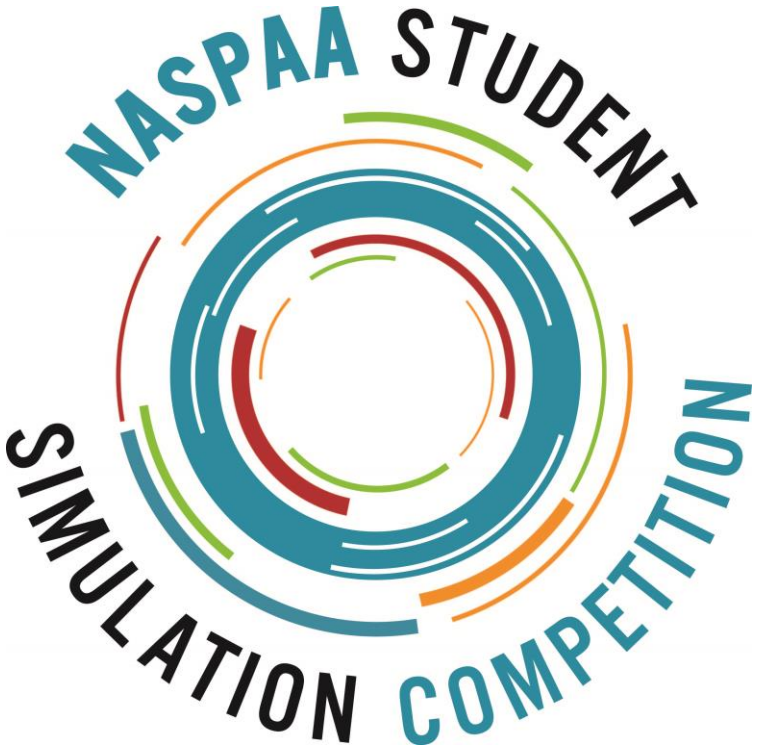


Creating a Locally-Led "Bottom Up" Reform to the Affordable Care Act
February 28, 2015

STUDENT MATERIALS

NASPAA Student Simulation Competition
February 28, 2015

Creating a Locally-Led "Bottom Up" Reform to the Affordable Care Act

8:00 am	Registration Opens
8:30 am	Welcome, Overview & Introductions
9:00 am	Task 1 Begins
9:45 am	Task 1 Ends
9:50 am	Overview of Task 2
10:15 am	Task 2 Begins
12:00 pm	Lunch available; students continue working
1:00 pm	Task 2 Ends (Students must Submit a Hearted Score)
1:15 pm	Task 3 Begins
3:40 pm	Task 3 Ends
3:45 pm	Task 4: Presentations Begin in Groups
4:45 pm	Judges Determine Final Winner & Students Socialize
5:30 pm	Winning Team Announced & Presentation from Winning Team

NASPAA
The Global Standard in Public Service Education

2015 NASPAA Student Simulation Competition
Creating a Locally-Led, "Bottom Up" Reform to the Affordable Care Act

***Synopsis**: Join Rodrigo Luna-Moralez in his first post-MPA job assignment. Working as a project manager for Lauren Bonneville, the state Commissioner of Health, Rodrigo will become part of a reform team based in the Urbis Region, a mid-sized metropolitan region nestled in the middle of the state. The Urbis team will be using the Tabiyat simulator to reimagine how health care services, treatment, and finance options can be rearranged into policy design packages that concurrently increase average quality of care, lower overall costs, and narrow disparities in health care outcomes[1]. Trained as a professional public administrator, Rodrigo will need to struggle with the many important management and implementation issues whose resolution will define the success of Urbis' policy vision. In contrast to the Affordable Care Act that some may see as a "top down" political give-and-take reform from Washington, health reform efforts in this case begin with a team of locally-based health care experts, business leaders, and community activists—all living in the Urbis region—who share a conviction that reforming health care is imperative to their local community and that they are empowered to initiate and design such reform. Yet they must operate within the context established by the monumental federal health care reform law. Rodrigo is learning the skills necessary to become a policy entrepreneur, using state-of-the-art technology and leading "bottom up" public policy and management reform.*

Rodrigo Gets his First Great Job:

Rodrigo Luna-Moralez is very excited about his first full-time post-MPA job. He is working as a project manager for Lauren Bonneville, the state's Commissioner of Health. Rodrigo understands that he will be on a team working on one of the state's highest priorities, refinement and improvement of current state efforts to implement the Affordable Care Act. Lauren Bonneville, also trained as an MPA in the 1990s, is a rising star in national circles. She has a reputation as a policy entrepreneur who knows how to pay close attention to all of the details of program management and policy implementation. She is an innovator who keeps abreast of the latest methods and approaches to policy analysis and management. Rodrigo understands that he will have a chance to work with a leading-edge simulator in his new job.

Rodrigo first met Lauren Bonneville at an on-campus event where she was the invited keynote speaker for a symposium sponsored by his MPA program. While Rodrigo had not previously been particularly interested in health care as a career focus, her talk demonstrated to him that thinking about health care reform is a good exercise for anyone interested in almost any field of public administration. Reforming and improving the Affordable Care Act responds to immense pressure to provide critically needed public services, while at the same time responding to the challenge of controlling run-away costs. Government's role is at the intersection of efforts to cooperate with, fund, and regulate a sprawling set of for-profit and non-profit health care industries. Rodrigo knew immediately that Lauren Bonneville would be an invaluable career mentor. He was thrilled when he got a job working on her newly formed reform team.

Bonneville has been out of the office for Rodrigo's first week on the job attending a symposium on "*Policy Informatics in Health Care Reform*" sponsored by the National Institutes of Health and the Robert Wood Johnson Foundation. Rodrigo has been left with the job of studying a website that provides background research for a project on community-led health care reform (see footnote 4 on next page). This project has been proposed by a local task force from the Urbis region, a mid-sized metropolitan area located in the middle of the state.

[1] Rodrigo Luna-Moralez and Lauren Bonneville are fictional characters intended to set the context for this case, but they face the very real challenges of re-designing the Affordable Care Act. The policies being examined in this case, the radical notion of "bottom up" reform, and the simulator itself are all very real.

The Context for Health Care Reform at the State and Local Level:

Rodrigo came to his new job in early December, a time when three intersecting forces were creating a "perfect storm" that favored the possibility to create significant reform in how health care is financed and delivered across the state[2]:

1. **Political Will**. The recent November elections had narrowed the Democratic majority in the state Senate to just one vote. Conservative pressures to contain soaring health care costs are now reinforcing progressive pressures to reform the basic structures of health care delivery. The political climate seems ready to support the granting of waivers on regulatory requirements and financing policies and to promote experimentation with some new ideas. The federal government has begun to grant legislatively-based waivers to support state and locally-based experimental reforms[3]. The federal government is also providing direct funding for innovations in many states under the HHS Innovation Center State Innovation Awards program (http://innovation.cms.gov/initiatives/state-innovations/)

2. **Locally-Driven Health Care Reform**. Over the previous summer, a partnership of health care providers, health care insurers, business leaders, and public health care officials from the Urbis region had approached the governor with an innovative approach to foster locally-based health reform (see Appendices A-1 and A-2 for some more details on the Urbis health reform team). The team from Urbis had really done their homework. They proposed over 20 separate policy initiatives that they wanted to explore — in different combinations — to form the basis for an omnibus policy reform package for the Urbis region. All of these options are presented in summary form in Appendix B. This base set of policy options was strongly supported by a review of the peer-review literature that they summarized in a library reference material guide[4]. This locally-based group recently received a five-year innovation grant from the CDC's Community Transformation Fund to support their projects. So in the first instance they were not seeking funding from the state; rather they were seeking flexibility in the form of relief from specific state and federal mandates and guidelines, giving them permission to experiment with new approaches (all within a framework of structured guidelines).

   Bonneville grasped that the new climate in the state legislature, coupled with gubernatorial support for reform and a demonstrated willingness by the federal government to support experimental innovations, was creating a unique possibility. What she now needed was a concrete method to focus all this emergent energy toward specific and substantive proposals that could be used to design the requests for granting administrative flexibility in Urbis.

3. **New Technology to Support Policy Redesign**. The third enabling piece fell in place at the national seminar on *Policy Informatics and Health Care Reform,* co-sponsored by the National Institutes of Health and the Robert Wood Johnson Foundation that Bonneville had recently attended. At that symposium,

[2] The "perfect storm" depicted in this case, while not representing the situation in any specific state, is ready to happen in several states. Having these three forces come together all at once would create a powerful opportunity for reform, and examples of several of the forces simultaneously at work already exist. In a number of states, political pressures for cost containment coupled with quality of care concerns have been able to produce break-through results. For example, New York State's Medicaid Redesign Team led by Jason Helgerson (a MPP-trained policy entrepreneur not unlike Lauren Bonneville in this case) and championed by Governor Andrew Cuomo has been able to achieve a dramatic reorganization of state-wide Medicaid-funded health care services while maintaining and improving care and saving the state and federal government substantial amounts of money.

[3] For example, an $8 billion federal waiver was granted to New York's Medicaid program to support experimental reforms based on proposals initially put forward by local stakeholders.

[4] http://libguides.library.albany.edu/NASPAAcompetition

Pat Aubry from the NIH described a line of health research based on emergent approaches in the system sciences. Susan Welder from the Robert Wood Johnson Foundation discussed a case of locally-driven health care reform in the Atlanta region, the ARHCI program that was supported by the Tabiyat simulator, an innovative approach to locally-driven health care reform recently developed by the Wave Foundation. Finally, Roger Mühlstein, speaking as a representative of the Wave Foundation, presented more of the technical details of the Tabiyat effort and how it is being used around the nation in a number of communities to support local health system reform.

Bonneville almost immediately recognized an opportunity to make breakthrough progress on her project in Urbis and approached Mühlstein to ask him if he could tailor his simulator to the specific agenda of policy reforms being proposed by the task force in Urbis. The simulator should be grounded in the demographic and health care data specific to Urbis, and incorporate the full set of policies being proposed by the Urbis working group.

Mühlstein had agreed to take up the challenge and pledged to produce a useable model by February of 2015. Bonneville, working with the Urbis task force, called for an initial meeting on February 28, 2015 of a high-level group to work with Mühlstein's simulator. Rodrigo was thrilled that Commissioner Bonneville has asked him to join this initial working group as a representative from the state's Department of Health[5].

The Situation in Urbis:

Urbis, USA is a mid-sized city located in the Mid-State Region on the banks of the Flumine River just west of the foothills of the Capstone Mountains. Urbis is also the county seat for Urbis County, centrally located within the Mid-State Region. The Mid-State Region consists of Urbis County plus two adjacent counties—one to the north and one to the south of Urbis County. Urbis emerged as a regional center of commerce in the early 18th century when a system of canals in the Urbis region was used to open a broad geographic area to economic development. Water power from streams flowing into the Flumine River from the Capstone Hills was an early source of industrial development in the UpState Region. Today, Urbis is the hub of a diversified economic region with a declining manufacturing base, a thriving service sector, and new economic growth led by high tech industries. Its current population is around 300,000. About one-third are economically disadvantaged which means they live in households with incomes less than 200 percent of the Federal Poverty Level (FPL). These people generally have poorer health and less access to health care. Medicare covers individuals over age 65 — 14.3 percent of the population — who also have poorer health and greater health care needs.

The Task Facing Your Group on February 28, 2015

February 28 is designed as a pilot test of the Wave Foundation's Tabiyat simulator as it has been calibrated for and applied to the policy interests of the Urbis task force. Working with members of the Urbis task force, Mühlstein's team at the Wave Foundation has crafted a simulator that represents the policy interests initially articulated by the Urbis team back in the summer. Appendix B summarizes the set of policies that Mühlstein and his team from the Wave Foundation have incorporated into the Urbis version of the Tabiyat simulator.

[5] Rodrigo Luna-Gonzalez and Lauren Bonneville are fictional characters used to set the context of this case, Pat Aubry, Susan Welder, and Roger Mühlstein are pseudonyms for real health care reformers who are currently working with innovations such as the Tabiyat simulator to craft radical "bottom up" approaches to health care reform in the United States.

Task One
9:00 am – 9:45 am

You can begin working on this first task before February 28 by reviewing the policy options. Appendix B gives a thumbnail sketch of the various policies that are "on the table" for consideration by the Urbis task force. These thumbnail sketches give summary information on what the policies are, what will be their impacts, and what it will cost to implement them. All of these policies are based on extensive peer-reviewed and evidence-based research on public health policy and finance reform. A sampling of that literature is contained in http://libguides.library.albany.edu/NASPAAcompetition. None of these readings are assigned readings for this case, but at some point, you may enjoy having access to a pre-sorted bibliography to work on this case.

Your first task on February 28 is to design a package of health policy and finance options from among those listed in Appendix B that you believe will have a good chance to succeed. On the morning of February 28, you will meet your team and begin working together. Your first assigned task will be to work with your team to select ***seven*** health policy and finance options that you believe have a chance to achieve significant reform in the Urbis region. Each of you will have your own ideas, but will need to come up with seven you all agree on. Limit yourself to seven options initially to give careful thought to which ones will work best together and have the greatest impact. (You will have the option to work with a larger set later in the day.) This first task needs to be completed without support from the simulator—just using good policy reasoning, a pencil and paper, and maybe a calculator to keep track of costs.

At the end of task one, you will have negotiated and decided with your fellow team members on the ***seven*** health policy and finance options that you believe have a chance to achieve significant reform in the Urbis region. This set of seven options will serve as a starting point for the analyses your team does in Task Two when you will input them into the computer to observe their impact. The objective in Task Two will be to improve on your initial set to get the best possible outcomes in terms of a "Super Score".

For this task (and for all other tasks today) your policies must meet and balance the following five criteria:

1. Reduce the average cost of care for residents of Urbis;
2. Make the population healthier;
3. Improve the content and quality of care;
4. Improve equity through such measures as the excessive mortality rate suffered by the economically disadvantaged;
5. Improve productivity of the Urbis work force by reducing disability due to illness and injury.

You must develop balanced packages—doing very well on one and poorly on others is unacceptable.

Additionally, beginning in Task One and throughout the day, you should be recording lessons learned which you will document on Worksheet 4 at the conclusion on the day. You will also make a final PowerPoint presentation in Task Four, so we encourage teams to begin working on presentation materials early and throughout the day.

Instructions for Task One:

- Worksheet 1, provided at the back of this case study, is designed to help you complete Task 1. Download the worksheet from https://app.box.com/2015NASPAAsim and complete the worksheet as a team.
- At the end of Task One, please save a copy of your completed Worksheet 1 on the team thumb drive.
- Download and complete the coversheet (from the link above) for your electronic portfolio contained in the thumb drive. This cover sheet identifies your group and its individual members.
- Throughout the day, judges will be meeting with each team to evaluate performance. You will talk to the judges in each task and they will provide a final score for your team at the end of the day, based on the rubric in Appendix C-2.

Task Two
10:15 am – 1:00 pm

Your second task is to explore and experiment with the simulator to find out how it works and report back on what a policy future for Urbis might look like within the assumptions of the Tabiyat simulator. This involves using the simulator to look forward for the next 30 to 40 years to broadly explore the implications of policy packages of interest to Urbis' task force. This task boils down to understanding how new policy Informatics technologies, in this case system dynamics-based simulation models, can support breakthrough (some might say "blue sky") policy thinking.

As indicated above, you will start this exercise by typing into the simulator the policy package that your group agreed on in Task One. Using that as your group's initial run, your group will work with the simulator to try and achieve better and better policy results that can improve performance on all five of the performance indicators listed above. Your final product at the end of Task Two will still be seven options that gauge performance along the same five dimensions that you used to evaluate Task One. However, in the case of Task Two, you will be able to experiment with many different sets of options, seeking to find what works best. In addition, the simulator will show you how well each option has scored along each of the five dimensions.

Mühlstein has cautioned members of the Urbis task force that they need to bear in mind a number of crucial caveats as they work with the simulator:

- **Do not use the model to make specific predictions about the future.**
- Do use the model to compare the impacts of various combinations of policies.
- Do not use the model for simply getting the best result in one area (such as the lowest cost).
- Do use the model to get the strategy that is the best balanced among the multiple objectives listed above.
- Be aware of potential pitfalls that make your strategy less effective and adopt policies to deal with those pitfalls (Hint: Use the "Pitfalls" selection on the All Graphs menu to see where you might be *encountering problems.)*

Instructions for Task Two:

- A key to doing well on Task Two is quickly learning how to use the simulator. Here is an 18-minute video which provides a simulation overview: *https://vimeo.com/118290764*. You are strongly encouraged to watch the video and experiment with the simulator **before you come to the competition on February 28.** Login details have been emailed to you. Access the simulator at *www.tinyurl.com/NASPAAdemo*. Note: not all options will be active on the simulator until February 28.
- Worksheet 2, provided at the back of this case study, is designed to help you complete Task Two. Download the worksheet from *https://app.box.com/2015NASPAAsim* and complete the worksheet as a team. This worksheet will alert you to some of the questions that the judges might ask.
- When the judges arrive at your team, present them with a summary of your proposal. You can show them materials on your computer and/or materials from the simulator. Judges will evaluate you based on the professional content and style of your interactions and the rubric presented in Appendix C-2.
- At the end of Task Two:
    - Save a copy of your completed Worksheet 2 on the team thumb drive.
    - In the simulator, indicate your best base run using the 'heart' feature. Go to the Manage page, and select the heart icon under the Favorite category. You can also do this from any page by using the Select Scenario menu on the left side of the screen, and clicking on the heart icon. This is the basis of 50% of your overall team score, which is calculated by the simulator. Your score will indicate how well your team balances the five criteria above.

Task Three
1:15 pm – 3:40 pm

Actually creating change involves much more than just thinking through "what if" policy choices. It involves getting into the nitty-gritty of implementation and public management—the real work of a public administrator. Bonneville's advisory task force for the Urbis region has representatives from all aspects of the health care system in Urbis. Your third task is to give Bonneville and her advisory task force your initial best thoughts on how model-based and locally-generated reforms in health care can be structured so as to meet the needs of all the stakeholders listed in Appendices A-1 and A-2. This task is immense and challenging—some might say impossible. But the excitement of working with and for Bonneville is that she shares the famous "can do" attitude embodied in the work of the Seabees during World War II and captured in the slogan, "The difficult we do immediately, the impossible takes a little longer".

Finally, you will prepare a 15 minute presentation of your final solution, including all of your work on all of the tasks; your presentation should take 10 minutes and you should leave 5 minutes for questions from the audience. Your presentation will be given during Task Four to 2 or 3 peer teams and one judge. You should download the template, but feel free to customize it based on your style.

***Instructions for Task Three**:*

- Worksheet 3, provided at the back of this case study, is designed to help you complete Task Three. Download the worksheet from *https://app.box.com/2015NASPAAsim* and complete the worksheet as a team. This worksheet will alert you to some of the questions that the judges might ask.
- At the end of Task Three, please save a copy of your completed Worksheet 3 on the team thumb drive.
- The following steps will help you prepare for your visits from the judges:
    1. **Assign Yourself Stakeholder Roles.** Divide the stakeholder roles presented in Appendix A-2 evenly among all members of your group. Make sure that each role is covered by a representative. All members will have to play multiple roles
    2. **Role Play and Critique Your Task Two Solution.** Using a role-playing approach, evaluate your final package of seven policy and finance options from Task Three from the point of view of all stakeholders. Critique your "best" policy package developed in Task Two from the point of view of all the roles in the case and decide what changes need to be made in the policy package from Task Two to meet stakeholder needs while maintaining a viable strategy.
    3. **Modify Your Task Two Solution to Meet Stakeholder Needs.** Presumably, you have chosen a package of options that best meets the five over-arching criteria described in Task Two. But now you have to add the additional dimension of feasibility and implementability from the point of view of these key stakeholders. For example, a policy that cuts into hospital profit margins might be refused by Harry Hospital. A policy package that severely constricts compensation for physicians might not be acceptable to David Doctor. A package that does not do enough to reduce inequity may upset Sally Social Worker. Create a revised policy package that both meets the five criteria and is broadly acceptable to all stakeholders. Identify:
        - Concerns raised by each stakeholder,
        - Compromises made to satisfy stakeholder needs, and
        - The effects they will have on the policy package's overall impact.
- Download the PowerPoint Template from *https://app.box.com/2015NASPAAsim*. This template is only a guide, feel free to customize the presentation based on your own content and style.
- Based on your PowerPoint, prepare a 10 minute formal presentation for your peers and the judge. You can prepare handouts or additional briefing materials as necessary.
- If your team is selected as the regional winner, you will make your presentation again and it will be videotaped for review when selecting the National competition winner.

Task Four
3:45 pm – 4:45 pm

Your final task is to give a 15 minute presentation of your final solution to your peers and a judge; your presentation should take 10 minutes and you should plan for 5 subsequent minutes for questions from the audience. There will be two or three presentation locations at each site with three or four presentations being made at each location. When you are not presenting, you will review and evaluate the presentations of other groups at your location using a rubric. You will not evaluate your own group.

When all of the presentations are complete, the judges will confer to decide the regional winner. The regional winner will be selected using the criteria, procedures, and scoring weights presented in Appendix C-1. Once the regional winning team has been selected, this team will make its presentation again to all participants and it will be videotaped. This videotape will be sent to a national panel of judges to view and consider when they decide on the national winner.

Instructions for Task Four

- Using the judging rubric from the folder you received at registration, (also Appendix C-2), score each peer team based on the 4 identified criteria. Your final score for each team should range from 0 – 16.
- Ensure that you identify the team name on the rubric and that the final score is legible.
- One student should volunteer to be the timekeeper for the presenting team so that they do not go over their allotted time for the presentation or the question/answer period.
- After each presentation, give your completed rubric to the judges.

After all peer presentations:

- Download and complete Worksheet 4 from *https://app.box.com/2015NASPAAsim*. This worksheet asks your team to reflect on what are the major lessons and insights that you have gained from this entire case exercise. This sheet should summarize and build on thoughts that you had throughout each task. This worksheet is the key document that will be used to evaluate your group for the second national prize—Best Documented Team Learning.
- Ensure that all materials for your electronic portfolio are saved to your thumb drive. This should include:
    - Coversheet indicating your team name, team members, and email addresses
    - Completed Worksheet 1
    - Completed Worksheet 2
    - Completed Worksheet 3
    - Final PowerPoint Presentation
    - Completed Worksheet 4
    - **Once all materials are ready, hand your flash drive to the NASPAA staff member onsite**
- Each team member should individually complete the post-test available at: http://tinyurl.com/NASPAA-PostCompetitionSurvey

As Rodrigo heads off for his assignment on February 28, working on health care reform in Urbis, he reflects on how wonderful it is that his very first job is giving him a chance to grapple with a really big policy and management challenge—taking a shot at making the impossible happen, having an opportunity to make a real difference with his life's work.

ADDITIONAL MATERIALS

APPENDIX A-1	A Local Initiative to Reform Health Care Provision in the Urbis Region
APPENDIX A-2	Biosketches of membership on the Urbis ad hoc Task Force on Health Care Reform
APPENDIX B	Policy Options for the Urbis Tabiyat Simulator
APPENDIX C-1	Selection of Winning Teams
APPENDIX C-2	Scoring Rubric for NASPAA Tabiyat Simulation Exercise

WORKSHEET 1	For use during Task 1
WORKSHEET 2	For use during Task 2
WORKSHEET 3	For use during Task 3
WORKSHEET 4	For use after Task 4
COVER PAGE	Please complete during Task 1

APPENDIX A-1:
A Local Initiative to Reform Health Care Provision in the Urbis Region

Earlier this year eight key stakeholders, all of whom hold key roles with respect to the provision of health care in the Urbis Region, met to create the Urbis *ad hoc* Task Force on Health Care Reform:

- Harry Hospital, CEO of the Urbis Medical Care Network, a non-profit health care system
- Connie Commissioner, Commissioner of the Urbis County Health Department
- Barry Businessman, Executive Director of the Upstate Regional Business Roundtable Special Interest Group on Healthcare
- Ingrid Insurer, Regional Director of the *Health First* Provider Network
- Nat Networker, Director of Alliance for a Healthy Upstate Region
- Sally Social Worker, Executive Director of Capstone Foothills Family and Parent Association
- David Doctor, President of the Urbis County Medical Society
- Nancy Nurse, CEO of Urbis Home Health Agency

While each of these stakeholders has differing and sometimes competing interests in the health care field, they all share an interest in creating a local health care system that is efficient and leads over time to a healthy and productive populace and workforce. More details about each key stakeholder are in Appendix A-2.

The group is interested in expanding its membership and exploring locally-based strategies that could improve the efficiency and effectiveness of the overall health care system in the Urbis region as well as improve overall measures of health for the general population. The group is especially interested in equity of health outcomes for all classes of citizens. The group is aware of a number of other such locally-based efforts that have involved the creation of innovative health care governance councils, the launching of an innovation fund, and initiating a number of best practices for health care delivery, disease prevention, and overall organization of health services in the region.

This group was thrilled when Lauren Bonneville, state Commissioner of Health, picked up on their proposal for locally-driven health care reform. Commissioner Bonneville has pledged to work closely with the Urbis group and has even arranged with a Foundation to have a Tabiyat simulator calibrated to the data and policy interests emanating from the Urbis region.

APPENDIX A-2:
Biosketches of membership on the Urbis ad hoc Task Force on Health Care Reform

Harry Hospital, CEO of the Urbis Medical Care Network

This role represents a ***regional hospital administrator***. The Urbis Medical Center Network consists of a downtown hospital that also serves as a teaching hospital for the Urbis Medical School. In addition, the Urbis Medical Center Network maintains a network of three feeder hospitals in outlying areas of the region. Physicians associated with the Network also teach in the medical school and maintain a number of regional clinics serving the UpState region including its more rural areas. Harry Hospital sees his hospitals as a critical health care resource for the region. He is interested in reforms that improve the health of his service area's population, but is especially concerned that the reforms not cause his hospitals to lose money and threaten their financial viability.

Harry's Interest Variables exactly as titled in simulator:

- Hospital Operating Margin
- Hospital Occupancy
- Disadv ER visits
- Readmissions

Connie Commissioner, Commissioner of the Urbis County Health Department

She is the ***local government health official*** directly concerned with the population's health. Urbis' Health Commissioner is broadly involved in all aspects of health care in Urbis County as well as in the broader region. She serves on a number of regional boards and regularly interacts with the State Health Department on many issues related to health care in Urbis County and the Upstate region. Her department provides some direct health care services such as Maternal and Child Health Clinics, a number of preventive programs such as smoking cessation and immunization, and regulation of some aspects of environmental health. She believes education, outreach, and serving all populations fairly are important aspects of public health and would like to see more dollars flowing through her department to help accomplish these goals.

Connie's Interest Variables exactly as titled in simulator:

- Severe chronic physical illness
- High risk behavior
- Disadv hazardous environ

Barry Businessman, Executive Director: Upstate Regional Business Roundtable Special Interest Group on Healthcare

The Executive Director of this SIG leads a ***business coalition on health care reform***. Upstate region has a very active Business Roundtable that is organized around a number of special interests. The Healthcare SIG is broadly interested in promoting reforms that improve the health of the region's population because it recognizes that a healthy (and well-educated) workforce is a productive workforce. Of more immediate interest, the business roundtable always advocates for the most efficient and cost-effective ways to keep down the costs of health care to reduce the insurance premiums paid by local businesses. It argues that lower health care costs are essential to maintain the competitiveness of local businesses and the health of the region's economy.

Barry's Interest Variables exactly as titled in simulator:

- Worker care costs
- Lost Productivity
- Value net of employee costs
- Any physical illness

Ingrid Insurer, Regional Director of the *Health First* Provider Network

Functioning in the role of an ***administrator of a regionally oriented health insurance plan***, the Regional Director of Health First is concerned with creating and sustaining an insurance-based network of physicians who provide care. She is concerned with containing health care costs all within the context of an insurance system that relies on premiums primarily from employers and assuring that those employers and their workers get value for their premium dollars. Always faced with competition from other health insurance systems, the **Health First Provider Network** must remain attractive to physicians who provide services within the network while at the same time maintaining a premium structure that is competitive in the market. The **Health First Provider Network** is always interested in experimenting with payment reforms such as alternative financing mechanisms to meet these competing objectives, but wants to be sure that any changes in care delivery or financing will not adversely affect its bottom line.

Ingrid's Interest Variables exactly as titled in simulator:

- Cost per capita by payer, commercial
- Non-urgent episodes to ER
- Readmissions
- Supply push

Nat Networker, Director of Alliance for a Healthy Upstate Region

The alliance is a ***community-based health advocacy organization*** that represents health care consumers. It is interested in promoting reforms that can increase the regional population's health, improve its access to care, and assure that consumers receive only the care that they need. In the past, the Alliance has focused on targeted areas where they believe joint action could meet the dual objectives of improving health and access to appropriate care, such as improved long term care for the elderly, health initiatives aimed at chronic diseases such as diabetes or chronic heart disease, and reduction in the unnecessary use of expensive diagnostic procedures. Participation in any reforms will help to increase his organization's visibility.

Nat's Interest Variables exactly as titled in simulator

- Untreated mental illness
- High risk behavior
- Severe chronic physical illness
- Disadv poor prev/chron care

Sally Social Worker, Executive Director of Capstone Foothills Family and Parent Association

Originally started in the foothills of the Capstone Mountains, this organization represents a ***non-profit social services provider*** with a strong interest in the provision of quality health care especially to the poor and disadvantaged in the region. While many of the services of the Foothills Family and Parent Association do receive third party reimbursement from Medicaid and other social services provided by the state government, the interests of the Foothills Association extends more broadly to advocacy for those least able to advocate for themselves. This agency has a strong record of advocating for equality of access to healthcare for all and for health-related outcomes that are equal for all socio-economic classes. She would also like to see more health care dollars flow to her agency since their services help to improve the population's health.

Sally's Interest Variables exactly as titled in simulator

- PCPs for disadv, uninsured
- PCPs for disadv, Medicaid
- Disadv severe physical illness
- Disadvuntreated mental illness

David Doctor, President of the Urbis County Medical Society

The Medical Society is an ***association of independent physicians*** that provides much of the medical care in the region. The stresses created by the vast amount of paperwork and quarreling with insurance companies has made the physician community an active participant in reform, hoping that it will lead to a more rational health care environment. Dr. Doctor hopes that by participating, the medical community can take a leadership role. He is especially concerned that the region shape reform in a way that protects physicians' financial interests and not sacrifice them in the pursuit of other goals.

David's Interest Variables exactly as titled in simulator

- PCP average income (2010$)
- Specialist average income (2010$)
- Unmet demand for prev/chron

Nancy Nurse, CEO of Urbis Home Health Agency

The Home Health Agency is a ***health care provider*** that cares for people recently released from the hospital. Ms. Nurse is especially interested in making sure there are policies in place to assure patients will get the necessary care once they have left the hospital. She has been trying to convince other health providers and insurers that better post-hospital services will prevent expensive readmissions for which hospitals are penalized. She has not had much success in doing so, but hopes that this new reform effort will provide an avenue for addressing her concerns. Naturally, she also wants see the region adopt reforms that help to assure her own agency's financial viability.

Nancy's Interest Variables exactly as titled in simulator:

- Readmissions
- Home health revenue
- Discharges to home health

APPENDIX B:
Policy Options for the Urbis Tabiyat Simulator

Intervention Options for Simulation Scenarios

This table shows where the direct effects of each intervention concentrate

Intervention Options for Simulation Scenarios

The table below shows where the direct effects of each intervention concentrate.

Risk	Healthier behaviors Environmental hazards	Crime	Pathways to advantage (family; student)
Care	Preventive/chronic care Mental illness care	Self care	Hospital infections
Capacity	PCP efficiency	Recruit PCPs (general; FQHC)	Hospital efficiency
Cost	Pre-visit consult Medical home	Coordinate care Included with above Shared decisions Generic drugs	Malpractice Post-discharge care Hospice
Trends	Uninsurance Local economy	Primary care slots Hospital occupancy	Inflation rate
Funding	Innovation fund	Reinvest savings	Contingent global payment

Initiative Options for Simulation Scenarios:

The following options are in the Health Dynamics simulation model.

Enable healthier behaviors

Promote healthy behaviors and help people to stop behaviors that can lead to chronic physical illness—smoking, poor diet, inadequate exercise, alcohol and drug abuse, unprotected sex, etc.

Consequences: Reduces onset of mild and severe chronic physical illness, the likelihood of urgent events (e.g., heart attacks from cigarette smoke), as well as the onset of mental illness associated with drug abuse. Also reduces the need for medications for lifestyle-related disorders including asymptomatic hypertension and high cholesterol.

Time and cost assumptions (modifiable): Risky behavior prevalence declines over time as cessation increases and new onset decreases. Costs $100 per capita per year for population engaging in risky behavior. One may choose, for budgetary or equity purposes, to focus this intervention only on the disadvantaged, or youth, working age, or seniors.

Reduce environmental hazards

Reduce the fraction of people with significant exposure to environmental hazards and pollutants in their homes, neighborhoods, or workplaces.

Consequences: Reduces onset of mild and severe chronic physical illness (e.g., cardiovascular disease, asthma, cancer, chronic lead poisoning), and the likelihood of injuries (e.g., due to fire, falls, drowning, heat stroke) and other urgent events (e.g., heart or respiratory attacks triggered by air pollution) requiring an ER visit.

Time and cost assumptions (modifiable): Takes an average of 5 years to remediate hazards. Costs $200 per capita per year for population in hazardous surroundings. One may choose, for budgetary or equity purposes, to focus this intervention only on the disadvantaged.

Reduce crime

Reduce the fraction of people who live and work in high crime areas.

Consequences: Reduces the likelihood of injuries requiring an ER visit, and also helps to discourage unhealthy behaviors (physical inactivity, drug abuse, unprotected sex) and encourage healthy ones.

Time and cost assumptions (modifiable): Takes an average of 5 years to reduce crime prevalence. Costs $200 per capita per year for population in high-crime areas. One may choose, for budgetary or equity purposes, to focus this intervention only on the disadvantaged.

Create student pathways to advantage

Provide programs for disadvantaged high school and college students to improve graduation and matriculation rates. Greater educational attainment improves one's chances to become advantaged through higher-paying jobs.

Consequences: The advantaged are less likely to engage in unhealthy behavior, or to live in hazardous or high-crime environments, or to develop chronic physical or mental illness, or to be uninsured, or to go to the hospital for non-urgent care; and more likely to engage in self-care and care-seeking activities.

Time and cost assumptions (modifiable): Takes an average of 5 years following completion of a student pathways program to move from disadvantaged to advantaged. Costs an average of $14,000, over the period of high school and college, per disadvantaged young person.

Create family pathways to advantage

Institute policies and programs (for example, living wage policies, tax credits and subsidies, and housing vouchers) to improve economic prospects so that some disadvantaged families—those earning below twice the federal poverty level—may become advantaged.

Consequences: (see student pathways consequences above.)

Time and cost assumptions (modifiable): Takes an average of 3 years to move families from disadvantaged to advantaged. Costs $1,000 per capita per year for the disadvantaged population.

Improve routine preventive and chronic care for physical illness

Improve physician compliance with all recommended guidelines for preventive and chronic physical illness care. Preventive care includes screening, immunization, lifestyle counseling, and referral to behavioral and mental health counselors as needed. Implementation may require investment in reminder systems and training.

Consequences: Reduces death rates and the frequency of acute and urgent episodes among patients with chronic physical illness, and rates of onset of mild and severe chronic physical illness; and increases rates of behavioral reform and mental illness control. These benefits are attained at the cost of additional physician visits and increased use of medications.

Time and cost assumptions (modifiable): Takes average 1 year to implement initiative features, and then average 2 years for improved care to reduce acute and urgent episode rates. Costs $20,000 per office-based physician as initial investment, then subsequent maintenance investment at rate of 10% per year.

Improve care for chronic mental illness

Help the mentally ill effectively treat their symptoms and live more positively and productively.

Consequences: Reduces urgent psychological visits to the ER, and unhealthy behaviors; and improves routine physical care-seeking and self-care. These benefits are attained at the cost of increased use of medications and additional visits to mental health care professionals.

Time and cost assumptions (modifiable): No delay in implementation. Costs $800 per capita per year for previously uncontrolled mentally ill population. One may choose, for budgetary or equity purposes, to focus this intervention only on the disadvantaged.

Support self-care

Help people who currently have problems with adherence to get regular preventive and chronic care and to follow physician advice for use of medications and other self-care. This may involve reminder systems as well as transportation and other support services for those who need them.

Consequences: Improves the extent and effectiveness of preventive and chronic physical illness care (with effects as described in the option above), and also reduces the likelihood of hospital readmission.

Time and cost assumptions (modifiable): Takes average 1 year to implement initiative features. Costs $100 per capita per year for previously non-adherent advantaged population, and $200 for disadvantaged. One may choose, for budgetary purposes, to focus this intervention only on the disadvantaged.

Prevent hospital-acquired infections

Implement procedural changes in hospitals to reduce the fraction of inpatients that develop a hospital-acquired infection.

Consequences: A lower HAI rate means fewer deaths and fewer extended lengths of stay for inpatients. Although most insurers today reimburse for the additional costs of an HAI, the trend is toward non-reimbursement. Thus, in the near future, a lower HAI rate will improve a hospital's profit margin.

Time and cost assumptions (modifiable): Takes average 1 year to implement initiative features. Costs $1,000,000 per 100 beds as initial investment, then subsequent maintenance investment at rate of 10% per year.

Redesign primary care practices for efficiency

Increase the fraction of primary care providers whose practices or clinics are streamlined to run as efficiently as possible. This is sometimes referred to as idealized design of clinical office practices (IDCOP). The IDCOP approach comprises a number of techniques for appointment scheduling, staff utilization, and use of information technology.

Consequences: Practice redesign helps PCPs better accommodate demand.

Time and cost assumptions (modifiable): Takes average 1 year to implement initiative features. Costs $20,000 per PCP as initial investment, then subsequent maintenance investment at rate of 10% per year. One may choose, for budgetary purposes, to focus this intervention only on FQHC PCPs.

Recruit primary care providers for general (non-FQHC) offices and clinics

Recruit more general PCPs serving the non-poor (both insured and self-paying) and/or the insured poor (Medicaid). Some tactics include first-year income guarantees and local PCP residency programs.

Consequences: An expanded supply of general PCPs can better accommodate demand from the non-poor and from the insured poor.

Time and cost assumptions (modifiable): Takes average 2 years for general PCPs to consider options, including recruitment offers and negotiations, and to relocate. Costs $200,000 per newly arriving PCP including costs of search and subsidy to guarantee minimum PCP income for some time after arrival.

Recruit primary care providers for FQHC clinics

Recruit more PCPs serving the poor (both insured and uninsured) in Federally Qualified Health Center clinics.

Consequences: An expanded supply of FQHC providers can better accommodate demand from the insured poor and from the uninsured poor.

Time and cost assumptions (modifiable): Takes average 2 years for FQHC PCPs to consider options, including recruitment offers and negotiations, and to relocate. Costs $200,000 per newly arriving PCP including costs of search and subsidy to guarantee minimum PCP income for some time after arrival.

Improve hospital efficiency

Make process improvements that reduce the average length of stay for inpatients.

Consequences: Allows for a reduction in beds for a given volume of inpatients, and thereby reduces operating costs and improves hospital profit margin.

Time and cost assumptions (modifiable): Takes average 1 year to implement initiative features. Costs $1,700,000 per 100 beds as initial investment, then subsequent maintenance investment at rate of 10% per year.

Offer pre-visit consultation for non-urgent episodes

Establish telephone call centers, staffed by trained triage nurses with software support, to advise callers on whether they should seek medical care for their non-urgent episode or instead take care of themselves at home.

Consequences: Can reduce the number of primary visits to physicians and non-urgent visits to ERs, without affecting the quality or intensity of care for conditions that should receive medical care.

Time and cost assumptions (modifiable): Takes average 1 year to implement initiative features. Costs $12 per capita per year across entire population.

Create medical homes

Ensure that more patients go to primary care providers (PCPs), rather than specialists or hospitals, for their routine care and as their first stop for non-urgent episodic care. Medical homes need electronic medical records and perhaps decision-support systems for more effective referrals.

Consequences: Has the potential to reduce the cost of routine visits and non-urgent acute care, to improve patient adherence, and to reduce the number of referrals and admissions generated by non-urgent acute care. Also, decision support for PCPs should reduce their susceptibility to the allure of costly new hospital service offerings. However, more patients means more demand on PCPs, creating the possibility (unless averted through other means) of a PCP shortage for some population segments.

Time and cost assumptions (modifiable): Takes average 1 year to implement initiative features. Costs $20,000 per PCP as initial investment, then subsequent maintenance investment at rate of 10% per year.

Coordinate health care

Coordinate patient care and provide coaching for patients and physicians to reduce duplicative or unnecessary referrals and admissions and to reduce medication costs. Care coordination requires sophisticated integrated information systems as well as coaching arrangements and protocols for shared decision making and use of generic drugs whenever appropriate. You may also choose, for additional program cost, to include a regular process by which new, higher-priced medical technologies are assessed as they start to become popular and rejected if they do not meet cost-effectiveness criteria.

Consequences: Reduces follow-up actions from an initial physician visit that might result in duplicative or unnecessary services—referrals to specialists, ambulatory tests and procedures, hospital admissions—without adversely affecting health outcomes. Also reduces ongoing medication costs by rationalizing use of prescription drugs.

Time and cost assumptions (modifiable): Takes average 1 year to implement initiative features. Costs $30,000 per office-based physician as initial investment, then subsequent maintenance investment at rate of 10% per year. The regular assessment of new technologies raises the maintenance cost by 25%.

Reform medical malpractice

Institute effective tort limits or a fairer adjudication process so that fewer lawsuits go forward and, as a result, doctors see less need to engage in purely defensive practices that do not benefit patients.

Consequences: Reduces referrals to specialists, ambulatory tests and procedures, hospital admissions, and use of high-priced medications- without adversely affecting health outcomes.

Time and cost assumptions (modifiable): Takes average 1 year to implement initiative features. Costs $1,500 per office-based physician for every year the initiative is in effect.

Improve post-discharge care to reduce hospital readmissions

Reduce the risk of hospital readmissions through improved discharge practices, including medication reconciliation and more referral to home health care and skilled nursing facilities for rehabilitation.

Consequences: Reduces hospital utilization and costs, but increases utilization and costs of home health care and nursing facilities.

Time and cost assumptions (modifiable): Takes average 1 year to implement initiative features. Costs $1,000,000 per 100 beds as initial investment, then subsequent maintenance investment at rate of 10% per year.

Expand the use of hospice care

Increase the fraction of end-of-life patients using hospice services and thereby choosing not to receive other services (e.g., physician, hospital, nursing home) when acute episodes occur.

Consequences: Reduces health care costs.

Time and cost assumptions (modifiable): Takes average 1 year to implement initiative features. Costs $1.25 per capita per year across entire population.

Establish innovation fund

All of the initiatives on the preceding pages require funding and can only be implemented if an innovation fund is in place. The fund is specified as a given dollar amount per year, starting in a specified year and extending for a specified duration, after which time no new funds are provided. If some of the innovation fund is unused in one year, the remainder rolls over to the next year, and may be used even after the conclusion of new funding.

Move to a contingent global payment (CGP) scheme

A contingent global payment (CGP) scheme combines payment on a per capita basis with basic care standards and rewards for certain beneficial activities. Thus, CGP by itself can lead to some provider-driven improvements (e.g., better preventive and chronic care, better coordination of care, and better post-discharge planning) even without community-level initiatives. Moreover, CGP has the potential to eliminate the resistance from providers to cost-reducing community-level initiatives (such as care coordination) that would occur in a fee-for-service environment. You may specify the extent to which such a scheme is instituted in the community through plans offered by commercial insurers, by Medicare, and by Medicaid (three separate intervention levers).

Consequences: When a large fraction of the total insured population in the community is covered by a CGP plan rather than fee-for-service, the "supply-push" responses of providers to loss of income is suppressed. Also, CGP improves the following provider-driven activities: Preventive and chronic care quality, Care coordination, Medical home, Adherence support, PCP practice redesign, and Post-discharge care quality.

Time and cost assumptions (modifiable): Takes average 1 year to implement initiative features. Costs $15 per CGP covered life as initial investment, then subsequent maintenance investment (e.g., due to an individual's change of insurance plan) at rate of 10% per year.

Reinvest Savings

Reinvesting savings involves negotiating with payers an arrangement in which they calculate healthcare cost savings against appropriate benchmarks (benchmarks normally rising over time with national health care inflation, but this change rate may be modified) and then return to the community some fraction of those savings. The fractions returned may vary by payer (commercial, Medicare, Medicaid) and are also assumed, per negotiation, to be reduced if sufficient funds have accumulated in reserve to cover the indicated program spending for several years (default: 15+ years of accumulation reduces the fraction to zero for all payers.)

The reinvested savings may be used to fund the initiatives on the preceding pages, with perhaps some savings shared with providers. Like the innovation fund, if some savings are unused in one year, the remainder rolls over to the next year. Reinvested savings are not segregated from innovation funds; the two are merged as total funds available to the community.

Some fraction (one fraction for physicians and another fraction for hospitals; default for both = zero) of each year's reinvested savings may be designated for sharing with physicians and hospitals, as a "cost of doing business" to secure their cooperation with the gain sharing arrangement and the selected initiatives it will fund. Shares to physicians are divided equally among all PCPs and specialists. The sharing with specialists may help offset any supply-push response that would occur as a result of Coordination or other cost-reduction initiatives that may negatively impact their income.

The following trends are assumed and may NOT be adjusted for 2015 and beyond during this competition
While the option to adjust trends exists, they have been fixed for the NASPAA Student Case Competition to ensure a level playing field for all teams.

Uninsurance due to federal mandate or expanded eligibility

To what extent will state and local authorities ultimately adopt and promote the new plans under ACA?

Adoption / Promotion of Commercial plans for Advantage — 75%

Adoption/Promotion of Medicaid plans for Disadvantaged — 75%

Start time for ACA eligibility expansion — 2014

End time for ACA eligibility expansion — 2018

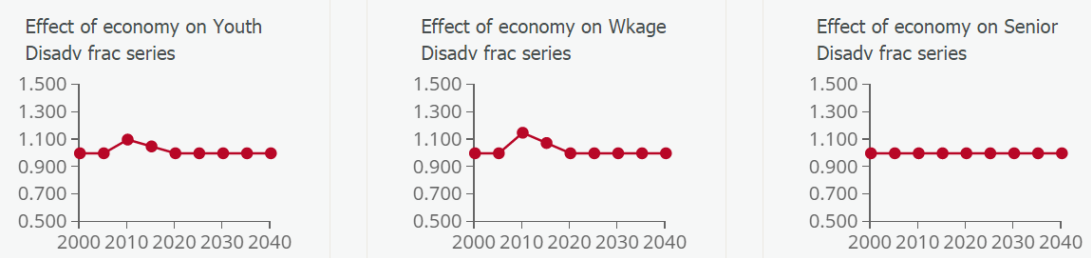
What fraction of currently uninsured locals would remain ineligible for insurance even under full adoption of ACA? For example, undocumented individuals remain ineligible under ACA. (National estimate = 0.33 of Advantaged Uninsured and 0.33 of Disadvantaged Uninsured.)

Ineligible Fraction of Advantaged Uninsured — 0.33

Ineligible Fraction of Disadvantaged Uninsured — 0.33

Consequences: Having insurance makes people more likely to seek preventive and chronic care, which is good from a health standpoint, but has mixed cost effects (more routine visits, more drugs, fewer acute episodes). Increased insurance may put added pressure on general PCP capacity, while it takes pressure off of FQHC PCP capacity, as the newly insured disadvantaged now have the choice of going to a general PCP—and these shifts may affect the volume of non-urgent ER visits. At the same time, more of the advantaged can now afford to see specialists and have elective tests and procedures, thereby increasing various costs.

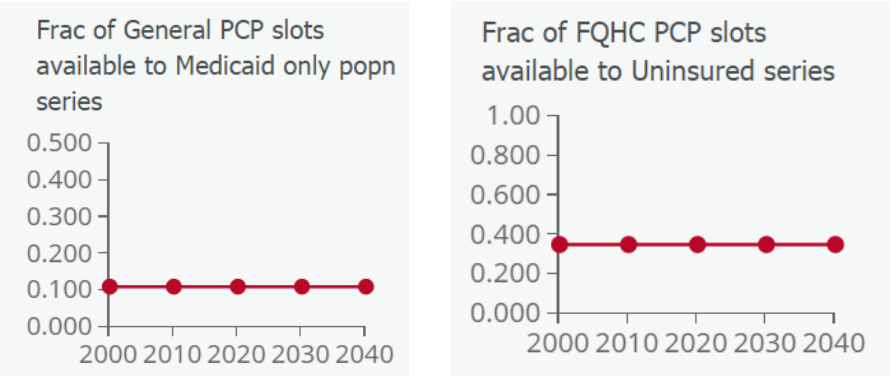
Economic conditions affecting disadvantage



These are multipliers reflecting general economic trends that affect the disadvantaged fractions of the population. This is done via three input time series: one series for youth, one for the working age, and one for seniors. A value of "1" indicates no effect of the general economy on disadvantage relative to the year 2000; "1.15" would indicate a 15% relative increase in disadvantage. Note that forces other than the general economy may affect disadvantage in the model, including chronic physical or mental illness (effects of disability), rising health care costs (effects of medical bankruptcy and job layoffs), as well as the Pathways to Advantage interventions.

Consequences: An increase in disadvantage has consequences that are the opposite of those described above for Pathways to Advantage.

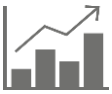
Primary care appointment slots for the Disadvantaged



This is the fraction of general (non-FQHC) PCP appointment slots available to the non-senior Medicaid-only population via input time series. A reduction in the fraction over time could reflect increased financial pressure on general PCPs due, for example, to declining Medicaid reimbursements.

Similarly, the fraction of FQHC PCP appointment slots available to uninsured disadvantaged patients is specified as an input time. As a default, this time series is assumed to remain at its initial value. A reduction in the fraction over time could reflect increased financial pressure on FQHC PCPs due, for example, to declining Medicaid reimbursement rates.

Consequences: A reduction in PCP appointment slots for Medicaid or uninsured patients could create or exacerbate PCP capacity shortages for these populations, leading to less adequate preventive and chronic care and more use of the ER for non-urgent events.



Real rate of inflation in healthcare costs

This real rate is measured as annual growth in national personal healthcare expenditures per capita minus growth in the general Consumer Price Index (CPI). It fluctuated generally in the 2-5% range during 2000-2005 and in the 0-3% range during 2005-2010. After 2010, the default rate is 1.5% per year.

Note that this real rate of health care cost inflation allows for growth in costs not only from price changes for specific items, but also from the adoption of new technologies and broadening criteria for the use of technology. In other words, it allows for a changing market basket of services and products applied to a given medical condition, and is thus conceptually different from the Medical Care portion of the CPI, which assumes a fixed market basket.

Consequences: Health care cost inflation is assumed to gradually raise the costs of all categories of healthcare costs in the model. It also gradually raises the cost of implementing "provider-level interventions", that is, the interventions listed above that require hospital or physician involvement.

Care Coordination can to some extent blunt the effect of healthcare cost inflation, but it must include the option to screen and potentially reject new, higher-priced medical technologies as they become popular.

In the model, increasing healthcare costs faced by employers leads to greater uninsurance for the working age population. Rising healthcare costs also lead to more people being forced into Disadvantage, due to high out-of-pocket costs (in some cases, bankruptcy) and job layoffs. Both trends have been evident nationally from the late 1990s to the present.

Goal for hospital occupancy

The hospital occupancy goal is assumed to remain at its initial value (66% for the US overall). An occupancy goal lower than the initial value of occupancy will lead to a decline in occupancy through more rapid growth of staffed beds. If the occupancy goal later increases, that would allow an increase in occupancy toward its new goal through slower growth of staffed beds.

The occupancy goal might differ from the initial occupancy, or might change over time, for two possible reasons. One is "passive": small hospitals generally have lower occupancy than large (typically urban) ones, so if there is a trend in the size of hospitals (say, due to increased or decreased urbanization), such a trend would naturally affect the occupancy goal as well. The second is "active": if hospitals start competing for patients on the basis of number and types of beds available, the resulting rapid growth of beds could drive the occupancy goal below its initial value. A decision by hospitals to end such a "beds race" could increase the occupancy goal; for example, allowing it to return to the initial value of occupancy.

Consequences: Lower hospital occupancy translates (other things being equal) to lower hospital profitability. If hospital profits are being threatened by interventions that reduce hospital volume (e.g., care coordination), then restoring profitability may require not only the hospital efficiency intervention to reduce average length of stay (see above) but also a decision by hospitals to raise the occupancy goal.

APPENDIX C-1
Selection of Winning Teams

NASPAA's National Simulation Competition will result in six regional winning teams and two national winning teams: National Winner for Best Performance and National Winner for Best Documented Team Learning.

Regional Winner

The regional winner will be determined to be those teams at each site that have the highest combined score at the end of the day's competition. The combined score is a weighted combination of:

- The calculated Super Score associated with the team's best run for Task Two (50%)
- The average score from judges as assigned once at the end of the day based on all rounds (35%)
- The average score gained at the peer review of presentations at the end of the day (15%)

Super Score (50%)

The Tabiyat simulator challenges teams to excel along five distinct dimensions of performance:

1. Reduce cost
2. Make the population healthier
3. Improve the content and quality of care
4. Improve equity as measured by such changes as reducing the excessive mortality rate suffered by the economically disadvantaged
5. Improve productivity of the Urbis work force by reducing disability due to illness and injury

The Super Score is calculated within the simulator and combines these five key performance areas using equal weighting. The Super Score submitted for each team in Task Two will be used to calculate this score.

Judges' Evaluation (35%)

During the competition, judges will visit each team multiple times. Teams should be prepared to engage in a fluid dialogue with the judges when they appear. Students will be requested to present and defend their then-current best proposal. During and after Task Two, the judges will be probing for how well each team responds to the five criteria that are used to evaluate policy performance within the Tabiyat Health simulator. Students will be evaluated according to how well they can present a compelling view of why and how their policy package is performing (as opposed to just presenting final scores for key variables). During and after Task Three, the judges will be probing for how well the policy proposal meets the needs of key stakeholder groups as defined within the case exercise. Student teams will also be judged on the clarity of their verbal presentation as well as their ability to think on their feet and respond to questions during the final presentation. The judges will assign three different scores to each team. Of the total score, the judge evaluation of Tasks 1 – 3 is 20%, the judge evaluation of the final student presentation is 5%, and the judge discussion is 10%, bringing the total weight of the judges' score to 35%.

Peer Evaluation of Proposals (15%)

At the end of the day, teams will be divided to present their best solution to their peers and the judges in a presentation lasting no more than 10 minutes, and then fielding 5 minutes of questions. When judging peer teams, each person will use the rubric in Appendix C-2 to evaluate the overall performance of other teams. Teams will not evaluate themselves.

National Winner for Best Performance

The national winner and runners up will be selected by a panel of national judges that will meet virtually on March 2nd. This panel will review the material submitted by each of the regions including the videos of presentations for the 6 regional winning teams. The national panel will use the same criteria and rubric as that used by the judges in the regional competitions.

National Winner for Best Documented Team Learning

NASPAA is interested in both the end product of what you have learned during the day and in the process by which you have learned during the day. This additional national prize recognizes the team that best documents what they learned and how they learned it. This award cannot be bestowed on March 2 because the review of materials for all competing teams will take time.

This task in the case asks each team to make sure that all of the materials developed while working on the case have been saved on a thumb drive. The complete portfolio of materials would include:

1. Coversheet indicating the team name, team members, and team email addresses
2. Final PowerPoint presentation
3. Completed Worksheet 1 for Task 1
4. Completed Worksheet 2 for Task 2
5. Completed Worksheet 3 for Task 3
6. Completed Worksheet 4: Inventory of Insights and Lessons for the Day

A key document in this electronic portfolio is the *Inventory of Insights and Lessons for the Day*. This document, intended to be completed and saved near the end of the day summarizes much of the work completed and lessons learned. This worksheet can be found at the end of the case and an electronic version is available at *https://app.box.com/*2015NASPAAsim.

A team of NASPAA faculty members will review these electronic portfolios using the following criteria:

1. Completeness of the documentation
2. Types of lessons learned and insights gleaned:
    - Before arriving at the competition
    - During Task 1 discussions
    - Through interaction with the simulator
3. Ability to relate lessons and insights to specific activities during the case exercise

APPENDIX C-2
Scoring Rubric for NASPAA Tabiyat Simulation Exercise[6]

Name of person scoring (circle one: Student/Judge) _____
Team name of person scoring (if student) _____
Team being judged _____

Criteria	Poor =1	Satisfactory = 2	Good = 3	Excellent = 4	Score Assigned
Team Explains Reasoning behind Policy Performance for all Five Assigned Criteria	Does not use assigned criteria or refers only to Super Score.	Discusses only performance of criterion variables with little or no reasoning	Performance on some of five dimensions explained with causal reasoning and referring to pitfall analysis in the model	Performance on all five dimensions explained with causal reasoning and referring to pitfall analysis in the model	
Solution Presented Meets Requirements of Key Stakeholders	Stakeholder interests are ignored in final presentation	Some stakeholder needs are discussed and analyzed	Most or all stakeholder needs are discussed but evidence and reasoning is not always clear	Team demonstrates how policy package meets needs of all key stakeholders in the case using evidence from the simulator	
Policy Package is clearly and completely presented	Presentation does not describe well performance against 5 criteria nor how stakeholder requirements are met	Policies presented clearly in terms of criteria OR stakeholder requirements, but not BOTH	Policies clearly present both criteria-based performance and meeting stakeholder requirements—but tradeoffs not clear	Describes trade-offs made between attaining high criteria scores and meeting stakeholder requirements	
Team is able to think on their feet and respond to questions and challenges	Team members are not able to respond adequately to questions	At least one member of team can respond to some questions and challenges	Most team members help answer most posed questions and challenges	Excellent response to all questions and challenges	
				Total Score	

Comments (use space on back as needed):

[6] **Scoring Instructions:** Fill out four scores (1-4) for each criterion plus a summary score. Comments will be used to support judging at higher levels and for feedback to the teams. Be sure to include name of team being evaluated and your own name (and team, if applicable)

WORKSHEET 1

Download a blank copy of this worksheet at https://app.box.com/2015NASPAAsim

Name Your Team: Your team's log-on and password for the simulator will be determined by a pre-assigned team number. However, every good team needs a team name that reflects the true character of your team. Below, please identify your team by both your assigned number and your chosen name. For example: **Maryland1: Alpha Zulu**. Your assigned number will be the name of your regional site, followed by NASPAA and then a number 1-9. (i.e.: GeorgiaNASPAA1 or CaliNASPAA6, etc.)

Team Number and Name: _____

Completing this worksheet does not require that you make any use of the simulator. Refer back to the listing of health policy and finance options found in Appendix B of the case study. Based on your preliminary readings, indicate the 7 initiatives your team has chosen to be the elements of the initial strategy you will pursue for Urbis.

1.

2.

3.

4.

5.

6.

7.

In a few sentences, explain the overarching strategy that caused your team to select these initiatives.

How much impact (great, moderate, little or no, negative) do you expect your strategy to have on Urbis with regard to each of the following measures being used to define success in this case exercise? Why?

1. Per capita cost

2. Deaths (as a measure of health status)

3. Content and quality (adequacy) of health care

4. Inequity in care and health outcomes between lower and middle and upper income groups.

5. Productivity of Urbis' workforce

What difficulties and pitfalls would you expect to encounter when implementing such a strategy?

When you are done with this task, save a copy of this completed worksheet on the thumb drive provided to your group.

WORKSHEET 2

Team Number and Name: _____

Download a blank copy of this worksheet from https://app.box.com/2015NASPAAsim

Tips and Instructions for Using the Simulator for this Worksheet

The simulator that you will use on February 28 to complete this worksheet is a sophisticated, state-of-the-art policy support tool. This simulator was originally developed to support teams of professionals working in select regions on health care reform. When NASPAA modified the simulator for use in the completion, we built a new user interface for the simulator. This interface did not "dumb down" the simulator, but it does provide a number of features that should speed your learning in the case. Seek out information and help as you get started using the simulator:

- Make sure that you have reviewed the 18 minute YouTube video on simulator use. You might even view it twice—one to get the general point and a second time following along.
- There are several planned presentations of "tips and pointers" during the day on February 28. Pay close attention to these and be prepared to ask questions.
- NASPAA has arranged for trained technical staff to be present in each of the regional sites. Seek them out and ask questions if you feel stuck.
- The judges have been through several technical training sessions as well, so they can assist you as needed.
- Learn from one another. If you learn a neat and helpful feature of the simulator, do not hesitate to share it with others. The point of the competition is to compete on policy strategy and implementation, not on details of how to use the simulator.

To complete this part of the case, refer back to this listing of health policy and finance options found in Appendix B of the case study. During the time allotted for Task Two, your team should be repeatedly running various combinations of 7 initiatives through the simulator. For each run, the simulator will give you information on how well this package works by giving you a single "Super Score" as well as its five components for each of the five base criteria. While in theory each of the five scores might be able to earn 100 points for an overall super score of 500 points, you will not be able to achieve the maximum a score in this run (among other things it would be much too expensive). **A strong final score for Task Two will be in the high 200s or low 300s.** Here are some heuristics for using the simulator as a learning tool:

- Explore options systematically. Only change one thing at a time so that you can understand what changes occur from each of the options.
- Look at the five component sub-scores of the overall super score (make sure you know how to see the breakdown of your score). Looking at the sub-scores gives you clues as to what policy to add next.
- There are known "pitfalls" that inhibit making good policy progress in this simulator (indeed in health care reform in general). The simulator has a set of functions that walk you through the most critical pitfalls for your current run. Find out how the pitfalls toolbar works and use it often.
- You can push the "reset" option to create a new set of 7 initiatives starting again from the base run. However, later on, you may prefer to just modify your current run by taking out one initiative and adding in one new one and then renaming the run. In order to do this, you will want to make sure that you are familiar how to manage the many runs that you will start to generate. There is a tool bar devoted to helping you to manage your runs.
- When you are finished with Task Two and have found your best run (as measured by the super score), make sure to mark this best policy using the "heart" function under the manage runs tab.

Based on the follow up work that you have done on the simulator, indicate the 7 initiatives your team has chosen to be the elements of the initial strategy you will pursue for Urbis. These seven initiatives should not be the same that you submitted for Task One. These are the 7 initiatives that form the final run that you have "hearted" as your best run giving you the highest super score.

1.

2.

3.

4.

5.

6.

7.

In a few sentences, describe the learning that took place as your team moved from the initial strategy and set of initiatives you developed in Task 1 to the strategy embodied in the final set of initiatives you have listed above. What enabled your team to make the strategy more effective?

What aspects make the strategy especially effective? How do the elements work synergistically to add up to a result that is greater than the sum of its parts?

Indicate the cumulative impact relative to the baseline in each of these areas and why you think the strategy had (or didn't have) the impact your team desired.

6. Per capita cost

7. Deaths/health status

8. Content and quality of health care

9. Inequity in care and health outcomes between lower and middle and upper income groups.

10. Productivity of Urbis' work force

In the course of developing your final strategy, what pitfalls did you encounter and how did you deal with those pitfalls?

If you had more time, what else would you have tried to improve your strategy? Why?

When you are done with this task, save a copy of this completed worksheet on the thumb drive provided to your group.

WORKSHEET 3

Team Number and Name: _____

Download a blank copy of this worksheet from https://app.box.com/2015NASPAAsim

This worksheet follows up on the role-playing exercise in the case study. The policy package that you "hearted" in Task Two may score high in terms of the five key policy indicators, but it may not be acceptable to key stakeholders. In order to increase the implementability of your proposed policy package, you may wind up proposing policies that score less well against the criteria, but are overall more acceptable to key stakeholders. The worksheet below challenges you to summarize the reactions to your selected strategy of each of the people playing key roles in the Urbis health task force. What were their key concerns and objections, if any?

- Harry Hospital, CEO of the Urbis Medical Care Network

- Connie Commissioner, Commissioner of the Urbis County Health Department

- Barry Businessman, Executive Director of the Upstate Regional Business Roundtable Special Interest Group on Healthcare

- Ingrid Insurer, Regional Director of the *Health First* Provider Network

- Nat Networker, Director of Alliance for a Healthy Upstate Region

- Sally Social Worker, Executive Director of Capstone Foothills Family and Parent Association

- David Doctor, President of the Urbis County Medical Society

- Nancy Nurse, CEO of Urbis Home Health Agency

In Task Three, you need to re-run the simulator to find policy packages that meet objections from major stakeholders, but will retain the best features of your overall Task Two proposal (hence, your Task Three super score in great likelihood will be lower than your Task Two super score) What changes did your team make in its strategy to deal with these concerns and objections? Why would these make the strategy more readily implementable?

1. Substitution of new initiatives for those in the strategy you developed at the end of Task Two

2. Strengthening or weakening of initiatives

3. Changes in the timing of particular initiatives

Indicate the changes in impact that occurred between the strategy you developed in Task 2 and the new strategy you developed in this Task. What were cumulative changes from baseline values for each of the following?

	Task 2 Strategy	Task 3 Strategy
Per capita cost		
Deaths/health status		
Content and quality of health care		
Inequity in care and health outcomes between disadvantaged and advantaged income groups.		
Productivity of Urbis' workforce		

Summarize the tradeoffs that occurred to make your preferred strategy more implementable. Is it still a viable strategy? What makes it worth implementing?

What other challenges, besides those raised by members of the task force, would you expect to encounter in implementing the strategy in Urbis with regard to:

1. Financing the initiatives

2. "Pushback" from various organizations whose authority or interests might be challenged by the strategy

3. Difficulties in implementing particular aspects of the strategy effectively

When you are done with this task, save a copy of this completed worksheet on the thumb drive provided to your group.

WORKSHEET 4:
Inventory of Key Lessons and Insights for the Day

Team Number and Name: _____

Download a blank copy of this worksheet from https://app.box.com/2015NASPAAsim . When completed, save this to the thumb drive.

This worksheet should be completed at the end of the day, although you may take notes to complete this during the day. This is the key document that NASPAA will use in awarding the second national award: *Best Documented Team Learning*. For each lesson or insight that you list, please be specific in your documentation of how or when in the computation you learned this lesson. For example, did this lesson come to you during pre-reading, or during your interactions with the simulator, or from discussions with your peers or judges, or from some other source.

Inventory of Team Lessons and Insights for the NASPAA National Simulation Competition

Key Lessons and Insights Your Group Takes Away from the NASPAA National Simulation Competition.	**Documentation of what specific activities during the day led you to this insight (be specific about readings, interactions with the simulator, peer-group interactions, discussions with the judge team, or other)**
1	
2	
3	
4	
5	
Add Rows as needed	

THUMB DRIVE COVER SHEET
NASPAA Student Simulation Competition

Please fill out this sheet and save it to the thumb drive provided for your group

Regional Site Location: _____

Team Number and Name: _____

Team Members:

Name	University	Email Address

NASPAA intends to use anonymized versions of the material in this portfolio as well as results from your pre- and post- test surveys to improve this simulation curriculum for use by member schools. This cover sheet indicates that members of your group give NASPAA permission to use anonymized versions of your group portfolio for the purposes of curriculum development and improvement. If one or more members of your group choose to not provide this permission, please indicate so below.

_____ Our group elects to opt out and not grant NASPAA permission to use our portfolio to improve this curriculum for future use. We understand that even if we opt out, our portfolio can and will be considered for the national prize for *Best Documented Team Learning*.