



Care delivery model work group meeting

STATE OF CONNECTICUT
DRAFT

Care Delivery Work Group Discussion
May 13, 2013

Agenda

**Introduce care delivery work
group team**

20 min

Share Connecticut's State Innovation
Model context, vision, and roadmap

40 min

Review target population and align on
prioritized sources of value

60 min

Welcome to the SIM design care delivery work group

■ Co-chairs

Mark Schaefer, PhD
Associate Project Director

Robert McLean, MD
Internal medicine physician, rheumatologist

Peter Bowers, MD
Anthem BCBS

Lynn Rapsilber, MSN, APRN
CT Advanced Practice Nurse Society

Meredith Ferraro, MS
Executive Director, Southwestern AHEC

Elsa Stone, MD
Pediatrician

Alice Forrester
Clifford Beers Child Guidance Clinic

Rosemary Sullivan, RN
Cigna

Jeff Howe, MD
Family physician

Thomas Woodruff
Office of the State Comptroller

Dawn H. Johnson, RN, MSN
Consumer

Bill Young
COO, Alcohol Drug Rehabilitation Center

Sal Luciano
Consumer, Union

Robert Zavoski, MD
Department of Social Services

Adam Mayerson, MD
Endocrinologist

NOTE: parallel process: UConn/DPH on workforce; DMHAS (Sue Niemitz), DPH, DCF - will attend as appropriate

Agenda

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Connecticut has a unique opportunity to address quality, access, and cost challenges today

Although Connecticut ranks at or above the national average on many indicators of health, there exists opportunity for improvement

- Connecticut is among the top five states with the lowest rates of smoking, premature deaths, and poor mental health days and the highest rates of immunization coverage; is among the top quartile of states with the lowest obesity rates; and is among the top 50% of states with the lowest rates of preventable hospitalizations, diabetes, infant mortality, cardiovascular deaths, and cancer deaths
- Health disparities, however, continue to exist across racial and ethnic groups, illustrated by the variability in the infant mortality rate of non-hispanic black infants that is 3x that of non-hispanic white infants

At the same time, Connecticut lacks a solution for the state to address the steep growth in state health expenditures

- Connecticut faces a potential ~\$1B budget deficit in 2014 and 2015, driven in part by an increase in health care spending, which continues to grow at a rate higher than Connecticut's gross state product
- Inefficiencies in health care utilization continue to exist today, illustrated by the significant utilization of high-cost care settings (e.g., emergency department) for non-urgent visits

While Connecticut has many payment and care delivery innovations underway, no common model is shared across Medicaid, Medicare, and Commercial insured populations

The funding and endorsement of the Center for Medicare and Medicaid Innovation (CMMI) as part of the State Innovation Models (SIM) initiative provides a unique opportunity for key stakeholders within the community to address these quality, access, and cost challenges in a statewide, multi-payer collaboration

CT has support from CMMI to innovate care delivery and payment model reforms and has high aspirations for what it can achieve

CMMI guidance for State Innovation Models (SIM) design states . . .

- Design care delivery and payment reform that touches **80% of state lives within 5 years**
- Roll-out across multiple payers' populations in a truly **multi-payer approach**
- Describe how **“broad-based accountability for outcomes, including total cost of care** for Medicare, Medicaid, and CHIP beneficiaries, is created”
- Test innovative payment and service delivery models that have the potential to **“lower costs,”** while **“maintaining or improving quality of care”**

. . . helped shape Connecticut's targeted aspirations

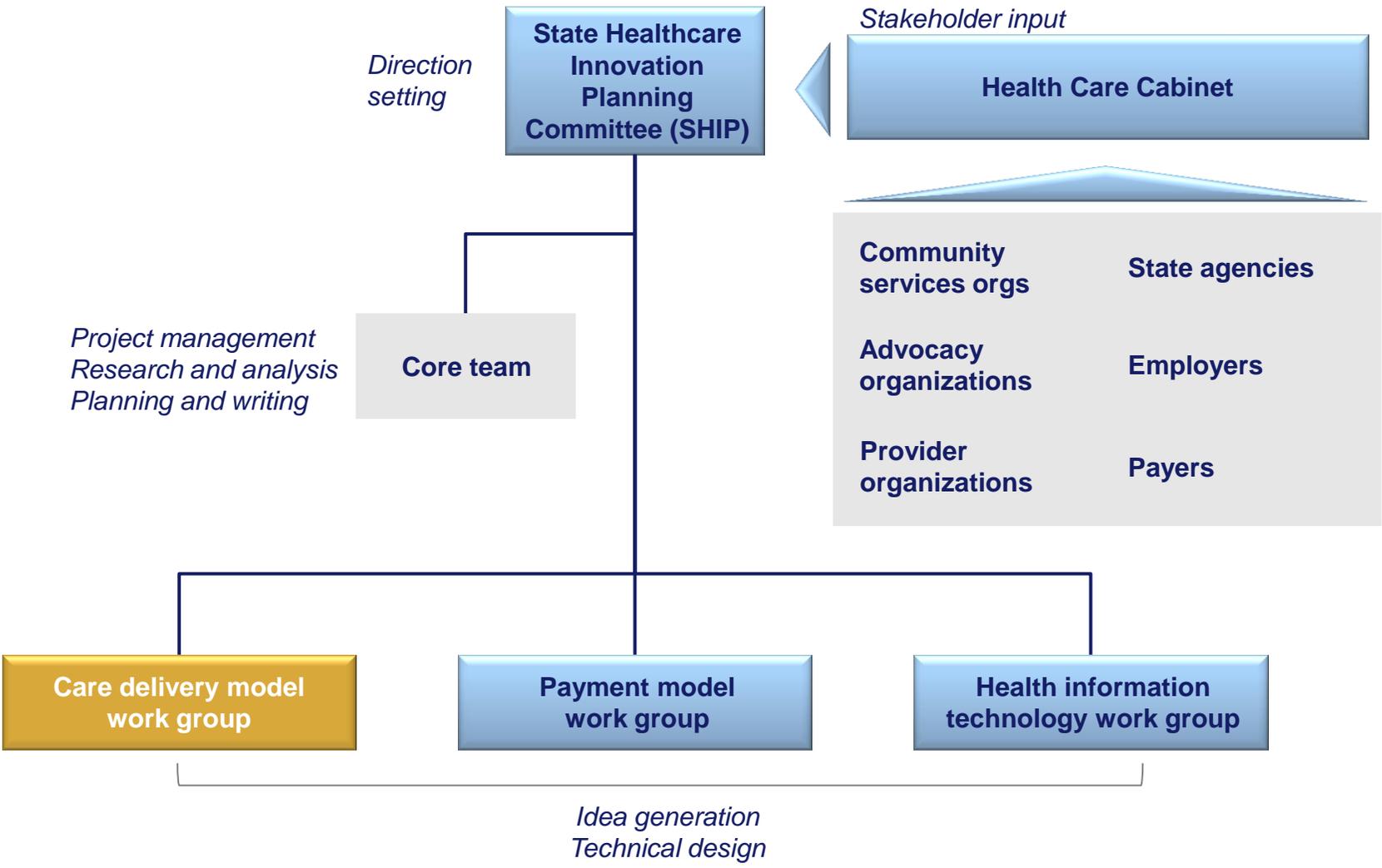
- Gain alignment around a common care delivery and payment model that is applicable across Medicare, Medicaid, and Commercial populations
- Define a solution that incorporates total cost of care accountability
- Maintain or improve leading indicators of health and patient experience under the new care delivery and payment model
- Establish timeline for rollout that will meaningfully curb health care spending growth within 3-5 years

We will largely define and design the SIM care delivery and payment models by the end of July 2013



April	May	June	August
Project set up and initial hypotheses <ul style="list-style-type: none"> Understand current state Establish vision 	Current state, best practice, and options <ul style="list-style-type: none"> Identify target populations and sources of value Develop health care delivery system hypothesis Pressure-test health care delivery system hypothesis Develop payment model hypothesis Align key stakeholders 	Design and planning <ul style="list-style-type: none"> Design detailed health care delivery system and payment model Develop implementation and roll-out plan Align on key quality metrics 	Syndication <ul style="list-style-type: none"> Draft testing proposal Syndicate with key stakeholders
			Finalization <ul style="list-style-type: none"> Refine and submit testing proposal

The care delivery model work group will provide recommendations to SHIP, the primary decision-making body



Working group norms - expectations for how we will work together

Presence

Expectations of work group members

- Attend bi-weekly meetings with full group
- As needed, meet with Core Team in between meetings to move the answer forward

Mindset

- Leave day job at the door, think of the best interest of Connecticut's citizens
- Seek consensus amongst working group to make recommendation to State Healthcare Innovation Planning Committee (SHIP)
- Recognize that project is on a tight timeline and milestones must be met

Action

- Build momentum and excitement in your respective communities
- Champion this effort with your colleagues and in the community
- Be part of implementing the solution



Agenda

Introduce care delivery work group team *20 min*

Share Connecticut's State Innovation Model context, vision, and roadmap *40 min*

Review target population and align on prioritized sources of value *60 min*

We will come to a recommendation by addressing key questions related to the focus, design, and implementation of an innovative care delivery model

 Today's discussion

Care delivery model work group recommendation

Focus of efforts

- Who are the target populations?
- What is the scope and scale of innovation we want to foster?
- What are the key sources of value to address?
- What barriers need to be overcome?

Model design

- What interventions and changes in behaviors, processes, and structures are required to capture prioritized sources of value?
- How will the care delivery model be defined based on the required changes?

Implementation plan

- What will be the performance and outcomes measures?
- What are the implications for:
 - Payment model
 - Data/ analytics
 - Workforce
 - Policy
- How will the care delivery model be phased?

We will focus on designing a care delivery model that targets the general population as part of the CT SIM design effort

 Focus

Description	Relevance to payers		
	Medicaid	Commercial	Medicare
Elderly/ adults (Chronic, at-risk) <ul style="list-style-type: none"> High risk adults and elderly ages 18+ with one or more chronic conditions Excludes dual-eligibles 	✓	✓	✓
Elderly/ adults (All the rest) <ul style="list-style-type: none"> Health adults and elderly ages 18+ Excludes dual-eligibles 	✓	✓	✓
Pregnant women/ newborns <ul style="list-style-type: none"> Maternal and neonatal care 	✓	✓	
Children <ul style="list-style-type: none"> Children, from newborn-18 years old (excluding special needs) insured by Medicaid or Commercial 	✓	✓	
Duals <ul style="list-style-type: none"> High risk adults dually-eligible for Medicaid and Medicare 	✓		✓
Other special needs <ul style="list-style-type: none"> Other populations requiring long-term services and supports, those with Severe and Persistent Mental Illness, and/or Developmental Disabilities 	✓		

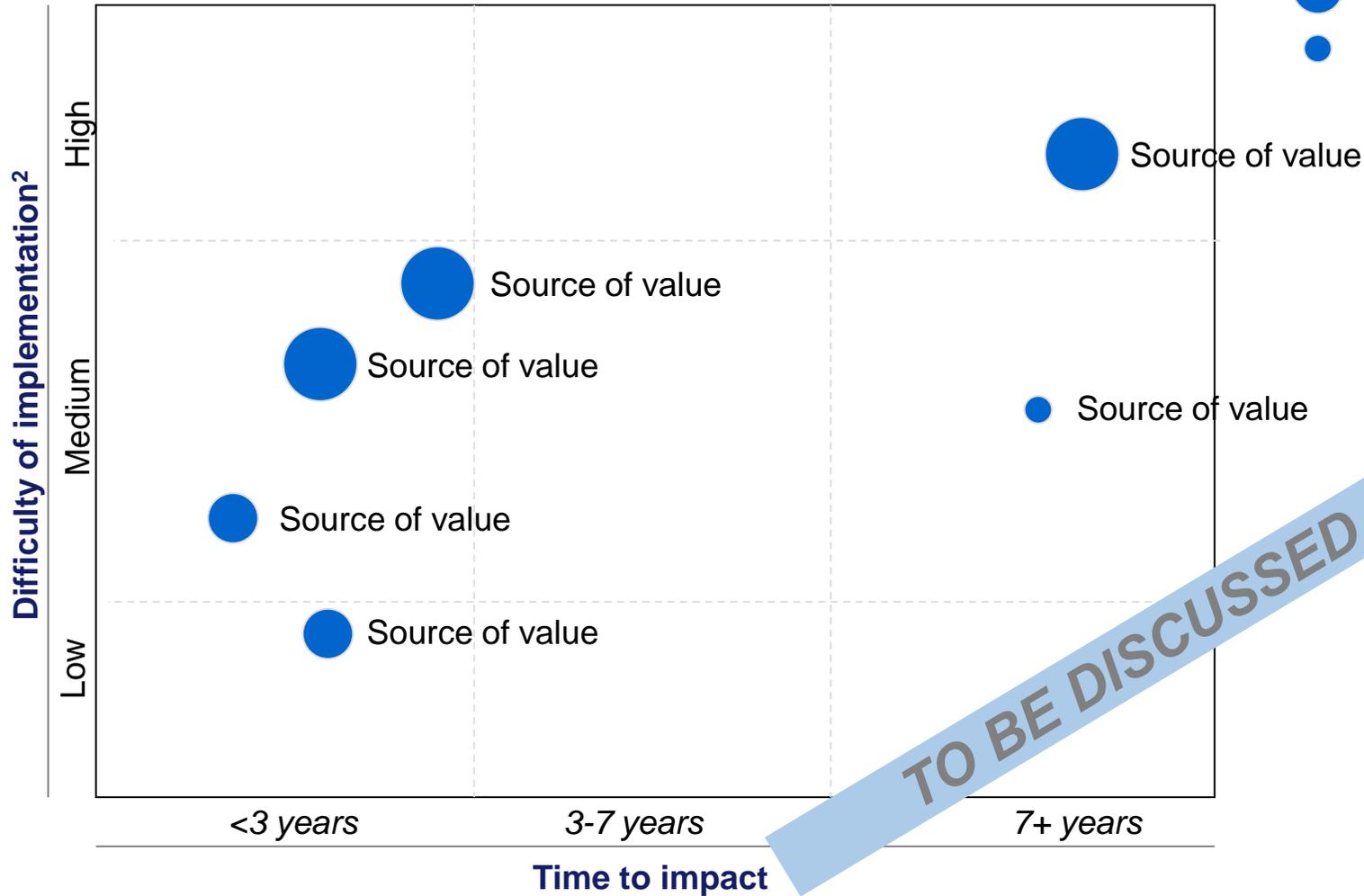
We will consider three broad care delivery models

	Description	Examples	
Population health	Provider(s) responsible for the overall health of a population of patients over a set period of time		Relationships with CT physician groups to support practice of evidence-based medicine and coordinated care, particularly for patients with chronic conditions
			Patient centered primary care program which supports access to primary care and enhances care coordination
Episodes of care	Provider(s) with direct or indirect control over majority of care delivery for a defined acute procedure or condition are responsible for all care associated with the procedure or condition (e.g., CABG)		Best practices created for discrete episodes based on national or local guidelines and enforced standard clinical protocols
			
Discrete encounters	Specialty or service providers with direct control over discrete components of care delivery are responsible for providing targeted care		Dedicated specialty hospital treats discrete eye procedures at lower costs and higher quality than in US

We will prioritize two or three sources of value to be targeted during care delivery model design

	Description	Examples
Primary prevention	<ul style="list-style-type: none"> Prevention of disease by removing root causes 	<ul style="list-style-type: none"> Smoking cessation Diet and exercise
Secondary prevention/ early detection	<ul style="list-style-type: none"> Early detection of disease while asymptomatic to prevent disease progression 	<ul style="list-style-type: none"> Cervical cancer screening Identification and management of patients at high risk for heart disease
Selection of provider type and care setting	<ul style="list-style-type: none"> Utilizing highest value provider types and care settings 	<ul style="list-style-type: none"> Choice of care setting for immunization administration Optimized utilization of physician extenders
Effective diagnosis and treatment selection	<ul style="list-style-type: none"> Evidence-informed choice of treatment method/intensity 	<ul style="list-style-type: none"> Enforcement of evidence-based inpatient clinical pathways
Provider productivity	<ul style="list-style-type: none"> Reducing waste at provider center 	<ul style="list-style-type: none"> Improve flow in OR to increase number of surgeries performed daily Streamline emergency room triaging
Care coordination / chronic disease management	<ul style="list-style-type: none"> Ensuring patients effectively navigate the health system and adhere to treatment protocols 	<ul style="list-style-type: none"> Care coordination, across specialties and care channels for chronic conditions (e.g., CHF, diabetes)

These sources of value can be prioritized based on size and timing of impact, and feasibility of implementation

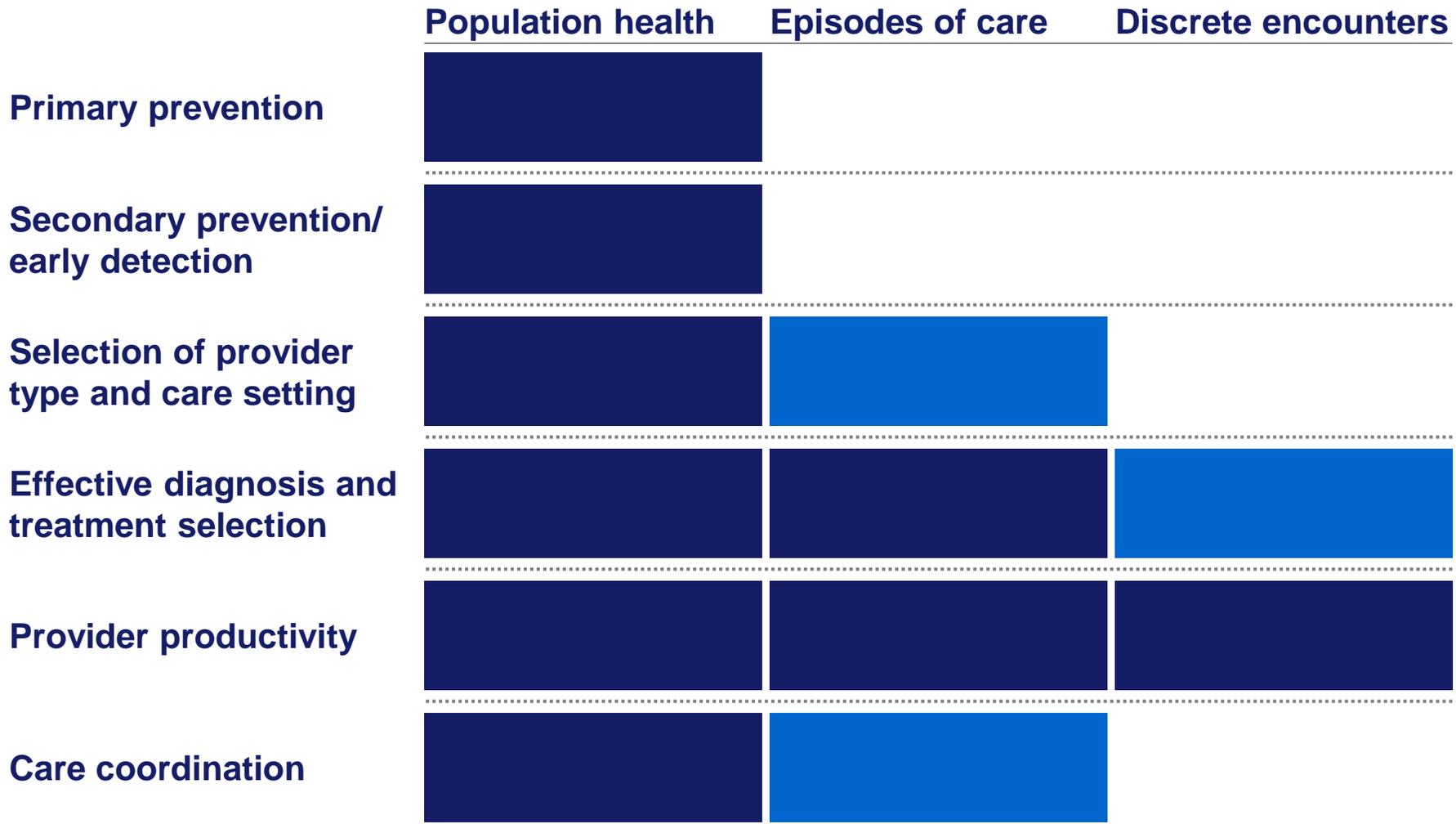


1 Estimation of total cost of care savings based on literature reviews, case examples, and CT and national statistics
2 Consideration of historical success rates and execution risk

The three care delivery models address different sources of value at different levels

Level of Influence¹

■ Direct ■ Sometimes



¹ Influence will vary by type of organization involved (e.g. integrated delivery system vs. Independent Practice Association)

What barriers does Connecticut's current care delivery system need to overcome?

Purpose

- Understand barriers that limit health, outcomes, access, and quality and increase cost levels in Connecticut today

Approach

- Individually: Write down the 2-3 largest barriers to capturing the sources of value that we prioritized in Connecticut today across consumers, providers, and the broader community
- Break-out into groups of 3 to come to consensus on the top 5-10 barriers
- Return to the larger group to share output

Timing

- **3 minutes:** Individual brainstorming
- **7 minutes:** Break out
- **5 minutes:** Report back and discuss as group

In following workshops, we will discuss changes in behaviors, processes, and structures required to address barriers to sources of value

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	Description	Examples
Changes in behaviors	<ul style="list-style-type: none"> What are the individual provider (i.e., clinicians) and patient behaviors that are desired, and what changes must be implemented 	<ul style="list-style-type: none"> Implementing evidence-based practices among groups of physicians/practitioners Engaging providers on the value of treatment selection decisions (patients)
Changes in processes	<ul style="list-style-type: none"> What are the necessary process changes in patient flow, information/data flow, clinical interactions that need to occur 	<ul style="list-style-type: none"> Care team meetings to review risk stratified patient registries Developing care plans with patients Follow-up and reminder phone calls
Changes in structure	<ul style="list-style-type: none"> What structural changes in delivery system are required, in terms of: <ul style="list-style-type: none"> Workforce competencies, capacity, and management Delivery setting (what should happen where) Physical space Governance and organization changes (i.e., how to achieve the “what should happen where?”) 	<ul style="list-style-type: none"> Creating networks to support care coordinators across multiple practices Creating accountable community organizations (e.g., OR CCOs) to align non-medical providers

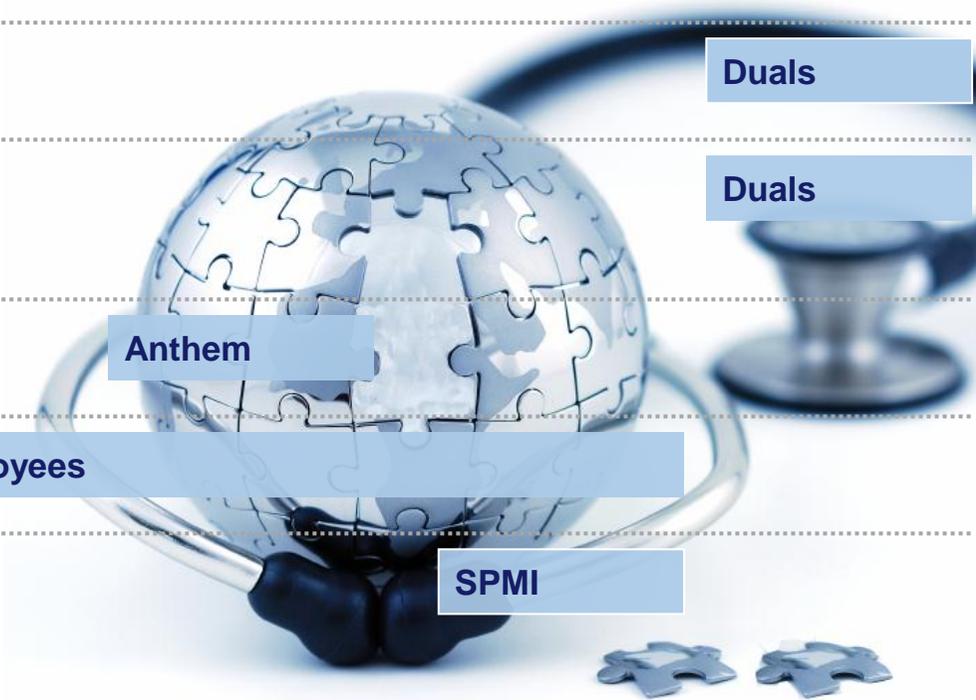
Next steps

- Co-chairs finalize prioritized SOVs based on today's inputs and follow-up conversations by May 17th; prepare recommendation to SHIP
- Work group members compile list of potential interventions that can address barriers to share in next work group meeting
- Convene in next work group meeting on May 28 to consider changes in behaviors, processes, and structures and potential interventions

Appendix

CT has many payment and care delivery innovations, but no model shared across Medicaid, Medicare, and Commercial insured populations

	Children	Adult	Special needs ¹	Duals, elderly
Patient-centered medical home <i>Enhanced FFS performance payment, TCOC accountability (Anthem)</i>	Medicaid			
	Anthem			
ACO <i>ProHealth, Hartford Healthcare, St. Francis, Primed, Collaborative ACO</i>	Cigna			Medicare
Integrated Care Initiative – ASO <i>SSP with state</i>				Duals
Integrated Care Initiative – Health Neighborhood <i>TCOC SSP with providers</i>				Duals
Episode-based payment <i>Joint replacement pilot</i>		Anthem		
Health enhancement program <i>Consumer based incentives</i>	State employees			
SPMI health homes <i>Care coordination capitation</i>			SPMI	



¹ Includes LTSS, SPMI, and DD patients

Care Delivery work group charter

Mandate

The care delivery work group will develop for recommendation to the State Health Care Innovation Plan steering committee a proposal on the design and plan for implementing a person-centered care delivery model. This model will promote the capture of prioritized sources of value (e.g., improved care coordination between primary and specialty care, primary prevention) within the target population. This work group will assess alternative care delivery design options and develop recommendations for the SHIP on key decisions, including those related to care delivery model; workforce development; and community outreach, education, and engagement

Key questions for work group recommendation

- 1 What is the scope and scale of innovation?
- 2 What are the key sources of value to address within target populations?
- 3 What barriers need to be overcome?
- 4 What interventions and changes in behaviors, processes, and structures are required to capture prioritized sources of value?
- 5 How will the care delivery model be defined based on the required changes?
- 6 What will be the performance and outcomes measures?
- 7 What are the implications for payment model, data/ analytics, workforce, and policy
- 8 How will the care delivery model be phased?

Key milestones

Date

(week of) **Milestone**

- | Date | Milestone |
|---------|--|
| May 20 | Development of hypothesis on broad definition of care delivery model |
| June 3 | Outline of new workforce capacity and skill requirements |
| July 1 | Proposal on the design of new care delivery model; strategy for fulfilling new workforce requirements; required types of consumer involvement under new care delivery model |
| July 15 | Final recommendation on care delivery model design, plan for workforce development, and plan for engaging community in testing and implementation of the state's care delivery model |

Interdependencies

- Payment work group: Types of behaviors to encourage, provider types to include, and metrics to track in new payment model
- Health Information Technology work group: Required systems capacity and capability to share data across providers and settings and to capture data

Barriers impact sources of value differentially

- Directly impacts
- Indirectly impacts
- Minimally impacts

	Consumers					Providers			
	Limited pricing and qual. & transp. data	Lack of health and healthcare literacy	Limited access to care	Limited exposure to poor health decisions	Limited exposure to poor healthcare decisions	Limited pricing and qual. & transp. data	Not aware of best practice clinical protocols	Limited infrastructure to support care coordination	Lack of value based reimbursement
Primary prevention	Directly	Directly	Directly	Directly	Directly	Minimally	Indirectly	Minimally	Minimally
Secondary prevention/ early detection	Directly	Directly	Directly	Indirectly	Indirectly	Minimally	Directly	Minimally	Minimally
Selection of provider types and care settings	Minimally	Minimally	Minimally	Minimally	Directly	Directly	Minimally	Minimally	Directly
Effective diagnosis and treatment selection	Indirectly	Indirectly	Indirectly	Minimally	Indirectly	Indirectly	Directly	Directly	Directly
Care coordination/ chronic disease	Directly	Directly	Directly	Minimally	Minimally	Minimally	Directly	Directly	Directly
Provider productivity	Minimally	Minimally	Minimally	Minimally	Directly	Minimally	Directly	Indirectly	Directly

**Supporting facts and literature
for sources of value**

Literature and case example insights provide a high-level view of cost savings, timing, and feasibility of addressing sources of value



These supporting facts and literature are:

- Order of magnitude estimation of cost savings potential for each source of value
- Sense of time to impact and feasibility of each source of value based on medical literature and case examples
- Base of tangible examples to foster a rich discussion



These supporting facts and literature are not:

- Intended to model out detailed projection of future savings for Connecticut
- Comprehensive list of actions to target within each source of value
- Mutually exclusive sets of savings
- Exclusively double blinded controlled studies
- Studies or case examples representative of entire population (results in one segment may not be representative of the broader population)

Literature and case example insights informing sources of value assessment – cost impact (1 of 5)

PRELIMINARY

Primary prevention

Risk factor intervention-obesity

Relevant facts

- Obesity related illnesses account for 4 – 10% of national health expenditures
- Published success rates of interventions show the capture rates ranging from 25-50%

Sources

- *Journal of Health Economics* 31 (2012) 219– 230
- *Diabetes, Metabolic Syndrome and Obesity: Targets and Therapy*, 2010 (3):285-295

Risk factor intervention-obesity

- Smoking related illnesses account for 4 -5% of national health expenditures
- Success rates of interventions range from 20-40%

- CDC. MMWR. Smoking Costs in USA. 2000-2004.

Literature and case example insights informing sources of value assessment— cost impact (2 of 5)

PRELIMINARY

Relevant facts

Sources

Primary prevention mothers/newborns

Health promotion

- Preterm births are ~10.1% of all births in CT each year (37.7K)
- ~75% of pre-term births are preventable
- A preterm infant costs \$42K more than a full term infant
- Connecticut health spending per year is ~\$30B per year

- March of Dimes CT statistics, 2012
- Preventable preterm births. *The Guardian* 2012.
- State Health Facts. KFF. 2009.
- Thomson Reuters. Cost of prematurity. 2008.

Secondary prevention /early detection

Screening

- Per life savings ranges from 0.14% for cervical cancer screening to 0.69% for colorectal cancer screening
- % of population not in compliance with screening ranges from 32% (breast cancer) to 65% (colorectal)
- Employer experiences demonstrate ability to fully capture

- Costs and benefits of cancer screening. Milliman 2005
- *Arch Intern Med.* 2012; 172(7):575-582.
- Caterpillar case example

Literature and case example insights informing sources of value assessment – cost impact (3 of 5)

PRELIMINARY

Relevant facts

Sources

Selection of provider types and care settings

Shift to lower acuity providers or care settings

- Savings from shifting:
 - ED volume to urgent care: ~67%
 - From physician to physician extender: ~21%
 - From hospital-based ambulatory surgery to ambulatory surgical center (ASC): ~40%
- As a % of total U.S. healthcare spend:
 - ~0.3% are low acuity ED visits
 - ~8% are labor costs of primary care visits
 - ~3% are hospital based ambulatory surgery
- Potential 50% capture rate given applicable volume ranges from 20% of ED patients to 90-100% of PCP and hospital outpatient surgery volume

- Health Affairs, 29, no.9 (2010):1630-1636
- *Health Services Research* 2004 June; 39(3): 607-626
- HCUP 2010

Literature and case example insights informing sources of value assessment— cost impact (4 of 5)

PRELIMINARY

	Relevant facts	Sources
<p>Effective diagnosis and treatment</p> <p>Reduce unnecessary services</p>	<ul style="list-style-type: none"> 31% of health care expenditures are wasted dollars spent on inefficient and/or ineffective care delivery 27.5% of wasted dollars spent are accounted for by unnecessary services, driven largely by ineffective diagnosis and treatment 	<ul style="list-style-type: none"> Institute of Medicine, September 2012
<p>Provider productivity</p> <p>Improve provider productivity</p>	<ul style="list-style-type: none"> Demonstrated savings from improving provider productivity and patient throughput range from 10-15% Inpatient costs represent ~21% of total health care spending 	<ul style="list-style-type: none"> Industry experts Health Care Cost and Utilization Report: 2011

Literature and case example insights informing sources of value assessment— cost impact (5 of 5)

PRELIMINARY

Relevant facts

Sources

Care coordination and disease management

Care coordination and disease management

Administrative simplification

- After adjusting for ~2% savings on 40% fewer readmissions, Geisinger achieved 5% total savings through a PCMH model combining care coordination and disease management

- Geisinger

- Savings from reducing administrative inefficiencies range from 5% from standardizing forms to 30% from co-locating payor/provider billing
- Administrative tasks comprise 15% of total health spend
- Capture rate of ~70-80% seen in a large state initiative

- Health Affairs 2005. 24(6)
- Industry expertise

Literature and case example insights informing sources of value assessment– level of difficulty (1 of 3)

	Level of difficulty	Relevant facts	Sources
Primary prevention	<ul style="list-style-type: none"> ▪ High 	<ul style="list-style-type: none"> ▪ Wide range of interventions of variable efficacy and feasibility ▪ Treatment effects for many interventions are relatively small (though population-level impact may still be high) 	<ul style="list-style-type: none"> ▪ AJMC, 2013 ▪ BMJ, 2007 ▪ CJC, 2007 ▪ Cochrane Review, 2009 ▪ Cochrane Review, 2010 ▪ Cochrane Review, 2012 ▪ Cochrane Review, 2013 ▪ JECH, 2012 ▪ JSH, 2008 ▪ NEJM 2009 ▪ NEJM, 2010
Primary prevention for mothers/ newborns	<ul style="list-style-type: none"> ▪ Medium 	<ul style="list-style-type: none"> ▪ Community efforts targeted at pregnant women have demonstrated success though there is challenge associated with changing behaviors 	<ul style="list-style-type: none"> ▪ Cochrane Review, 2008 ▪ Cochrane Review, 2010 ▪ Cochrane Review, 2012
Secondary prevention / early detection	<ul style="list-style-type: none"> ▪ Medium 	<ul style="list-style-type: none"> ▪ Risks of over-diagnosis/treatment ▪ Uptake may be lowest in highest needs sub-groups ▪ Targeted programs for specific risk groups can be delivered through disease management 	<ul style="list-style-type: none"> ▪ BMJ, 2008 ▪ Cochrane Review, 2013 ▪ Cochrane Review, 2011 ▪ Cochrane Review, 2011 ▪ EHJ, 2008 ▪ NEJM, 2012 and 2009

Literature and case example insights informing sources of value assessment– level of difficulty (2 of 3)

	Level of difficulty	Relevant facts	Sources
Selection of provider and care setting	<ul style="list-style-type: none"> ▪ Low 	<ul style="list-style-type: none"> ▪ Has been successfully demonstrated ▪ Role substitution can meet initial resistance ▪ Requires appropriate coaching, management and oversight ▪ Requires extensive collaboration between care providers ▪ Effective for stroke patients 	<ul style="list-style-type: none"> ▪ BMJ, 2013 ▪ Cochrane Review, 2009 ▪ Cochrane Review, 2011 ▪ Cochrane Review, 2012 ▪ IJIC, 2012 ▪ The Health Foundation, 2010
Effective diagnosis and treatment selection	<ul style="list-style-type: none"> ▪ Medium 	<ul style="list-style-type: none"> ▪ Behavior change at level of individual clinical pathways may be onerous ▪ May meet provider resistance given autonomy of clinical practice ▪ Addressing unwarranted variation may be controversial 	<ul style="list-style-type: none"> ▪ Birth, 2012 ▪ Dartmouth ▪ Cochrane Review, 2011 ▪ NEJM, 1988 ▪ JAMA, 2002 ▪ PDS, 2012 ▪ Robert Wood Johnson Foundation, 2013
Provider productivity	<ul style="list-style-type: none"> ▪ Medium 	<ul style="list-style-type: none"> ▪ Size of efficiency opportunity likely to vary significantly between providers ▪ Potential impact is extrapolated from specific patient groups/ pathways and may not be applicable to all patient types 	<ul style="list-style-type: none"> ▪ Cochrane, 2011 ▪ Cochrane Library, 2013 ▪ Health Affairs, 2012 ▪ MHI case study ▪ NEJM, 2011 ▪ McKinsey blinded client data- hospital lean operations

Literature and case example insights informing sources of value assessment– level of difficulty (3 of 3)

	Level of difficulty	Relevant facts	Sources
Care coordination and chronic disease management	<ul style="list-style-type: none"> ▪ Medium 	<ul style="list-style-type: none"> ▪ Several case examples exist of successful care coordination ▪ Lack of clear evidence on what type of program to introduce for any specific population 	<ul style="list-style-type: none"> ▪ Camden Coalition of Healthcare Providers case ▪ Care Oregon case ▪ Care More case ▪ Colorado Childrens' Health Program case ▪ New York Care Coordination Program case

Literature and case example insights informing sources of value assessment– time to impact (1 of 3)

	Time to impact estimate	Findings from literature and case examples	Sources
Primary prevention	<ul style="list-style-type: none"> 7 + years 	<ul style="list-style-type: none"> Due to need to address root cause of disease and time course of disease progression, primary prevention requires 10+ years to achieve meaningful cost impact though medical benefits may accrue sooner 	<ul style="list-style-type: none"> AJMC, 2013 BMJ, 2007 CJC, 2007 Cochrane Review, 2009 Cochrane Review, 2010 Cochrane Review, 2012 Cochrane Review, 2013 JECH, 2012 JSH, 2008 NEJM 2009 NEJM, 2010
Primary prevention for mothers/ newborns	<ul style="list-style-type: none"> < 3 years 	<ul style="list-style-type: none"> Specific, identified opportunity to improve outcomes through pregnant women’s behaviors (e.g., vitamins, alcohol avoidance) Shorter-term cost impact via healthier newborns 	<ul style="list-style-type: none"> Cochrane Review, 2008 Cochrane Review, 2010 Cochrane Review, 2012
Secondary prevention / early detection	<ul style="list-style-type: none"> 7 + years 	<ul style="list-style-type: none"> Similar to primary prevention, screening for early signs of disease requires 10+ years to achieve cost impact given time course of disease progression 	<ul style="list-style-type: none"> BMJ, 2008 Cochrane Review, 2013 Cochrane Review, 2011 Cochrane Review, 2011 EHJ, 2008 NEJM, 2012 and 2009

SOURCE: Case examples and medical literature review

Literature and case example insights informing sources of value assessment– time to impact (2 of 3)

	Time to impact estimate	Findings from literature and case examples	Sources
Selection of provider and care setting	<ul style="list-style-type: none"> < 3 years 	<ul style="list-style-type: none"> Cost impact can be achieved immediately by changing referral patterns to high value providers 	<ul style="list-style-type: none"> BMJ, 2013 Cochrane Review, 2009 Cochrane Review, 2011 Cochrane Review, 2012 IJIC, 2012 The Health Foundation, 2010
Effective diagnosis and treatment selection	<ul style="list-style-type: none"> < 3 years 	<ul style="list-style-type: none"> Time to achieve cost impact primarily restricted by provider behavior changes required (e.g., prescribing behaviors and clinical pathways) Engaging patients in decision making and dropping rate of unnecessary elective procedures has faster impact 	<ul style="list-style-type: none"> Birth, 2012 Dartmouth Cochrane Review, 2011 NEJM, 1988 JAMA, 2002 PDS, 2012 Robert Wood Johnson Foundation, 2013
Provider productivity	<ul style="list-style-type: none"> <3 years 	<ul style="list-style-type: none"> 3-6 months for provider-initiated reforms 2-3 years for system initiated payment reform 	<ul style="list-style-type: none"> Cochrane, 2011 Cochrane Library, 2013 Health Affairs, 2012 MHI case study NEJM, 2011 McKinsey blinded client data- hospital lean operations

Literature and case example insights informing sources of value assessment— time to impact (3 of 3)

	Time to impact estimate	Findings from literature and case examples	Sources
Care coordination and chronic disease management	<ul style="list-style-type: none">< 3 years	<ul style="list-style-type: none">Case examples achieved meaningful cost savings impact in 1-3 years	<ul style="list-style-type: none">Camden Coalition of Healthcare Providers caseCare Oregon caseCare More caseColorado Childrens Health Program caseNew York Care Coordination Program case