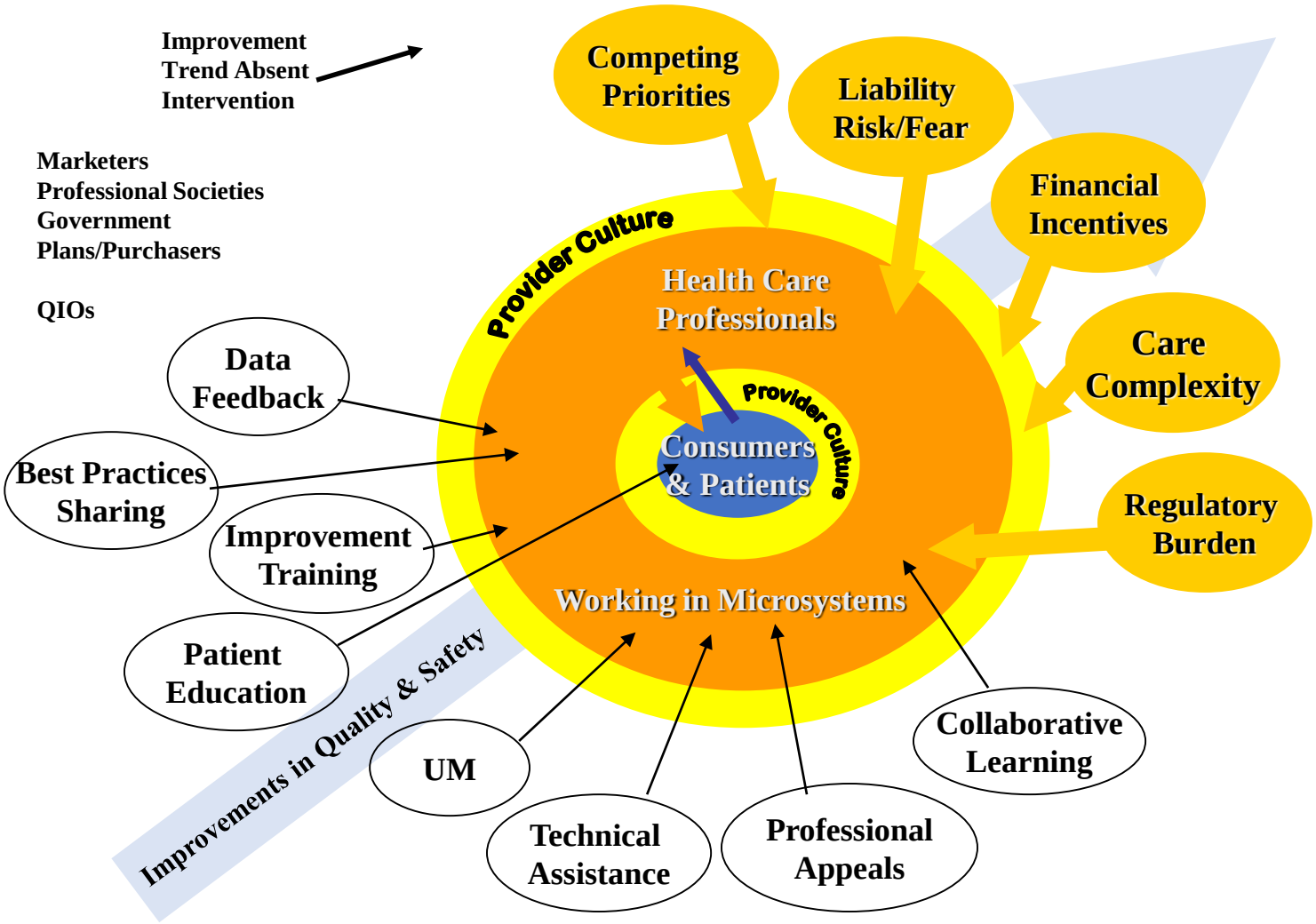
Competencies for Success in the Emerging Environment

Technology and Analytics	HIT and analytics for population care and care coordination	Infrastructure to monitor, manage, and report quality and cost	Track, receive, distribute payments and savings
Management	Governance and leadership with culture of teamwork and improvement	Ability to manage financial risk, contract negotiation; assess options	Provider relationships management
Processes (Clinical and Business)	Expertise in engaging and activating patients Patient education tools	Experience in process redesign and quality improvement; and effectively connecting to community resources	Infrastructure, protocols, and agreement for collaborative care



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The real challenge is that most of our traditional quality improvement strategies are “weak” signals when compared to the strong forces driving results in healthcare. These stronger forces are often pushing back against quality improvement efforts

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The “big levers” need to be redesigned to align with system aims—dramatically increasing impact—or minimized to limit their impact relative to other push or “nudge” efforts.

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Premise:

Moving these “transformational” levers will be more effective than simply working harder and smarter at traditional QI.

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Further premise:

We can’t work on these transformational change strategies one at a time. The dramatic results we seek will require that we remove several barriers and redesign the system simultaneously.

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Further, Further Premise:

We can’t work the big levers alone. We need partners and we need broad co-ownership of the aims and of the work.

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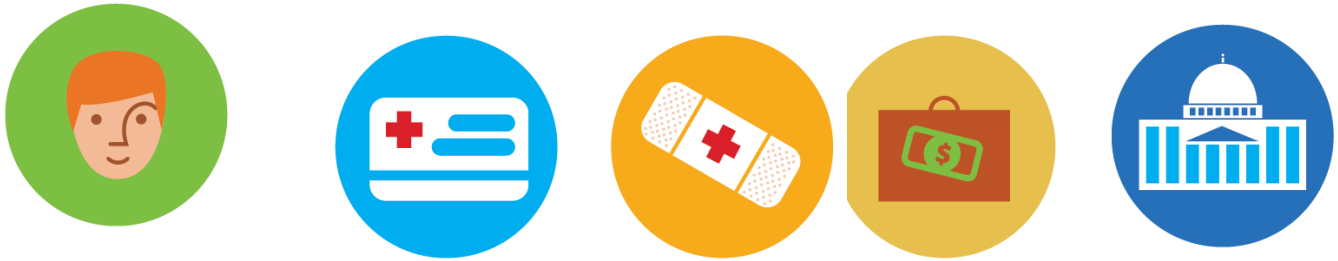
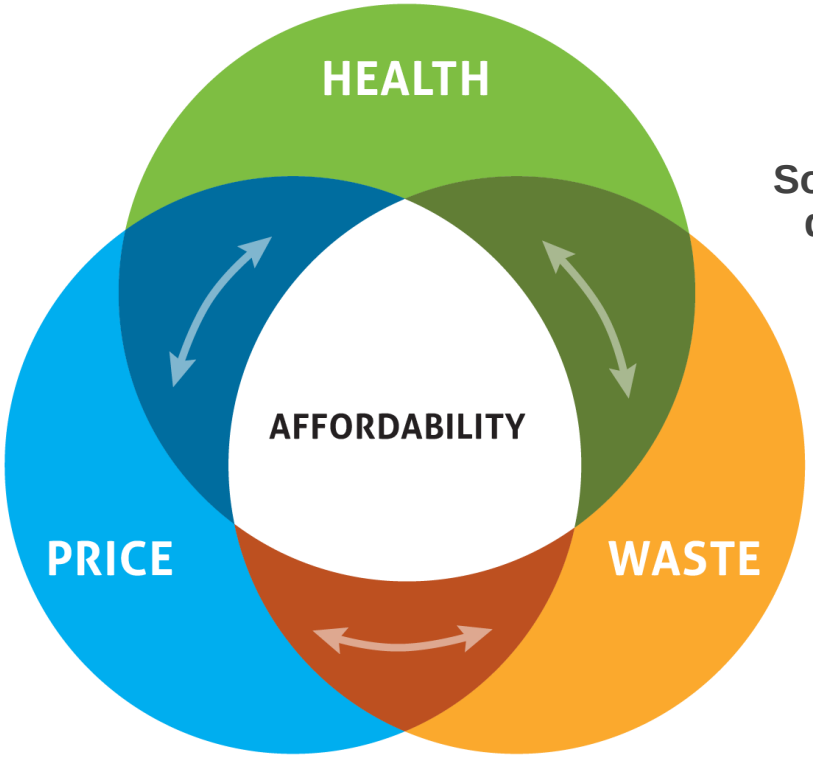
We ALL created this problem.
We ALL need to be part of the solution.

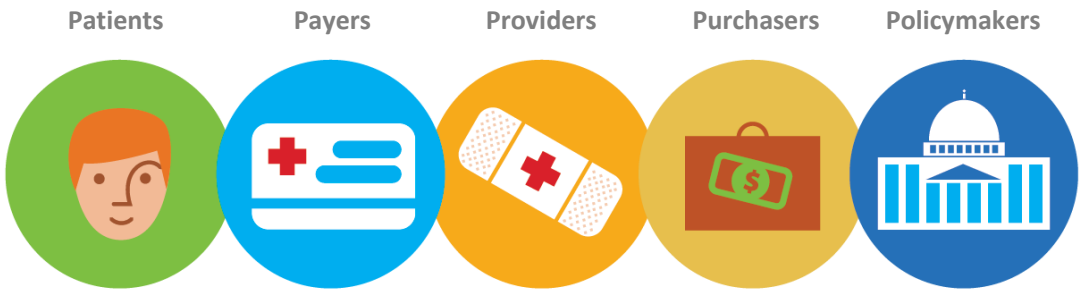


The major drivers of affordability.



Solving one issue in isolation does not achieve the goal.

There is hope.



In many regions across the country we are coming together to untangle complexities and find a path to affordability.

Addressing the drivers of affordability has systemic benefits — in addition to the positive economic impact.

+ HEALTH

Healthier populations:

- use fewer resources
- increase productivity
- enhance communities

- WASTE

Unnecessary clinical procedures:

- increase clinical harm
- cause emotional distress
- incur financial harm

Administrative burden:

- increases cost
- is burning out providers

- PRICE

High prices:

- don't correlate with quality
- incentivize waste
- misallocate resources

The Path to Affordable Healthcare

Affordable Care Together
Network for Regional Healthcare Improvement

We have a problem.

The way we receive healthcare in the United States is broken, and as a result Americans are less healthy while paying more.

We all created the situation. It will take all of us working together to solve it.

Patients · Payers · Policymakers · Providers · Purchasers

Regional Health Improvement Collaboratives

What does it take to address the problem?

- Transparency
- Data & Information
- Aligning Incentives
- Community Engagement
- Collaboration Across Sectors
- New Payment Models
- Informed Consumers

Who could do all this?

Patient Education	Paying for What Matters
Analysis & Reporting	Quality Improvement

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Reflection and Discussion

- In your work, what are the most helpful models you have observed or used to support and sustain transformation?
- What are the most important “levers” for change?

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Understanding CMS Strategy

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Transformation of Health Care at the Front Line

At least six components:

- Quality measurement & transparency of measurements
- Comparative effectiveness and evidence available
- Health information technology: usable & interoperable
  - As close to “real-time data” as possible
- Training of clinicians and multi-disciplinary teams
- Aligned payment incentives
- Quality improvement collaboratives and learning networks

Source: P.H. Conway and Clancy C. Transformation of Health Care at the Front Line. JAMA 2009 Feb 18; 301(7): 763-5

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CMS Quality Priorities for 2019

- “Meaningful Measures” (related to clinician burden reduction)
- Fighting the Opioid Epidemic
- Improving Behavioral Health
- Improving Patient Safety (reducing harm caused to patients by the health care system)
- Improving Care and Quality for Patients with Chronic Diseases
  - Diabetes
  - Cardiovascular Disease
  - CKD and ESRD (renewed focus since 10 July 2019)
- Continuing to improve the Quality of Care Transitions
- Improving Quality of care in Long Term Care, including reducing abuse of patients in Nursing Homes

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Improving Quality of Care in Long Term Care, including reducing abuse of patients in Nursing Homes

The OIG determined that **3,330** of the incidents occurred in some type of medical facility,

- More than 9,000 were associated with an incident that was not reported to law enforcement

https://skillednursingnews.com/2019/06/oig-calls-on-cms-to-crack-down-on-abuse-in-nursing-homes-other-settings/

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Clear Direction

“We are moving away from fee-for-service.”

Administrator Seema Verma

CMS Quality Conference, 2018

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Weaknesses of Fee for Service Payment

Credit: Paul McGann, MD; CMS

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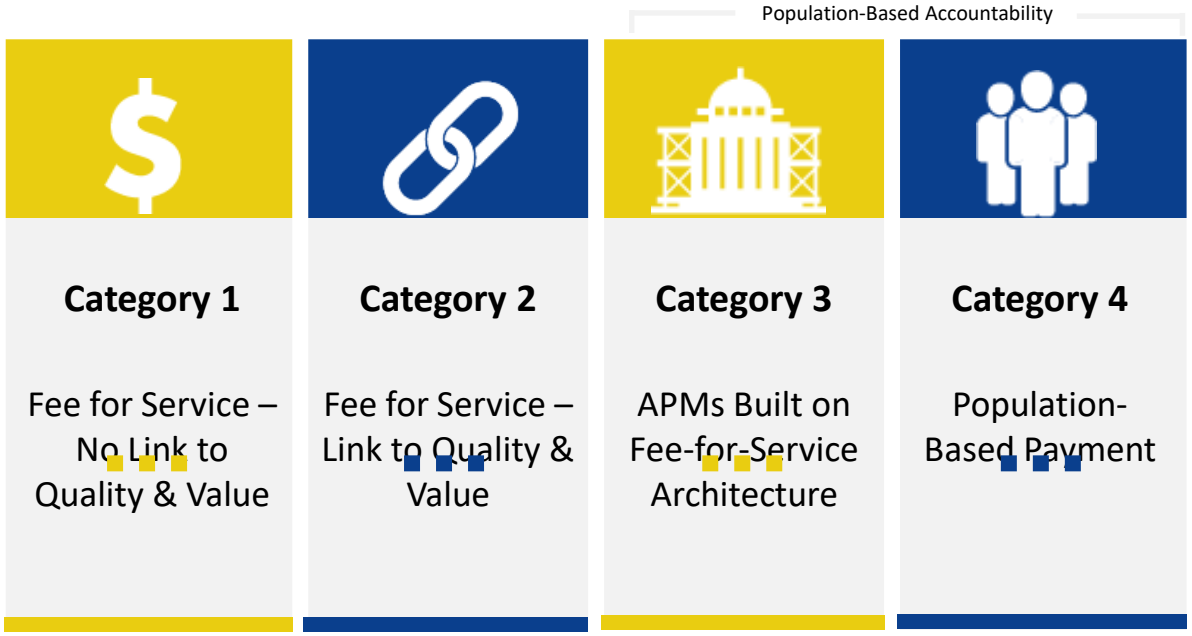
CMS has Adopted a Framework that Categorizes Payment to Providers



Source: Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

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Credit: Paul McGann, MD; CMS

Characteristics of this work

- It is “cutting edge” (many clinicians have not done this before)
- It requires the understanding and acceptance that FFS is almost over
- It requires advanced data capabilities
- It requires teamwork
- “Person (Human) Centered Design” is very helpful
- “Agile” project management is very helpful
- It requires excellent change management skills and capability

Credit: Paul McGann, MD; CMS

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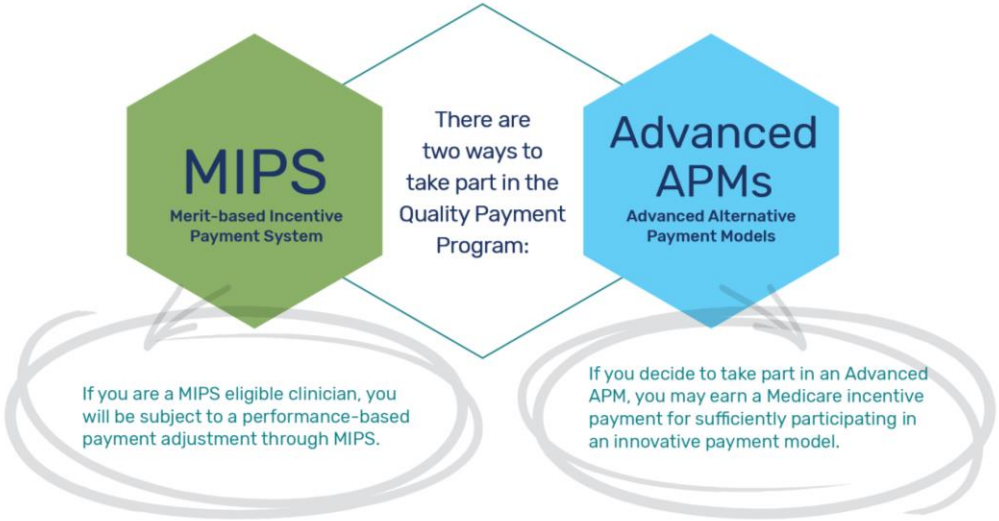
Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides two participation tracks:



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Credit: Paul McGann, MD; CMS

Considerations

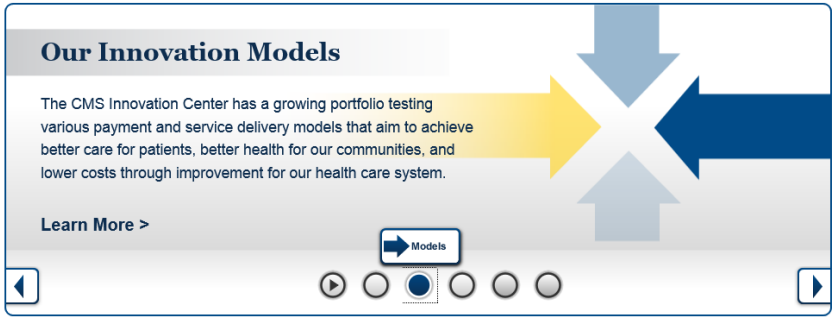
Quality Payment Program

- Improve beneficiary outcomes
- Reduce burden on clinicians
- Increase adoption of Advanced APMs
- Maximize participation
- Improve data and information sharing
- Ensure operational excellence in program implementation
- Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov

Credit: Paul McGann, MD; CMS

Innovation Continues: CMMI Recent Models



Accountable Care	Accountable Care	Episode-based Payment Initiatives	Episode-based Payment Initiatives
Comprehensive ESRD Care Model	**Voluntary Kidney Models**	**ESRD Treatment Choices (ETC) Model**	**Radiation Oncology Model**
The Comprehensive ESRD Care Model is designed to improve care for beneficiaries with ESRD while lowering Medicare costs.	These models incentivize kidney disease prevention, encourage kidney transplantation and offer distinct payment options to further these goals.	Encourages greater use of home dialysis and kidney transplants for Medicare beneficiaries with ESRD, while reducing Medicare expenditures and preserving or enhancing the quality of care furnished to beneficiaries with ESRD.	This proposed model aims to improve quality of radiotherapy treatments for cancer patients and reduce provider burden through a predictable payment system.
Stage: Ongoing, Announced	Stage: Announced	Stage: Announced	Stage: Announced

Primary Care Transformation	Primary Care Transformation	Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models	Initiatives to Speed the Adoption of Best Practices
Direct Contracting Model Options	**Primary Care First Model Options**	**Emergency Triage, Treat, and Transport (ET3) Model**	**Medicare Diabetes Prevention Program (MDPP) Expanded Model**
Voluntary payment model options that innovate Medicare fee-for-service approaches to produce value and high-quality care outcomes.	Voluntary payment model options that reward value and quality through innovative payment structures and emphasizing the doctor-patient relationship supporting advanced primary care.	Voluntary payment model that will provide greater ambulance care team flexibility to address Medicare beneficiary emergency care needs following a 911 call.	This program is a structured lifestyle intervention to prevent onset of diabetes in pre-diabetic individuals.
Stage: Announced	Stage: Announced	Stage: Announced	Stage: Participants Announced, Ongoing

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Credit: Paul McGann, MD; CMS

State Medicaid Agencies: "Laboratories of Democracy"

- "1115 Waivers" enabling experimentation
- Common strategies, especially enabling communities to implement cross-sector interventions
  - New York's "Performing Provider Systems" (PPS)
  - North Carolina's "Health Opportunities"
  - Oregon's "Coordinated Care Organizations" (CCO)
  - Washington's "Accountable Community of Health" (ACH)

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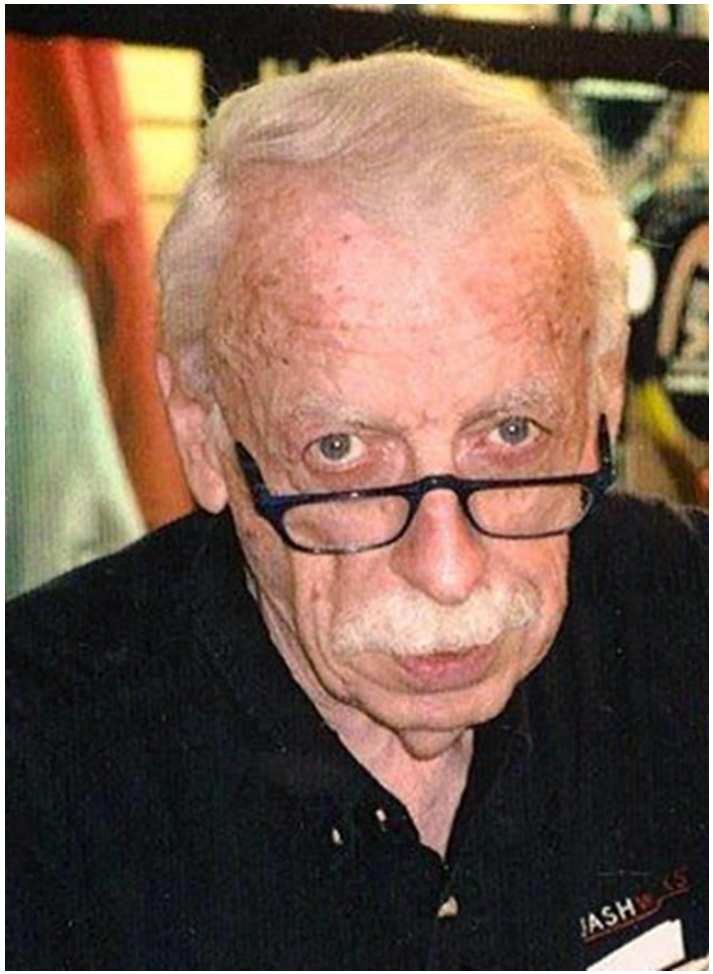
Why This All Matters



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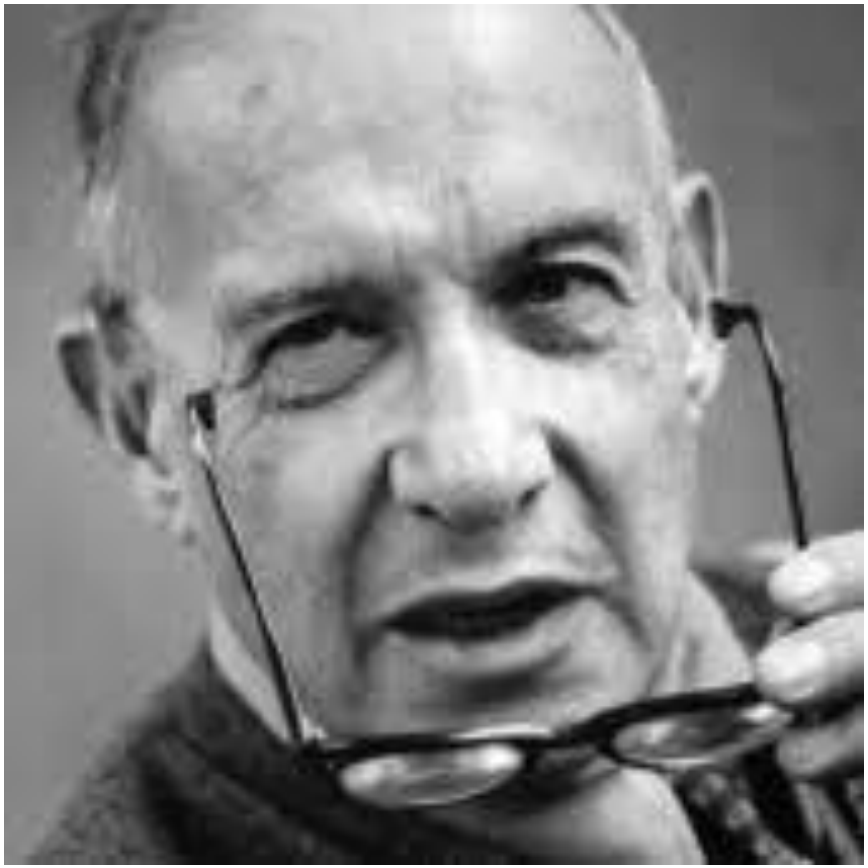
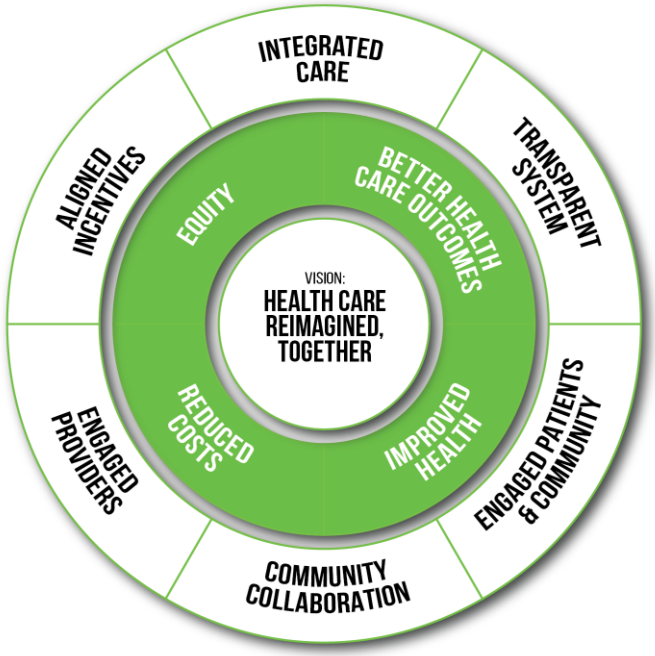


“The best way to predict your future is to create it.”

Peter Drucker

Comagine Health Outcomes: Equity; Improved Health; Better Health Care Outcomes; Reduced Costs



- **Equity.** Diversity is valued and respected. Disparities in health and related outcomes associated with socio-economic status, race or ethnicity, gender or identity, rurality, access to care or other differences are actively identified and eliminated.
- **Improved Health.** Communities and the health care system focus on the health of all people. There is respect for, attention to, and investment in connectedness and community, the livability of the environment, safety, education, economic stability and security, and other social determinants of our health.
- **Better Health Care Outcomes.** The health care system uses effective processes to achieve high quality outcomes for all patients.
- **Reduced Costs.** Participants in the health care system understand that there are constraints on resources available. Accordingly, health-related policy decisions and improvement interventions are guided by the potential value they can produce. Total cost of care is reduced and health care is affordable for all.

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Why We Do What We Do

- We believe we really can change the world around us.
- "**Never doubt** that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has." —Margaret Meade

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Questions?

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