

The DALLAS CHOICE PLAN

“A HEALTHCARE PROPOSAL on Becoming a Great City”

v.11 6.2.16

Introduction

Dallas is a great city and intends to remain that way. Among other things, great cities create opportunities for all and protect the vulnerable. Often they do this by developing well-crafted public/private partnerships to further their goals, and by embracing technology to generate efficiencies. * The Dallas Choice Plan avails itself of both techniques in service of protecting the most vulnerable in healthcare in our community.

Instead of debating how to reform the national healthcare system, the Dallas Choice Plan proposes pragmatic, creative and independent Dallas action to address the “access gap” that still impacts about 30% of our citizens. Thousands “in the gap” today are in working families with children. Lack of access for parents and children obviously affects each family’s security and well-being, and also indirectly affects us all through the impacts on our businesses, schools, public and private hospitals, etc.

To the city’s (and county’s) credit, Parkland’s Financial Assistance Program already covers a portion of the gap, as do a number of loosely-related or unrelated private sector charity and other initiatives. That said, over half the gap goes without healthcare or accesses it in the most expensive manner possible, often through emergency room care. The Dallas Choice Plan is the next step in refining and expanding on foundations laid by Parkland and the private sector in an even more holistic manner—drawing also from other community assets such as private physicians, etc. An effective new local health information exchange is also a part of the plan, and represents an efficient technological improvement that would begin paying for itself immediately through better coordination of community care and elimination of duplication of service.

Dallas continues to evolve into an ever-larger city, and the Dallas Choice Plan is intended to help us solidify one part of our infrastructure that will keep us a great city. Our community has an opportunity to lead through action, and by consolidating efforts around a structurally sound organization like Parkland, the Dallas Choice Plan has the potential to become a notable success.

**See 9/2013 McKinsey & Company study on “How to make a city great”*

I. Background and Aim

While the debate in Texas and in the nation continues over how best to reform healthcare, this proposal intends to equip Dallas to act independently and decisively to foster a healthy community. Through this document, a broad collaborative of stakeholders seeks to lay out the building blocks of a bold, replicable plan to provide meaningful, integrated health care access to Dallas area residents who currently are unable to afford or access healthcare.

The compelling issue is that up to 30% of Dallas residents still lack access to affordable healthcare. Emergency Departments are not the solution, nor should they be the safety net for providing healthcare. Despite the recent expansive efforts of Parkland, local charitable clinics, and well intentioned private physicians, many with serious illness are left only with this option, or are left suffering in ways that are intolerable to a modern and well-resourced community like Dallas.

II. Guiding Principles

Principle 1: The solution must be designed to meet the problem instead of simply following the money:

Too often solutions for healthcare access are aimed at doing what is necessary to ensure ongoing funding for institutions instead of first ensuring the solution actually addresses the specific healthcare needs of the community.

Enough resources exist in this community to cover the healthcare access gap, but it is being misused, misdirected, or inefficiently applied. Millions of dollars are flowing into Dallas intended to help vulnerable and uninsured populations such as subsidies to hospital corporations, tax breaks granted to not-for-profit health systems, local hospital district taxes, or charitable giving from foundations. These resources ought to be enough to cover the healthcare needs of the community, but regrettably this is not happening.

Prior funding has been too heavily focused on delivery of care at private hospitals, with no consideration or funding available to non-hospital providers. While private hospitals are critical to have involvement with designing solutions for the community's most vulnerable and uninsured populations, their role must be balanced with the need to provide access to more affordable medical care in community-based outpatient and private practice settings.

Whenever possible and feasible, healthcare should be delivered outside of the hospital, not only because of the cost savings, but because it is a more compassionate and effective approach to treating and preventing illness.

Rather than starting with the question of how to ensure traditional funding strategies from federal and state sources, this proposal seeks to squarely meet the most pressing healthcare needs of the Dallas community. If the solution is compelling enough, funding will come, or funding that is currently being used in other less effective ways will be re-directed to support this proposal.

Principle 2: The thrust of the proposal must be to first ensure all Dallas citizens have access to affordable healthcare (See Appendix – Figure 1):

While there are many important healthcare related problems in Dallas, the most pressing one is the lack of any access to affordable healthcare for upwards of 30% of the population. Besides the injustice of allowing so many of our neighbors to needlessly suffer, the cost to the community in terms of lost wages, lost work days, unnecessary disability, and emergency department overcrowding is staggering. It is hard to conceive of how the city will make any meaningful progress in other areas of healthcare reform until the gap of the uninsured is significantly closed.

Affordable healthcare can be defined as:

- A patient can establish a relationship with a primary care provider who provides:
 - Comprehensive first contact and continuing care for undiagnosed signs and symptoms or health concerns (AAFP Definition of Primary Care)
 - Health promotion, disease prevention, health maintenance and education
 - Referrals to specialists and other healthcare services
 - Behavioral health support or referral
- A patient has access to healthcare coverage that prevents unexpected illnesses or chronic medical condition costs from exceeding 9.5% of his or her household income in any given year.
 - A person with coverage has access to the full range of specialty and hospital care that is considered to be the standard practice of healthcare delivery in this country.
- A patient only accesses Emergency Rooms for medical emergencies.

Principle 3: Parkland can anchor a network of providers that spans the healthcare continuum, including private primary care and specialty care physicians: Parkland Hospital and its large network of Community and Specialty Clinics already exist for the purpose of caring for patients who reside in the healthcare access gap with a full range of healthcare services. And though Parkland provides excellent care to a large number of people, the gap is simply too large for Parkland by itself. Additionally, Dallas' private practice physicians have consistently also served the same population and will seek participation in this new design under Parkland's leadership.

Principle 4: The network must be supported with a robust and meaningful health information exchange: Costly duplication of medical services and procedures such as CT scans or MRIs can be avoided through an effective, community-wide, health information exchange (HIE), aggregating patient-level information from all key stakeholders to help identify opportunities to reduce or eliminate disparities in access to timely health care for high-risk patients. The HIE will serve as the hub of information for the new network of providers, to help reduce duplication of expensive service, producing immediate savings that should more than cover the cost of the HIE operations.

Principle 5: Population health methods must be integral to the networks' function (need to also include cost containing or value oriented reimbursements): The provider network will adopt evidence-based quality, efficiency and patient-engagement performance metrics. These metrics will be utilized to measure and report performance of each provider type and the delivery of value-based health care services. We believe those providers performing at higher levels should be disproportionately rewarded with financial bonuses. We also believe these financial bonuses would be afforded by the savings produced by higher levels of preventive health services to at risk populations.

Principle 6: Strategically located patient-centric medical neighborhoods, for adults and children, will form the cornerstones of the outpatient care delivery network. These will include, but not be limited to, Parkland COPCs: A new provider network should be developed, resourced by today's existing providers of health care for the uninsured and underinsured. A key component to the next network's structure would include patient-centered medical neighborhood clinics, conveniently located near in underserved communities and encompassing a broad array of social and health-related resources. As conceptualized, the medical neighborhood clinics could leverage Dallas' existing primary care infrastructure currently operating. These enhanced clinics will enable patients to more easily access the complex array of resources necessary to maintain their health status.

Principle 7: Physicians must be the champions and leaders of this solution, working as trusted and neutral advocates who ensure the patients' needs are put ahead of corporate or government interests: We are committed to developing a network of providers that involves the entire healthcare community of Dallas instead of entirely separate and unequal networks – i.e. one for lower income vulnerable patients, and one for everyone else. The healthcare disparities that are bound to exist in a two-tiered network of providers is unacceptable to us. We believe Dallas physicians can and should be involved in helping to address the broad community need related to improving health care access. Our strategy must include elements that enable

physicians to “lean-in” to the solutions being proposed. Further, physicians must reclaim the civic roll of protecting the healthcare commons, such that practicing responsible medicine in Dallas translates to elective and proportionate participation in the solutions developed.

III. Plan

A key premise in the design of the **Dallas Choice Plan** (DCP) is that great cities build and support great institutions. The stakeholders developing the Dallas Choice Plan, believe that we must leverage some of our great institutions to create a new solution to improve access to care for our vulnerable population. In Dallas, Parkland Health & Hospital System is unique in its ability to create and sustain complex relationships among a diverse number of stakeholders. Parkland is the iconic Dallas medical resource, well respected and appreciated by all stakeholders in this community. Already focused on the many complex issues regarding healthcare for vulnerable populations, Parkland remains the choice to host DCP which will build upon Parkland’s administrative infrastructure and clinical movement toward population management within an accountable health care environment.

In choosing to build upon Parkland’s foundation, DCP is expanding Parkland’s functional clinical and administrative infrastructure to facilitate the incorporation of private sector primary care and specialty care physicians and non-profit clinics that have not formally participated in providing assistance to solving the access to care problem for vulnerable populations. When successful, DCP will create a vehicle for engaging a wider segment of the area’s health care infrastructure, enabling a greater proportion of the community to have accessible primary health care.

Tactically, the **Dallas Choice Plan** (DCP) is an excellent “demonstration project” serving as an illustration of how the State of Texas could simultaneously expand both health insurance coverage and access for low income, uninsured and vulnerable populations with limited access to primary health care within an accountable care organizational structure. The basic framework of the DCP combines the assets of 1) Parkland’s Community Health Plan; 2) Parkland Hospital & Health System clinical infrastructure; 3) Dallas County Medical Society physician membership; 4) Dallas’ non-profit charity clinic network; 5) Dallas’ FQHCs, and Mental Health Care Clinics; 6) UTSW’s specialty physician network; and 7) Parkland’s philanthropic foundation.

The DCP’s overview includes:

- **Dallas Choice Plan Outline**
- **Sponsoring Organizations**
- **Eligible Populations & Member Qualifications**

- **Supporting Infrastructure**
- **Outcome Metrics**

Dallas Choice Plan (DCP) is an extension of Texas Medicaid’s HMO product operated by the Parkland Community Health Plan, extending health care insurance coverage to uninsured individuals up to 200% of the Federal Poverty Level (FPL) and linked to primary care access. Funded through some type of sustainable federal funds matching program, or a new State of Texas 1115 waiver, DCP will function as a community accountable care organization (ACO) with financial rewards available to all participating providers for achieving targeted quality and efficiency metrics. The DCP will pay providers at Medicare FFS rates and function as a public-private partnership with DCMS’ private physicians and Dallas’ private hospitals, as well as local health care organizations (both publically funded and private non-profits) serving both behavioral and physical health care needs.

Sponsoring Organizations will provide the backbone of the DCP. These organizations would include:

- Publically-funded health facilities in Dallas (Behavioral Health and Medical Clinics)
- Aligned non-public health facilities in Dallas (private non-profit charity clinics)
- Federally funded FQHCs, 330 Clinics, FQHC look-alike, Indian Health Service and Urban Indian Health Service units in Dallas

These entities would identify and refer potentially eligible patients to the DCP staff working under the leadership of Parkland Community Health Plan’s administration. The DCP would serve as a Qualified Health Plan (QHP) as defined by the Accountable Care Act (ACA), and be responsible for paying all providers at current Medicare reimbursement rates, whether or not the provider is enrolled in the network. However, only enrolled providers would be eligible for financial rewards achieved through meeting or exceeding designated quality and efficiency performance metrics.

Eligible Populations would include individuals sponsored for enrollment by the Sponsoring Organizations. Examples of **Qualifications for Participation** include individuals meeting the following potential criteria (See Figure 1):

- Texas Resident
- Meeting family income guidelines up to and including 200% of the FPL
- Sponsored by a Qualified Sponsor
- Be uninsured and not eligible or enrolled in any comprehensive health coverage, Obamacare, CHIP or Medicaid, Medicare, Tricare or Veterans Administrations coverage

Supporting Infrastructure includes the development of a “community Health Information Exchange” that links clinical and claims information in a central data repository accessible by all providers working with the enrolled DCP population. Additionally, high-risk patient identification computer modeling will be utilized in conjunction with nurse care coordination, case management and community health work care navigation (See Figure 2).

Another key supporting structure will be a business solutions center, reducing the business issues related to participation in DCP. This centralized “administrative clearing house” will have the capacity to 1) eliminate the physician practice hassle of both billing and collecting fees, and 2) reduce the time and effort burden on practice staff related to specialty physician referrals.

Outcome Metrics will be collected and reported to help demonstrate the impact of DCP on the following performance metrics:

- Net increase in payments to both Sponsoring Organizations and DCP Network Providers
- Net staff changes in Sponsoring Organizations
- Efficiency Metrics demonstrating the change in primary care access dependent preventable admissions
- Quality Metrics demonstrating the change in primary care access dependent preventive and chronic disease management conditions

The **Dallas Choice Plan** has the potential to substantively change the Dallas health care landscape by re-engaging the private physician community in a critical area of need within our city. The resulting impact on avoidable and unnecessary morbidity and mortality among vulnerable populations would underscore the aspiration of Dallas to achieve world-class status. By consolidating efforts within a structurally sound organization, like Parkland, gives the demonstration project the potential for sustainability and scale.

IV. Topics for further discussion

- Will the plan require approval from Texas Health and Human Services Commissioner?
- Will the plan need to be regional or replicable in other counties?
- How will the plan sustain itself if federal funding is not provided?
- Is there legislative interest in an alternative model?
- What is in this for the hospitals? Why would they want to support this?
- How would this engage the doctors who currently do not participate in Medicaid?

- Can someone scale up patient navigation, education, and medication consistency to the level of patient care?
- This is more than just paying physicians and hospitals for services, can this also include all the wrap around services, including behavioral health, transportation, translation, medications, etc.?
- How would patients flow into and out of Parkland?
- Can we be assured that payments to physicians and hospitals meets all the standards of the federal laws, including anti-kickback provisions?
- What happens when this plan is seen as a better plan than current Exchange plans or commercial plans?
- Patients' feedback drives physicians to improve. Can the plan include quality metrics to incentivize physicians and their practices to satisfy patients?
- Who will do data analysis and outcomes for the plan? How public will the results be?
- How many patients would have to be served to make a difference?
- How many vulnerable patients are children?
- Can DCMS be charged with creating the exhaustive list of wrap around services that the plan must deliver?
- Will the plan be built for everyone, including undocumented?
- What services are NOT included, such as transplants, cancer treatments, etc.?
- Can we lean on the existing strength within our institutions, PCCI's predictive modeling, and "curative" medicine, for example?

V. Appendix

Figure 1

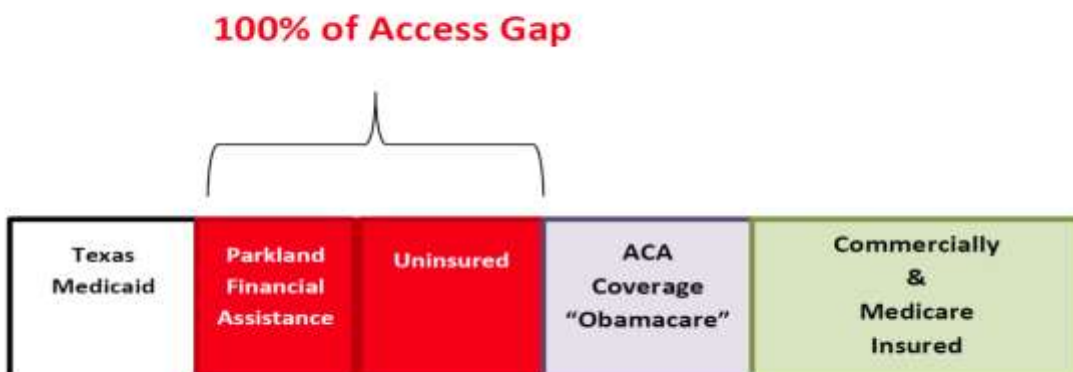
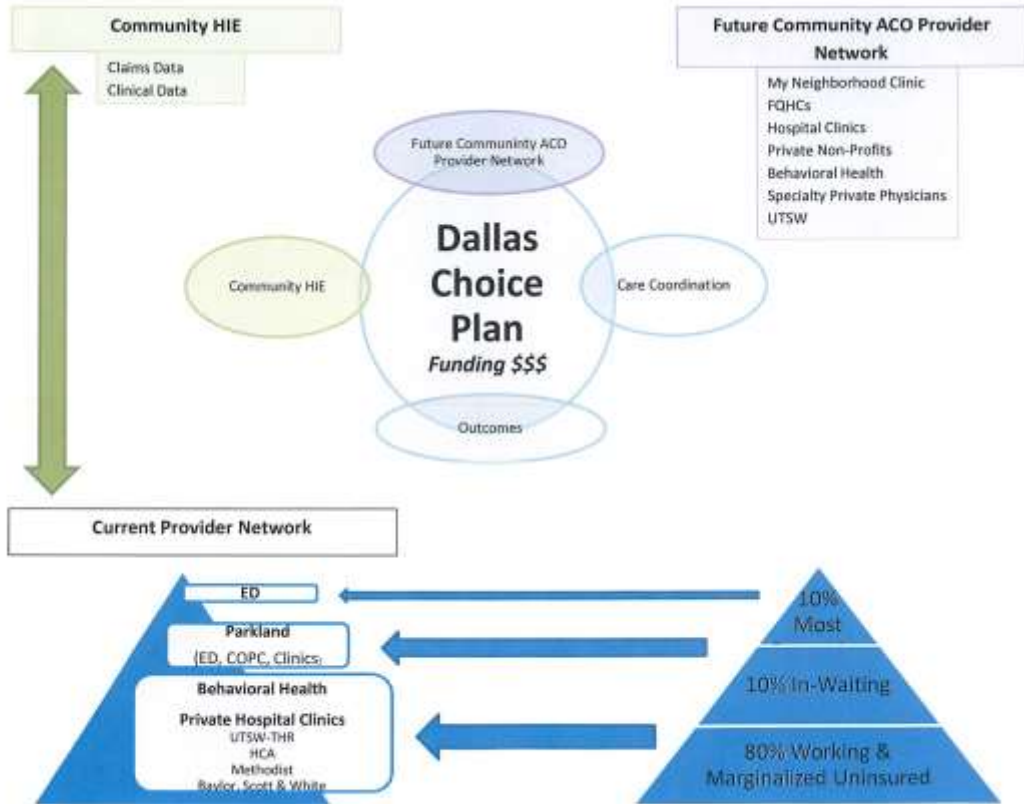


Figure 2



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Figure 3

**The Dallas Choice Plan
A Community ACO Model**

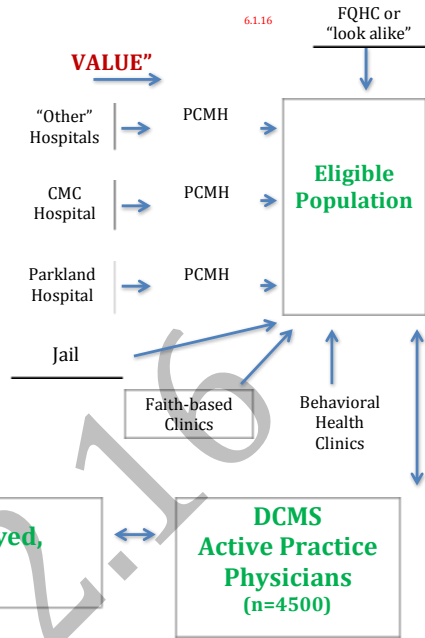
Administrative Infrastructure

- Patient Enrollment
- HIE
- Data Analytics
- Performance Improvement
- Care Coordination
- Transportation
- Prevention
- New PCP sites
- Pharmacy
- Social Services
- Translation

Potential Clinical Focus Areas

- Adult Services
 Behavioral Health
 Gastroenterology
 Rheumatology
 ENT
 Physical Medicine/ Rehab
 Neurology
 Dermatology
 Vascular Surgery
 Pain Management
- Pediatric Services
 ENT
 Development/Speech
 PT
 Behavioral Health
 Allergy/Asthma
 Cardiology
 Orthopaedics
 Dermatology

**Parkland
Community
Health
Plan
Administrative
Infrastructure**



**Physicians: UTSW, Employed,
Independent**

**DCMS
Active Practice
Physicians
(n=4500)**