



ChooseHealth
DELAWARE

State Innovation Model Operational Plan

Model Test Year 1

February 1, 2016 – January 31, 2017

Table of Contents

- I. Project Summary..... 4
 - A. Project Summary..... 4
 - B. Driver Diagram 4
 - C. Core Progress Metrics and Accountability Targets 4
 - D. Master Timeline for SIM Model 5
 - E. Budget Summary Table..... 5
- II. Detailed SIM Operational Plan..... 5
 - A. Narrative Summary of Component/Project..... 5
 - 1. Establishing Infrastructure 5
 - 2. Technology 6
 - 3. Population Health..... 6
 - 4. Workforce..... 7
 - 5. Clinical..... 7
 - 6. Payment..... 7
 - 7. Patient and Consumer 8
 - B. SIM Component Summary Table 8
 - C. Risk Assessment and Mitigation Strategy..... 8
- III. General SIM Operational and Policy Areas..... 9
 - A. SIM Governance, Management Structure and Decision-making Authority 9
 - B. Stakeholder Engagement..... 12
 - C. Plan for Improving Population Health 15
 - D. Health Care Delivery System Transformation Plan..... 22
 - 1. Consistent patient/consumer voice and focus on the patient experience 23
 - 2. Practice transformation..... 23
 - 3. Promoting ongoing coordination of care 25
 - 4. Integration of Behavioral Health and Primary Care 26
 - 5. Value-based payment models linked across all payers by a common scorecard. 27
 - 6. Attribution of all individuals to a primary care provider..... 28
 - 7. Focus on health promotion, prevention, and chronic disease management 28
 - 8. More effective diagnosis and treatment..... 28
 - 9. Technology-enabled care delivery transformation 29

10.	Workforce and education initiatives to enable transformation	29
E.	Payment and/or Service Delivery Model(s)	31
F.	Leveraging Regulatory Authority	34
G.	Quality Measure Alignment	35
H.	SIM Alignment with State and Federal Initiatives	36
I.	Workforce Capacity Monitoring	37
1.	Stakeholder Engagement	38
2.	Data Collection	38
3.	Removing Barriers with Legislative, Regulatory or Executive Action	40
4.	Workforce Capacity Programs	40
J.	Health Information Technology	42
1.	Rationale	42
2.	Governance	54
3.	Policy	58
4.	Infrastructure	60
5.	Technical Assistance	62
K.	Program Monitoring and Reporting	63
L.	Data Collection, Sharing, and Evaluation	63
M.	Fraud and Abuse Prevention, Detection and Correction	64

I. Project Summary

A. Project Summary

Through the State Innovation Model Test Grant and the Design Grant that preceded it, Delawareans have come together in an unprecedented collaborative effort to develop and implement a multi-stakeholder plan to improve health, health care quality and patient experience, and reduce the growth rate in health care costs. Delaware has developed a bold plan to improve on each dimension of the Triple Aim, plus one: to be one of the five healthiest states, to be among the top 10% of states in health care quality and patient experience, to bring the growth of health care costs in line with GDP growth, and to improve the provider experience.

The core elements of this plan include: 1) supporting local communities to work together to enable healthier living and better access to primary care; 2) transforming primary care so that every Delawarean has access to a primary care provider and to better coordinated care—between primary care and behavioral health, other specialists, and hospitals—for those patients with the greatest health needs; 3) across all payers, including Medicare, Medicaid, State Employees, and major commercial payers, shifting to payment models that reward high quality and better management of costs, with a common scorecard; 4) developing the technology needed for providers to access better information about their performance and for consumers to engage in their own health; and 5) providing the resources to the current health care workforce to transition to team-based care and employing strategies to develop the future workforce to meet the diverse needs of Delaware’s population.

While Delaware’s approach is consensus-based, the State will use its purchasing and regulatory authority to support these changes, including through its requirements for Medicaid Managed Care Organizations and Qualified Health Plans on the Health Insurance Marketplace. Governor Markell and other public and private-sector leaders from across the state remain committed to the success of this initiative.

Through this plan Delaware aims for 90% of Delaware’s 1,267 primary care physicians to participate, as well as advanced practice nurses practicing under the Collaborative Agreement, improving health and health care for nearly 800,000 beneficiaries across Medicare, Medicaid, State Employees, and major commercial payers.

B. Driver Diagram

Delaware’s Driver Diagram is included as Tab 1 in the attached Excel workbook “DE SIM Op Plan 01-15-16.xls”.

C. Core Progress Metrics and Accountability Targets

Delaware’s Core Progress Metrics and Accountability Targets are included in the attached Excel workbook “DE SIM Reporting Metrics 01-15-16.xls”. Please note that Delaware does not

currently have baseline data for its model performance metrics. Delaware expects to have an initial view of the baseline for these measures by mid-2016, at which point Delaware will be able to share targets. Delaware is developing a view of performance across both Medicaid and commercial payers through the Common Scorecard - however this view does not exist today. Therefore, the first baseline information will be available only when the state rolls out the scorecard in mid-2016.

For the state health care landscape measures, on an annual basis Delaware will send an email survey to each payer in the state requesting the following information: 1) a list of all value-based payment programs in the state; 2) for each program, the number of participating providers (by provider type) and the number of attributed beneficiaries for each. Delaware will then aggregate the data across payers to develop a perspective on the state health care landscape. Delaware will share this requirement with payers in early 2016 so they can be prepared to report on the data

D. Master Timeline for SIM Model

Delaware's Master Timeline is included as Tab 3 in the attached Excel workbook "DE SIM Op Plan 01-15-16.xls".

E. Budget Summary Table

Delaware's Budget Summary Table is included as Tab 4 in the attached Excel workbook "DE SIM Op Plan 01-15-16.xls". Note that contracts beyond January 2016 for vendors not explicitly listed have not been finalized and are therefore not included in the spreadsheet. We plan to finalize contracts in January 2016.

II. Detailed SIM Operational Plan

A. Narrative Summary of Component/Project

1. Establishing Infrastructure

The Delaware Health Care Commission is the Governor's designated recipient of the SIM grant. To ensure ongoing support and long-term stability of the innovation effort in Delaware, stakeholders established the Delaware Center for Health Innovation (DCHI), a non-profit entity with representatives from the public and private sectors that formalizes and sustains the deep involvement of stakeholders in the implementation of the State Health Innovation Plan. First convened in April 2014, the Board has five standing committees focused on delivering specific services, as well as a Technical Advisory Group to coordinate with the Delaware Health Information Network (DHIN). All Board and committee members are volunteers. The DCHI is privately funded through stakeholder contributions and in-kind services. SIM funds have been used to provide staff support to committees and carry out certain start-up activities; SIM support for DCHI will be reduced in 2016 and future years as that organization's infrastructure is

established. The DCHI hired its first Executive Director in October 2015 and staffing for the organization is expected to ramp up in 2016 to support the organizational structure and project areas. Establishing the DCHI is critical to maintain the engagement of key partners, to promote transparency into the decision-making process surrounding SIM activities, to ensure accountability through goal-setting, evaluation, reporting, and correction, and to sustain the programs and vision of the SIM after the test grant period.

2. Technology

Delaware's approach to HIT consists of three major elements in support of statewide health transformation: (a) Transitioning to value-based payment models and transforming the healthcare delivery system to improve outcomes, (b) Engaging patients and consumers in their care, and (c) Research, evaluation and planning — for the SIM program overall and at the individual community-level (e.g., Healthy Neighborhoods). For each of these elements, there are several technology strategies Delaware seeks to employ to achieve a transformed system of care:

- Delivery system and payment model
 - Aggregate claims-based information
 - Increase clinical data access
 - Generate scorecard measures from clinical measures
 - Enable event notifications across healthcare system
 - Provide EMR adoption incentives for behavioral health
 - Increase direct secure messaging
- Patient and consumer engagement
 - Develop public tools to increase health literacy
 - Enable consumer transparency into cost and quality information
 - Ensure equity and access for telemedicine
 - Enable patient access to their health information
- Research, evaluation and planning
 - Conduct public health planning through multi-payer claims aggregation
 - Use datasets to support SIM dashboard
 - Use datasets to support community-level health goals for Healthy Neighborhoods

Additional details on each topic are detailed in Section III.J.

3. Population Health

Healthy Neighborhoods is Delaware's innovative approach to population health that will support communities coming together in new ways to design and implement locally-tailored solutions to some of the state's most pressing health needs. The program provides a framework for community development and formal partnerships across organizations and supports communities with resources and expertise as they work to make real changes – enabling healthy behavior, improving prevention, and facilitating

better access to primary care for their residents. The Healthy Neighborhoods program directly addresses challenges in Delaware's communities by bringing together organizations in communities across Delaware to tackle some of the state's most significant health needs and achieve meaningful change.

4. Workforce

Delaware will support delivery system transformation with a novel workforce strategy. We want to position Delaware as a "Learning State," actively engaged in transforming our current workforce and training the next generation of workforce so it can provide a person-centered, team-based approach to deliver coordinated integrated healthcare. Currently, capacity shortages persist with HPSAs for primary care, behavioral health, and dental care, there is a need for more coordination in curricula, and a burdensome accreditation process exists. In addition, providers report a lack of support as they seek to practice at the top of their training and license, and gaps exist in skills and capacity for coordinating care. Delaware's workforce strategy will focus on retraining the current workforce, building sustainable workforce planning capabilities, and training the future workforce in the skills needed to deliver integrated care.

5. Clinical

Delaware's goal is to be in the top 10% of states on health care quality and patient experience within five years by focusing on more person-centered, team-based care. Delaware will prioritize integrated care (including with behavioral health) for high-risk individuals (i.e., the top 5-15% that account for 50% of costs) and more effective diagnosis and treatment for all patients. Delaware's market is both highly fragmented (for primary care practices in particular) and highly concentrated (i.e., six hospitals and the Veteran's Affairs hospital). Providers across the state are already actively pursuing models of integrated care. Delaware's plan supports independent providers as well as health systems. It is market-driven, and its goal is to support and accelerate adoption of existing models in the market. The plan emphasizes the role of primary care as a linchpin in the system that unites accountability for quality and cost for a defined panel of patients. Delaware's goal is for every Delawarean to have a primary care provider.

6. Payment

To enable care coordination and cost-effective diagnosis and treatment, our goal is for most care in the state to transition to outcomes-based payments. The models will incentivize both quality and management of total medical expenditures over the next five years. Delaware's plan is for all payers to introduce at least one Pay for Value (P4V) program that incorporates reimbursement tied to quality and utilization management for a panel of patients, and one Total Cost of Care (TCC) program with shared savings linked to quality and total cost management for a panel of patients, for eligible PCPs beginning in 2016. The approach will build from the different models in the system today and support the broader delivery system transformation underway (e.g., population health improvements, behavioral health access and integration). Core

technical details will continue to be defined between payers and providers (e.g., shared savings level, minimum panel size), however all payers will support the following common principles to simplify participation for providers:

- Attribution of all Delawareans to primary care physicians (pediatrics, family medicine, general internal medicine) or advanced practice nurses. Delaware will rely on individual payer attribution methodologies as the basis for this attribution (these methodologies range from retrospective attribution based on the plurality of visits to assigned attribution at enrollment). Delaware expects to make significant progress on this aspiration, with 90% of providers participating in value-based models by the end of the grant period.
- Flexibility to include independent primary care providers, as well as those employed by or affiliated with a health system.
- At least one P4V and one TCC model available from each payer, with at least one model that has some form of funding for care coordination, whether in the form of per member per month fees or payments for non-visit based care management.
- Payment tied to common scorecard for all models, with a minimum percentage linked to common measures and the balance linked to performance on payer-specific measures.
- Commitment by all payers working in partnership with providers to achieve 80% of payments in these models within five years.

7. Patient and Consumer

The patient / consumer is at the center of Delaware’s initiatives on health care innovation. Individual engagement in health and wellness is essential to achieving Delaware’s broader goals to improve the health of Delawareans, improve the quality of care and patient experience, and reduce health care cost growth. Each component of the State’s Health Care Innovation Plan depends upon successful engagement by individuals in their health and health care. There will be a specific outreach and education effort to increase awareness about changes in the health care delivery system that will directly affect patients. In addition, a significant part of the HIT strategy focuses on using technology to enable consumer transparency and choice.

B. SIM Component Summary Table

Delaware’s SIM Component Summary Table is included as Tab 5 in the attached Excel workbook “DE SIM Op Plan 01-15-16.xls”.

C. Risk Assessment and Mitigation Strategy

Delaware has evaluated the potential risk factors for each SIM component and developed a risk mitigation strategy for each. This information is available in the CMMI-provided template, file name “DE SIM Risk Mitigation 01-15-16.xls”.

III. General SIM Operational and Policy Areas

A. SIM Governance, Management Structure and Decision-making Authority

Since the early stages of planning for the State Innovation Model, Delaware has built a strong public-private partnership that will ensure success. As the Governor's designated grant award recipient, the Delaware Health Care Commission (HCC) continues to lead the SIM initiative as it has since July 2012, in close partnership with the Delaware Health Information Network (DHIN) and the Delaware Center for Health Innovation (DCHI). HCC, DHIN, and DCHI are closely coordinated, bound together by articles of incorporation and Board representation. The bylaws of the DCHI name the DHIN as its sole member, giving DHIN the obligation and right to approve appointment and removal of board members, incurrence of any debt or long-term borrowing, any merger, acquisition, or dissolution of DCHI, or any changes to its bylaws. DHIN must consult with HCC to ensure that such authority is exercised in a manner consistent with the objectives of both the DHIN and HCC in promoting the delivery of cost-effective quality health care to all Delawareans.

The Delaware Health Care Commission (HCC) functions as an independent authority and as the primary health policy forum in the state, with the goal of ensuring quality, affordable access to care. Commission members include three Cabinet Secretaries, the Insurance Commissioner, and seven private citizens of whom five are appointed by the Governor, one by the Speaker of the House and one by the Senate President Pro Tempore. HCC facilitates an integrated approach across federal and state programs, HIT efforts, Medicaid expansion, and the new Health Insurance Marketplace. It also administers the State Loan Repayment Program, Delaware Institute of Medical Education and Research (DIMER), Delaware Institute of Dental Education and Research (DIDER), and the Health Resources Board (responsible for Delaware's Certificate of Need program). The following defines the role of the HCC in the SIM initiative:

- Manage the federal funds for all grant-related activities
- Contract with vendors for specific grant-related services, including:
 - McKinsey & Company – supporting project management and payment reforms, clinical transformation, HIT, and population health initiatives
 - ab+c Creative Intelligence – providing outreach, marketing and communications support
 - Public Consulting Group – supporting workforce and education and end-of-life initiatives
 - MedAllies – contracted to provide Practice Transformation support
 - Medical Society of Delaware/MedNet – contracted to provide Practice Transformation support
 - New Jersey Academy of Family Physicians – contracted to provide Practice Transformation support
 - Remedy Healthcare – contracted to provide Practice Transformation support

- Other vendors TBD for State-led Evaluator, workforce initiatives, etc.
- Provide regular updates to the Governor and the public regarding the status of the initiative
- Liaise with other state agencies to promote and leverage resources in support of the SIM

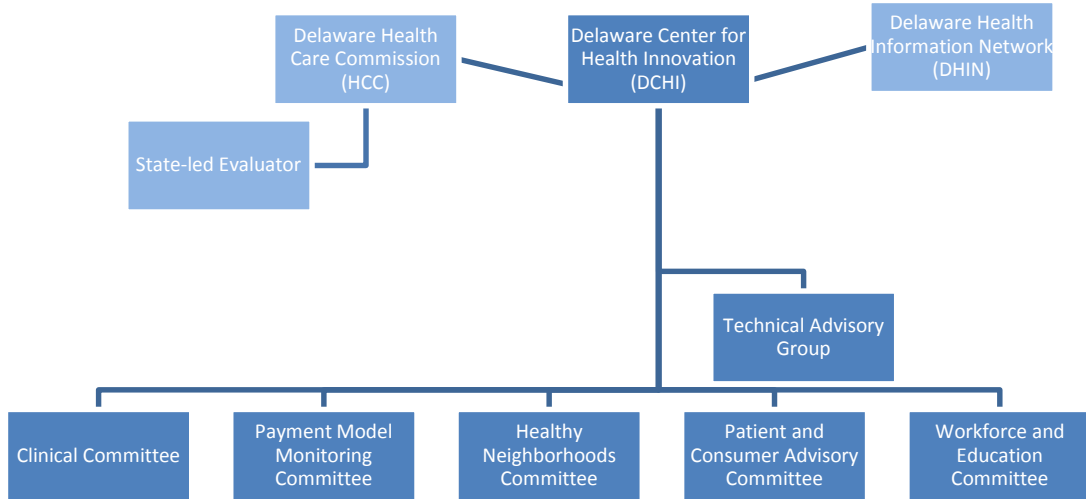
Delaware Health Information Network (DHIN) is Delaware’s health information exchange (HIE), providing Delaware with a nationally-leading HIT infrastructure. It serves as a steward for health data in the state, and electronic access to information provided through the DHIN enables higher quality care. It is centrally responsible for the development of HIT capabilities needed to implement the State Health Care Innovation Plan (SHIP). Its board includes individuals from diverse organizations such as Delaware Health Sciences Alliance, State Chamber of Commerce, Delaware Office of the Controller General, and leaders from health systems and payers. The following defines the role of the DHIN in the SIM initiative:

- Provide leadership on issues related to health information technology

Delaware Center for Health Innovation (DCHI) is a non-profit entity with representatives from the public and private sectors that formalizes and sustains the deep involvement of stakeholders in the implementation of the State Health Innovation Plan. The multi-stakeholder board meets monthly and includes three permanent seats for state officials – HCC Chair, Secretary of Department of Health and Social Services (DHSS), and Director of the Office of Management and Budget (OMB). The CEO of the DHIN and Executive Director of the DCHI hold non-voting seats. The Board has five standing committees focused on delivering specific services, as well as a Technical Advisory Group (TAG) to coordinate with DHIN. The DCHI is privately funded through stakeholder contributions and in-kind services. DCHI has had fundraising conversations with stakeholders around the state and has already received funding. In the event that DCHI is unable to raise sufficient contributions to fund the full initial year’s budget, Delaware may choose to re-purpose some of the existing SIM commitments to cover DCHI staff positions in order to ensure the smooth launch of programs in 2016. The DCHI hired its first Executive Director in October 2015 and staffing for the organization is expected to ramp up in 2016 to support the organizational structure and project areas. The following defines the role of the DCHI in the SIM initiative:

- Serve as the convener of stakeholder groups
- Provide thought-leadership for all aspects of SIM related initiatives
- Provide a sustainable structure for the work beyond the grant award

Exhibit 1: Delaware SIM Organizational Chart



Collectively through the three leading organizations, Delaware's leadership team includes all of the primary state leaders responsible for health (Executive Director of HCC, Chair of HCC, Secretary of Department of Health and Social Services, Director of Division of Medicaid and Medical Assistance, Director of Division of Public Health, Director of Division of Services for Aging and Adults with Physical Disabilities, Director of Office of Management and Budget, Director of Statewide Benefits, CEO of DHIN), a variety of providers (large health systems, small health systems, Federally Qualified Health Centers, behavioral health practitioners, private practice physicians, nurses, and others), payers, businesses (e.g., State Chamber of Commerce), and educational institutions (University of Delaware and Delaware Technical Community College). Stakeholder representatives are fully integrated into the SIM leadership team. The most senior leaders across all stakeholder groups in Delaware are committed to this program. Several hold DCHI board seats in addition to leading specific program areas and providing expertise, data, and in-kind staff support.

HCC has direct contract with the Governor's office. Meredith Tweedie, general counsel to the governor, has the responsibility to bridge between the SIM program and the governor's office. HCC leadership meets with Ms. Tweedie on a regular basis (2-3 times/month) to brief her on the SIM program and has engaged her in identifying SIM priorities for the governor.

In addition, the HCC will contract with an independent, state-led evaluator to monitor and evaluate SIM activities to support continuous quality improvement. The evaluator will work in conjunction with the federal evaluator to determine the impact and effectiveness of SIM-related activities.

B. Stakeholder Engagement

Delaware has achieved and maintains an extremely high level of stakeholder engagement. Participants in the initiative have included senior leaders (presidents, CEOs, CMOs, CFOs, medical directors, etc.), with 100 percent participation in many categories (including all of Delaware’s health systems and FQHCs). The DCHI has led this stakeholder engagement and functions as the convener of the majority of the public meetings supporting the functional work of the plan.

Leaders from State government are actively involved, including the Governor’s Office, the Delaware Health Care Commission, the General Assembly, Department of Health and Social Services, Office of Management and Budget, Department of Insurance, and the Department of State.

Stakeholder support is overwhelmingly positive. Generally, the case for change resonates strongly with Delawareans. Stakeholders agree that there is a compelling case for change in Delaware. As a small state, Delaware has the unique advantage of being able to bring together stakeholders – public and private – to discuss and address the state’s most pressing health issues.

The DCHI was established in early 2014 to work with the Health Care Commission and DHIN to guide the State Innovation Model effort and track its progress. DCHI has a 15-member Board of Directors representing both the private and public sectors. As a group, the Board has experience working across Delaware’s major providers, payers, state agencies, community organizations and the business community. Current members of the DCHI Board are:

- Julane Miller-Armbrister, Executive Director of DCHI – Ex Officio
- Dr. Jan Lee, CEO of DHIN – Ex-Officio
- Matt Swanson, Innovative Schools – Chairman of the Board and Co-Chair of Healthy Neighborhoods Committee
- Tom Brown, Nanticoke Health Services – Treasurer and Chair of Payment Model Monitoring Committee
- Rita Landgraf, Secretary of Dept. of Health and Social Services – Chair of Patient & Consumer Advisory Committee
- Kathy Janvier, Delaware Technical Community College – Chair of Workforce and Education Committee
- Dr. Alan Greenglass, Christiana Care Health System – Co-Chair of Clinical Committee
- Dr. Nancy Fan, St. Francis Healthcare and Chair of Delaware Health Care Commission – Co-Chair of Clinical Committee
- Lolita Lopez, Westside Family Healthcare – Co-Chair of Healthy Neighborhoods Committee
- Mary Kate Mouser, Nemours Health and Prevention Services
- Dr. Gary Siegelman, Bayhealth Medical Center
- Traci Bolander, Psy.D., Mid Atlantic Behavioral Health
- Brenda Lakeman, Delaware Office of Statewide Benefits

The DCHI Board has formed five committees focused on specific elements of Delaware's strategy for improving health and health care. Through the membership on each committee and the public meetings of the committees the SIM initiative has participation from a variety of stakeholder groups.

Healthy Neighborhoods Committee: Delaware's population health strategy actively engages a broad set of stakeholders statewide, including the Department of Health and Social Services, Division of Public Health, health systems, FQHCs, community organizations, providers and provider organizations, and payers (insurers and employers). Stakeholders generally play four roles: 1) leading the multi-stakeholder workstream for population health; 2) participating in working sessions; 3) sharing feedback and best practices; and 4) identifying connections with ongoing initiatives.

Clinical Committee: Providers across Delaware – including physicians, behavioral-health providers, community-based and long-term care providers, every hospital and FQHC, provider organizations (including MSD and Delaware Healthcare Association – Delaware's hospital organization), other providers, and the state — continue to work together on this initiative.

DCHI and members of the clinical committee have and will continue to: 1) meet with provider organizations, working with them to reach out to providers; 2) attend local meetings of provider groups (e.g., at grand rounds); and 3) conduct regular discussion forums statewide. Through this engagement and the committee's leadership, Delaware will seek to incorporate provider clinical and operational expertise into the ongoing implementation of the plan, as well as share information to encourage participation in new payment, delivery, and population health models.

Payment Committee: Patients, insurers (the largest commercial carriers, current MCOs, and employers), health advocates, consumer groups (e.g., AARP), colleges and universities, pharmaceutical organizations, DHSS, and local government officials have all been actively involved. Delaware's major commercial payers and the state have all committed to align quality measures and have worked to align on the technical details of a common scorecard. In addition to the overall approach to stakeholder engagement, Delaware will work actively with payers on rolling out new payment models and aligning quality measures.

Patient/Consumer Advisory Committee: This committee meets monthly to engage with patients and consumers. The patient/consumer is at the center of Delaware's initiatives on health care innovation. Individual engagement in health and wellness is essential to achieving Delaware's broader goals to improve the health of Delawareans, improve the quality of care and patient experience, and reduce health care cost growth. Each component of the SIM initiative depends upon successful engagement by individuals in their health and health care. The health care system will also be transformed to reach out to individuals and support them throughout their care experience.

The Patient and Consumer Advisory Committee has the following goals: 1) Ensuring the consumer perspective is reflected in all of the work of the Delaware Center for Health Innovation; and 2) Promoting outreach and education to Delawareans about how Delaware's health transformation supports and empowers patients and consumers.

Workforce Committee: There are three core responsibilities for the Workforce and Education Committee: 1) retraining the current workforce; 2) building sustainable workforce planning capabilities; and 3) training the future workforce in the skills needed to deliver integrated care. Committee members include human resource professionals, institutions of higher learning, providers, and the state's Department of Education. The Workforce and Education Committee's responsibility over the next several years is to partner with state and regional educational institutions to set out a comprehensive strategy for training that ensures a sustainable pipeline for Delaware's health care workforce.

In addition to these five committees, the **Technical Advisory Group (TAG)** will collaborate with DHIN to lead development of any shared data infrastructure that may be necessary for the SIM initiative. The TAG will provide input from provider and payer organizations to guide infrastructure development. It was established as an advisory group, not a committee. Its purpose is to provide information to DCHI, DHIN, HCC, and others about options, assessment of level of effort, etc. It is chaired by Dr. Gary Siegelman, Chief Medical Officer of Bayhealth. Members include representatives from DHIN, the major payers (e.g., Highmark, Aetna, United), providers (e.g., Christiana Care, Bayhealth), and the state (e.g., DPH, Medicaid). The TAG is linked into the DCHI organization and DCHI board which has representation across all committees. Those constructs are the platform by which information is shared across committees, not only for technology, but for all topics of relevance. Direct conversations and interactions with other committees also occur when needed.

Stakeholder input continues to be essential to the success of all SIM initiatives. Public meetings, including monthly Health Care Commission meetings, public DCHI Board and Committee meetings, posted minutes and presentations, as well as directed focus groups, will be utilized to continue to engage stakeholders in Delaware. Additionally, collateral and other informational materials are being developed for stakeholder outreach.

Delaware will continue the active stakeholder engagement that has been a hallmark of its approach so far. In order to ensure a sustainable, inclusive approach, Delaware has defined the governance and approach:

Governance: The HCC, DHIN, and DCHI have primary responsibility for stakeholder engagement. DCHI was created and sponsored by the DHIN and HCC to provide a structure for systematically engaging leaders across the state to represent the best interests of Delawareans. Each entity has a multi-stakeholder structure that ensures broad representation across the health care community. They will convene public forums, lead engagement with individual stakeholders, and ensure an inclusive and open process.

Approach: Delaware will pursue a structured approach to stakeholder engagement. The foundation will include: monthly HCC meetings; meetings of the DCHI Board; and quarterly cross-committee meetings. Committees of the DCHI and the Technical Advisory Group also will meet regularly to work on specific components of the strategy. The HCC and DCHI will post materials to their websites and use periodic surveys.

C. Plan for Improving Population Health

Healthy Neighborhoods is Delaware’s innovative approach to population health that will support communities coming together in new ways to design and implement locally-tailored solutions to some of the state’s most pressing health needs. The program provides a framework for community development and formal partnerships across organizations and supports communities with resources and expertise as they work to make real changes – enabling healthy behavior, improving prevention, and facilitating better access to primary care for their residents. The Healthy Neighborhoods program directly addresses challenges in Delaware’s communities by bringing together organizations in communities across Delaware to tackle some of the state’s most significant health needs and achieve meaningful change. Additional detail about the operating model for Healthy Neighborhoods can be found on the DCHI website at <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Healthy-Neighborhoods-Operating-Model.pdf>.

Healthy Neighborhoods builds on a foundation of five core innovative elements, drawing from the experience of collaborative models of population health from across the country and around the world. First, the program brings organizations together – across sectors and areas of focus – to work together in new ways. Second, the structure of each Healthy Neighborhood ensures that healthcare providers and systems integrate with community organizations to both identify problems, and create and execute solutions. Third, the program dedicates full-time staff to convene stakeholders, facilitate the identification of community health needs and prioritization of initiatives, and ensure consistent implementation of collaborative programs. Fourth, Delaware’s Healthy Neighborhoods program provides communities with shared access to resources and new opportunities for partnership to support their work. Fifth, the program supports organized efforts for Healthy Neighborhoods to seek and maintain funding, including through technical support for grant application and management. These five elements create benefits for participating organizations, including unprecedented access to resources, partnerships, and funding.

Additionally, Healthy Neighborhoods collaborations can accelerate and/or expand organizations’ existing initiatives. Organizations participating in Healthy Neighborhoods have an opportunity to shape a novel community health approach, and to help improve the health of the population statewide. Healthy Neighborhoods will develop and implement a three-year strategy to improve health in one or more of the following priorities:

- Healthy Lifestyles
- Maternal and Child Health

- Mental Health and Addiction
- Chronic Disease Prevention and Management

Delaware prioritized these measures by identifying areas on its population health scorecard (i.e., America's Health Rankings) where 1) Delaware had great need and 2) the area had a high cost or high impact on health. Consequently, these themes link directly to that scorecard. Delaware also ensured that these themes link to the Common Provider Scorecard. Delaware has at least one measure on the Common Scorecard that links to one of these themes (e.g., Screening for Depression is a measure on Delaware's Common Provider Scorecard and links directly to the Mental Health and Addiction theme for Healthy Neighborhoods).

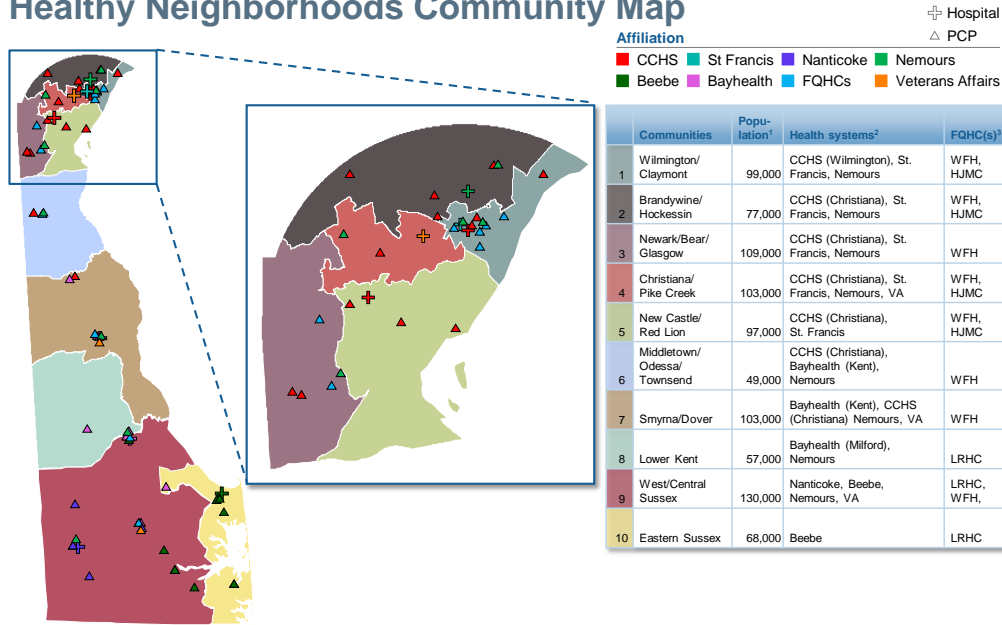
Healthy Neighborhoods exist within broader geographic areas called Communities. Each Community is a defined geographic area within which local leaders form a leadership Council consisting of representatives from a diverse set of community health, business, municipal, and provider organizations. Each Council will assess its own Community's health needs and develop a multiyear strategy that prioritizes a set of initiatives to be carried out by Neighborhood Task Forces to address those needs in a coordinated fashion.

The aspiration is for nearly all Delawareans to live in a Healthy Neighborhoods Community within the next few years. The Community structure balances ensuring this broad coverage with maximizing flexibility for organizations to come together in Neighborhoods within each Community that are relevant and recognizable to the individuals in their respective Communities. While the goal is to improve health for all Delawareans through the work of Healthy Neighborhoods, the initial focus may be on individuals living in areas of particularly high need.

The DCHI Healthy Neighborhoods Committee has designed ten non-overlapping Communities of approximately 50,000- 100,000 residents that will try to balance all of these parameters and extensive feedback from stakeholders. Many of the proposed Communities will have at least one hospital or FQHC physically located within the boundaries, but all of them will be served by at least one of these providers. It is expected that many health systems and FQHCs will be active participants in multiple Communities. In addition, health systems focused on specific populations, such as Nemours for the pediatric population and the Veterans Administration, may participate in all or most Communities.

Exhibit 2: Healthy Neighborhoods Map as Approved

Healthy Neighborhoods Community Map



1 Rounded to nearest thousand
 2 Locations of hospitals and primary care centers shown on map; CCHS = Christiana Care Health System; VA = Veterans Administration
 3 HJMC= Henrietta Johnson Medical Center; WFH= Westside Family Healthcare; LRHC= La Red Health Center
 SOURCE: Health System and FQHC websites, Esri Geographical Information Services (ArcGIS)

Each Community will be governed by a Council, which will serve as the forum for fostering collaborative dialog and have accountability for the success of the program at the Community level. Council members will be supported in their work by full-time DCHI staff. The Council’s responsibilities fall into six areas:

1. *Identify current needs, resources, and gaps in the Community* – identify existing sources of data or opportunities to collaborate on needs assessment (e.g., from a hospital community health needs assessment), create a plan for collecting supplementary data as needed, take inventory of local efforts, and identify potential sources of funding for initiatives
2. *Prioritize the thematic area(s) of focus for the Community* – select the focus for initiatives: Healthy Lifestyles, Maternal and Child Health, Mental Health and Addiction, Chronic Disease Prevention and Management
3. *Draft a three-year strategic plan for the Community* – design a proposal outlining overall vision for the Community, priority initiatives (and the Neighborhood Task Forces needed to carry them out), timeline, and sustainable funding plan
4. *Create and implement an outcomes-based action plan* – determine what program success will look like, create a plan for collecting and analyzing data including, but not

limited to, community engagement, service utilization, client satisfaction, health status measures, and cost savings

5. *Oversee monitoring and evaluation of initiatives* – regularly assess initiatives including process and outcomes towards goals
6. *Share best practices across Healthy Communities* – by participating in the Healthy Communities Learning Collaborative

One of the overarching goals of Healthy Neighborhoods is to bring diverse stakeholders to the table and encourage collaboration between organizations that have historically worked in silos. To that end, creating a diverse leadership team representative of the Community is a top priority; these teams, or Councils, will be created with an eye to Community representativeness and will strive for inclusion of existing groups, individuals, and service providers across sectors.

In some Communities, many organizations may present themselves as eager participants from the outset; in other Communities, some organizations may initially express interest and others may have to be actively recruited. DCHI will conduct initial outreach and engagement to potential Council members to facilitate the formation of a Council and test the readiness of the Council to be recognized as a Healthy Neighborhood (including, for example, the level of commitment that council members make to the principles of Healthy Neighborhoods). The exact “readiness check-list” is still under development by DCHI. Then Councils, with support from DCHI staff, will engage their broader stakeholders, e.g., by hosting town halls in each Community as a way for organizations and leaders to come together. DCHI staff will facilitate meetings of the Council, assessing interest in participation, planning meetings, and inviting key stakeholders.

The optimal size for Councils is 10-15 organizations, with 1-2 designated representatives from each organization. Each Community has discretion to determine the membership composition of its own Council. However, to ensure collaboration across sectors, the following types of organizations should be considered for representation, where appropriate:

- Social support (e.g., mental health/behavioral health/addiction, nutrition assistance)
- Municipal/state organizations (e.g., prison, police, parks and recreation)
- Children’s services (e.g., schools, children’s welfare services)
- Care delivery (e.g., hospitals, FQHCs, nursing homes, primary care providers, care coordinators)
- Community organizations (e.g., civic associations, community-based coalitions)
- Local residents (e.g., community leaders, consumers, advocates)
- Social services (e.g., religious institutions, senior centers/retirement communities, local nonprofits)
- Businesses/employers (e.g., large employers, pharmaceutical companies)
- Payers (e.g., commercial insurance companies, Medicare/Medicaid)

In order to foster integration with the care delivery system, Councils must have representation from health systems and providers. Some organizations may choose not to serve on the Council, but may be actively involved in Healthy Neighborhoods initiatives.

The goal of Healthy Neighborhoods is to create integrated – rather than parallel – initiatives to maximize leadership, staff, and resources, and reduce barriers to collaboration. Consistent with the spirit of locally-tailored solutions to the state’s most pressing health needs, Councils primarily will be self-governing. However, since Healthy Neighborhoods focuses on enabling people and organizations to work together in a different way than how they have historically been operating, Councils must commit to the following common areas of governance:

- Council voting rights – each organization on the Council has an equal vote
- Council leadership – each Council will elect a chair who will facilitate decision making and drive action, and a secretary who will handle communication and documentation, among other responsibilities; additional roles may be created based on Council needs
- Council attendance guidelines – members are expected to attend at least 75% of all meetings either in person or by phone and are not to send delegates
- Council charters/memorandum of agreement – as one of the first items of business, Council members will amend and approve a charter supplied by the Healthy Neighborhoods Committee; this charter will provide details about the composition of the Council, short- and long-term deliverables, and the names and affiliations of Council members, as well as any other pertinent elements of governance
- Learning Collaboratives participation – Council members shall send at least 1 member to quarterly Learning Collaboratives hosted by the Healthy Neighborhoods Committee; Councils shall periodically submit written materials detailing lessons learned and best practices to the Committee. Further details on the learning collaboratives will be defined by Q2 2016, with the plan to coordinate with the learning collaboratives for primary care practice transformation.

Other governance decisions, such as meeting frequency/length, participation in Council program/initiatives, additional time commitments, and additional Council leadership (such as community/funder/initiative liaison, treasurer, etc.) will be decided by individual Councils, with support from DCHI Healthy Neighborhoods staff.

Each Community Council shall create Neighborhood Task Forces to carry out initiatives that aim to deliver on the strategy it lays out. Task Forces may be focused on smaller geographic areas within the Community or on issues applicable to the entire Community. These Task Forces will be comprised of leaders of local organizations doing work that directly pertains to the initiative being driven by Task Force and will vary in size. Responsibilities may include:

- Identify existing initiatives/resources and gaps and develop a detailed action plan for executing on any strategic priority relevant to their Neighborhood
- Seek funding as appropriate for strategy

- Set targets and monitor outcomes

One of the key elements of the Healthy Neighborhoods program is support provided by 6-8 designated DCHI staff members (“Healthy Neighborhoods Program Managers”) who will work to ensure the success of the Councils and each Community. Each DCHI Healthy Neighborhoods Program Manager will support two Councils full time.

Leaders across Delaware have reported that local organizations struggle to collect and analyze data and translate findings into practice. They have also expressed that identifying funding opportunities and applying for and managing grants can be difficult and resource-intensive. In order to support Healthy Neighborhoods, DCHI will make available the following tools and resources:

- Implementation support – resources to help community organizations work better and deliver their services more effectively, including, but not limited to project management, task execution, communication support, relationship management, and community engagement
- Technical expertise – including, but not limited to identification of existing data sources, plan for collecting supplemental data (e.g., community health needs assessment or community focus groups), data collection, data interpretation and translation of findings, selecting data-based outcomes, determining impact of initiatives
- Funding support – resources to help Healthy Neighborhoods obtain and manage funds, including, but not limited to identifying potential funding sources, managing funder relationships, and grant writing/management. DCHI will engage with grantmakers and foundations across Delaware and around the country to expand access to funding for Healthy Neighborhoods
- Other – Councils may request additional support as needs arise. These tools and resources will be provided by DCHI staff, working in conjunction with partnering organizations as appropriate.

The Delaware Department of Health and Social Services (DHSS), which includes the Delaware Division of Public Health (DPH), the Division of Substance of Abuse and Mental Health, the Division of Medicaid and Medical Assistance, and the Division of Services for Aging and Adults with Physical Disabilities, has committed to support and collaborate with each Neighborhood as they begin their work (including by providing technical expertise and access to data). Delaware ensures a close linkage between these state agencies and the Healthy Neighborhoods work by having the Secretary of DHSS serve on the Board of DCHI and the Director of DPH serve on the Healthy Neighborhoods Committee.

Cross-pollination of ideas will be highly encouraged. Staff supporting different Councils will regularly communicate internally. A Learning Collaborative will be held quarterly as a forum for Healthy Neighborhoods to share experience and best practices with one another.

Delaware's plan is to rollout Healthy Neighborhoods in three waves, with the first wave of communities beginning in 2016. Delaware has prioritized three communities (one in each county) for consideration in the first "wave" to pilot the concept. These neighborhoods were identified based on relative need. In January 2016, the DCHI Board approved the rollout plan for Healthy Neighborhoods.

DCHI plans to focus on up to three Communities for Wave 1: **Wilmington/Claymont, Smyrna/Dover, and West/Central Sussex**. The Communities all demonstrate a high level of need for each of the Healthy Neighborhoods priorities (healthy lifestyle, maternal and child health, mental health and addiction, and chronic disease prevention and management). At the same time, the Communities have varying geographic profiles, existing programs, and levels of local collaboration, thus creating the opportunity to generate lessons learned from three distinct archetypes to support the launch of future Communities.

DCHI will perform a readiness assessment shortly after the formation of the Healthy Neighborhoods local Council. Each Council must be able to demonstrate a commitment to collective impact, the formation of a diverse and active local Council, a commitment to sharing outcomes on a regular basis, an established vision for the Community, and a high level project plan and sustainability plan (See Exhibit 3).

Once a Community is established, DCHI will offer staff and resources to support planning (e.g., launch Community needs assessment), coordination (e.g., monitor Task Force implementation), and funding (e.g., seek funding opportunities aligned with strategy).

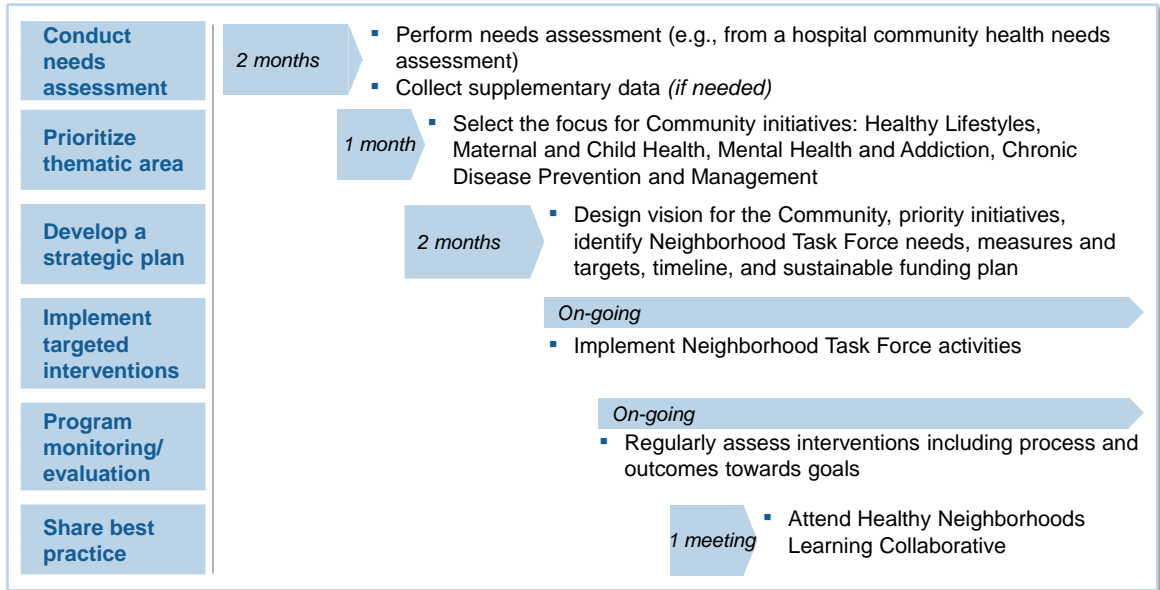
Timeline

Prepare for Wave 1 implementation (Q1 2016): This phase will focus on DCHI staffing, initial outreach to Wave 1 communities (i.e., identify and link individuals or organizations from the Community who may serve as members of their local Council), developing resources to support communities (e.g., synthesizing existing data to enable prioritization of areas of focus), and developing a framework for sustainable funding.

Delaware recognizes that in order to be successful, communities need to develop and implement a sustainable funding model. Grants may be used in the near-term to catalyze change, but over time the work of each neighborhood needs to be integrated into a more sustainable funding model. DCHI has had initial discussions about the different approaches being used around the country (e.g., the Accountable Care Community model). The launch of Healthy Neighborhoods concurrently with the introduction of value-based payment models for primary care providers across the state will create a foundation to achieve sustainability (for example, as a basis to create partnerships between the work of the Healthy Neighborhood and the clinical community to achieve shared savings over time). In order to ensure sustainability over time, DCHI will convene a workgroup of its Healthy Neighborhoods Committee to develop recommendations on sustainability in the first half of 2016.

Staggered launch of up to 3 neighborhoods in Wave 1 (Q2-Q3 2016). This phase will focus on engaging community members within the Healthy Neighborhoods and working with the Neighborhood Councils to begin operations. Delaware expects each Neighborhood Council to follow roughly the timeline shown in the exhibit below.

Exhibit 3: Healthy Neighborhoods implementation timeline for each Neighborhood



Assess Wave 1 and plan for Wave 2 (Q4 2016). This phase will focus on assessing the initial progress and feedback from the Wave 1 communities. Ultimately, success will be measured by progress on Delaware’s population health scorecard (i.e., America’s Health Rankings). DCHI will play an active role in monitoring Healthy Neighborhoods through its dedicated staff members. The specific measures of success to determine whether and how to scale to additional neighborhoods will have been defined in Q2 2016.

Prepare for Wave 2 and Wave 3 implementation (2017-2018). The approach for these waves will follow a similar approach to the first wave described above.

D. Health Care Delivery System Transformation Plan

Delaware’s plan promotes more coordinated and integrated care across the health system through a transition to Advanced Primary Care (including through adoption of Patient Centered Medical Homes or Accountable Care Organizations (ACOs)) and participation in value-based payment models across all payers. These models of care are built on a foundation of primary care and focus on integrating a multi-disciplinary team of providers across the medical neighborhood. The aspiration is for these models to be accessible to practices of all sizes and structures (from solo practitioners to large practices that are part of a clinically integrated network or ACO). Delaware’s strategy has nine core elements that contribute to the

transformation of the health care delivery system consistent with the characteristics described in the SIM operational plan guidance:

1. Consistent patient/consumer voice and focus on the patient experience

Delaware’s goal from the start of its SIM Design grant has been to achieve a more person-centered care delivery system. Delaware’s approach incorporates several elements that ensure the state’s health care delivery system progresses towards that vision. First, the Health Care Commission’s partner organization, the Delaware Center for Health Innovation (DCHI), has a Patient and Consumer Advisory Committee as one of its standing committees. This Committee focuses on providing the voice of the patient and consumer across all of the SIM transformation work and developing specific initiatives to engage patients in the health care delivery transformation process. Second, Delaware’s Common Scorecard (a scorecard for primary care providers to be used by all payers in Delaware for value-based payment models) will include a measure of patient experience. Delaware expects the functionality to report on that measure to be available in the second half of 2016. Finally, Delaware’s approach from the start has been open and transparent. Delaware has numerous meetings open to the public each month and posts information about meetings of the Health Care Commission and the Board of the DCHI online.

2. Practice transformation

Delaware’s strategy is to support providers to deliver care in these new models by providing access to “practice transformation” resources. In the pre-implementation phase, the DCHI adopted a consensus paper on practice transformation that identified the capabilities required for primary care to deliver more coordinated and integrated care, recommendations on the types of resources that would best support providers to achieve this, and a proposed set of milestones to measure whether providers have been making progress towards building the capabilities needed to deliver care differently¹. The milestones represent important goals for participating in integrated or virtually integrated delivery models. For example, one of the milestones is to implement a process for following up with patients after hospital discharge; another milestone focuses on developing a plan to integrate primary care with Behavioral Health (Delaware is also developing a specific strategy on integrating primary care and Behavioral Health). Based on the recommendations of the DCHI and on feedback from a Request for Information (RFI) run by the Delaware Health Care Commission in 2015, the Delaware Health Care Commission issued and completed a Request for Proposals (RFP) for “practice transformation” vendors to support primary care providers across Delaware to transform their practices. Delaware selected four vendors to support

¹ Consensus paper is available online at <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Primary-Care-Practice-Transformation.pdf>

practice transformation: MedAllies, Remedy, NJ Academy of Family Practice, and the Medical Society of Delaware/Health Team Works. Practice transformation may take up to 24 months for an individual practice site, depending on their baseline capabilities. Delaware expects practice transformation support to continue over the next three years.

Rollout plan

Delaware plans to rollout practice transformation support in three waves of enrollment. The first wave began in Q4 2015. Delaware will launch the subsequent waves in 6 month increments following the first wave.

Initial awareness for the first wave: Outreach to primary care providers and their affiliated organizations began shortly after contracting with the vendors to create awareness and support enrollment in practice transformation. The HCC and DCHI hosted a session with Delaware's ACOs to introduce them to the vendors. An informational video and background information has been posted on the DCHI website (www.dehealthinnovation.org), and information was distributed to primary care practices by mail and email in December 2015 and January 2016. Delaware hosted two information sessions for providers in January 2016, one with the largest clinically integrated network, and one that was a joint session of Delaware's professional societies. DCHI has also set up a link on its website so providers can request to receive information from the vendors. Following this initial outreach, vendors will be responsible for follow-on outreach to clinicians and provider organizations across the state.

Ongoing monitoring and reporting: HCC has set reporting requirements for each vendor to monitor outreach and enrollment activities. These include the following:

- **Monthly enrollment reports:** Each vendor will submit a summary template monthly providing the list of practice sites enrolled and current status of support for each site (e.g., pre-transformation assessment complete, tailored curriculum developed).
- **Monthly activity reports:** Each vendor will submit a narrative report monthly describing all practice transformation activities undertaken for enrolled practices throughout the month and any operating issues related to providing support including, but not limited to, vendor capacity constraints or challenges with provider participation.
- **Semi-annual assessments:** Each vendor will submit a report every six months upon completing an assessment of progress towards the nine practice transformation milestones adopted by DCHI at each enrolled practice site. The report shall describe the milestones that have been achieved by each practice site and provide summary statistics on the number of practice sites achieving each milestone for each

enrollment wave. It will also describe any practices that are “at-risk” of not achieving some or all milestones on the expected timeline.

HCC will use these reports to hold vendors accountable for outreach and then actively engaging with their enrolled practices. HCC and DCHI will initiate additional provider outreach if necessary. HCC intends to follow a similar approach for subsequent waves.

3. Promoting ongoing coordination of care

Practice transformation lays the foundation for primary care providers to integrate across the medical neighborhood and coordinate care on an ongoing basis. Delaware’s strategy further supports ongoing care coordination in three ways. First, Delaware will align on shared expectations about care coordination across payers and providers. DCHI approved a consensus paper on care coordination describing a common definition and shared expectations about the scope and intensity of care coordination. It also sets out a perspective on what resources, if any, may be required to support providers to coordinate care on an ongoing basis.

Common definition: The consensus paper develops a shared perspective on the definition and core elements of care coordination, including: 1) Identify high-risk patients; 2) Enroll the patient in the Care Coordination program; 3) Identify the patient’s health and psychosocial goals; 4) Develop a care plan that is co-created with the patient; 5) Maintain a multidisciplinary team that works smoothly together; 6) Provide medication management; 7) Ensure access to opinions of clinical specialists; 8) Ensure access to behavioral health, community, and population health support resources for those who need them; 9) Develop a care transition plan to ensure continuous care and community support; 10) Discuss cases in regular conferences; 11) Review and update the care plan with the patient and the family on a regular basis; and 12) Review the performance and process of Care Coordination within the multidisciplinary team.

Support model: In addition to elements already described in this plan (e.g., for practice transformation), Delaware will also convene payers, ACO leaders, and providers that are currently investing in care coordination resources of varying types and degrees. This group will align on common approaches, procedures and templates to standardize care coordination across the state. For example, a common care plan may facilitate interoperability and minimize the burden on PCPs.

Rollout timeline

Q1 2016: DCHI’s Clinical Committee will begin implementation of care coordination by working with providers and payers to clearly define opportunities to standardize approaches to care coordination where relevant.

Q2 2016: DCHI’s Clinical Committee will make recommendations to the DCHI Board on areas to standardize to improve care coordination.

Q2-Q3 2016: Delaware will conduct outreach to primary care practices and ACOs participating in practice transformation to understand whether they have any further areas where they require support to coordinate care effectively.

Q1 2017-onward: Practices that have enrolled in value-based payment models begin receiving care coordination funding and coordinating care.

4. Integration of Behavioral Health and Primary Care

In 2015, DCHI's Clinical Committee convened an advisory group consisting of members of the committee as well as other experts across Delaware to develop a common vision for integrating primary care and behavioral health, current challenges facing the state, the support required to achieve the vision (including, for example, technical assistance and common standards for reimbursement of integrated care delivery across all payers), and an implementation plan. Implementation of the strategy will begin by Q2 2016. This work is meant to complement Delaware's PROMISE program, but there are no plans to integrate it at this time.

Beyond support described elsewhere in this operational plan (e.g., practice transformation, support for Behavioral Health clinicians to adopt electronic health records), Delaware's strategy to support Behavioral Health-Primary Care integration includes the following components:

- **Support for incorporating integrated care into practices (e.g., from third party vendors):** Providers require resources (e.g., vendors, training resources or learning collaboratives) to design and implement tailored integration plans and share best practices for behavioral health integration (e.g., assistance for PCPs to identify patients needing services). This may include assistance with selecting and implementing a behavioral screening tool (e.g., PHQ-9) to identify at-risk patients or developing and managing a patient registry.
- **Support for building telehealth capabilities:** PCPs and behavioral health clinicians should be provided with support to operationalize telehealth capabilities and connect with established behavioral healthcare groups that offer telehealth services. Types of support may include technical assistance for implementation, funding for infrastructure and/or technology, and guidance on reimbursement. Support for telehealth should focus on primary care practices in areas with behavioral health professional shortages to build their tele-behavioral health program.
- **Data and reporting to enable integrated care:** PCPs should be supported with data and reporting to identify high-risk patients with behavioral and physical health comorbidities or those at-risk for developing chronic disease.
- **Guidelines and common templates for information sharing:** DCHI recommends convening providers to develop a consensus view on common standards for information sharing (ideally electronically).

- **Sustainable funding:** The DCHI Payment Committee will form a work group to address payment barriers to integrated care (for example, that some joint visits cannot be reimbursed by all payers).
- **Establishment of a knowledge community on integrated care:** In collaboration with the health sciences community, DCHI supports the longer-term strategy to build capabilities for integrated care through knowledge elevation and dissemination.

Implementation approach

Delaware will implement its Behavioral Health Integration strategy in three phases during the testing period.

Q1-Q2 2016: Detailed implementation planning. This will include estimating the number of clinicians to be supported, determining the specific form the support will take and over what time period support should be offered, developing a budget, and identifying potential options for funding support for each component of clinician support. It will also include convening a joint working group across the DCHI Clinical and Payment committees to identify specific opportunities to align payment to support integrated care delivery. The planning phase may include an evaluation of different approaches to implementation such as a phased approach where different collaborative models may be tested in a variety of practice types (e.g., large practices with existing behavioral health integration, small practices, residencies).

Q2-Q3 2016: Develop required capabilities for support. This phase will include development and release of an RFI or RFP(s) by DCHI or HCC to identify organizations to provide technical assistance. It may also focus on identifying the data and reporting needs to enable integrated care delivery. This analysis would serve as a starting point to help providers tailor their plans for behavioral health integration based on the needs of their patient panel and other practice-specific contextual factors. This phase will also focus on convening any advisory groups needed to achieve the recommendations described in this strategy (e.g., convening payers and ACOs).

Q3-Q4 2016: Deliver support for integration. This phase will focus on outreach about integrated care and on providing the support that will be made available to providers to achieve the vision described in this strategy.

5. Value-based payment models linked across all payers by a common scorecard.

Delaware aspires for at least 80% of payments to providers from all payers to be in fee-for-service alternatives that link payment to value. Delaware expects payers to introduce a pay-for-value model (with payment linked to quality and management of utilization) and a total cost of care model (with payment linked to quality and

management of total cost) for primary care providers. These expectations and assumptions about participation are described in greater detail in Section III.E below. Delaware intends for these new payment models to link quality to payment through a Common Scorecard across all payers (for more detail, please see Delaware’s response in Section III.G related to quality measure alignment). Delaware expects its payers to structure their value-based payment models so that the incentives in these models are based on performance on at least 75% of the measures on Delaware’s scorecard (recognizing that some payers may have additional measures that need to be used to align with their national programs). Delaware’s major Medicaid and Commercial payers (United Medicaid, Highmark Medicaid, Highmark Commercial, and Aetna Commercial) have committed to reporting on the Common Scorecard. The Scorecard includes measures of quality, patient experience, utilization, and cost and has been an important element of Delaware’s approach to health care delivery transformation. It will help ensure that performance in quality and cost measures is consistently high. The Scorecard will be reported to providers on a quarterly basis so that providers can use data to drive health system processes and improvements.

6. Attribution of all individuals to a primary care provider

In order to support the aspiration for every resident of the state to have a primary care provider who is accountable both for the quality and for the total cost of their health care, Delaware’s strategy calls for the value-based payment models to attribute individuals to a primary care provider. Delaware will rely on individual payer attribution methodologies as the basis for this attribution (these methodologies range from retrospective attribution based on the plurality of visits to assigned attribution at enrollment). Delaware expects to make significant progress on this aspiration, with 90% of providers participating in value-based models by the end of the grant period.

7. Focus on health promotion, prevention, and chronic disease management

Delaware’s strategy includes several important components to ensure that population health measures are integrated into the delivery system. First, Delaware’s Common Scorecard includes multiple measures focused on prevention (e.g., breast cancer screening, appropriate treatment for children with upper respiratory infections). Second, Delaware’s innovative approach to population health (see more detail in Section III.C) through “Healthy Neighborhoods” focuses on collaboration between community-based initiatives and the care delivery system to promote population health.

8. More effective diagnosis and treatment

Delaware will address unexplained variation in care delivery for all populations (both the individuals with complex chronic conditions and those that are relatively healthy who have sporadic use of the health system). Delaware will convene providers beginning in Q2 2016 to identify the areas with the greatest variation and develop a strategy to improve the quality of care in these areas.

9. Technology-enabled care delivery transformation

Delaware will facilitate increased coordination in care delivery by enabling providers to support transitions of care and share data across settings. As one component of the strategy, the DHIN will facilitate increased event notification of providers when their patients are admitted, discharged or transferred between settings of care (e.g., from hospital to skilled nursing). In general, event notifications are valuable because they enable timely follow-up (e.g., scheduling primary care appointment after hospitalization). The DHIN is currently working to automatically generate a list of patients for each primary care provider to whom alerts will be sent. This process helps to address a previous barrier of providers not having capacity to provide DHIN with the patients to track. The DHIN is working with eligible providers to automatically submit Continuity of Care Documents (CCDs) at the completion of an encounter to the DHIN's community health record. CCDs are valuable because they allow primary care providers to respond to care decisions made during a planned or unplanned hospitalization. CCDs also allow hospitalists to base decisions on existing aggregated patient information (e.g., in case of medical emergency). Further, Delaware also plans to offer funding for DHIN to work with EMR vendors to automatically import CCD information from the community health record into the provider's EMR, to reduce manual work for providers. Additional detail on the implementation of CCDs and event notifications is provided in Section III.J.

10. Workforce and education initiatives to enable transformation

Delaware's workforce strategy will focus on retraining the current workforce, building sustainable workforce planning capabilities, and training the future workforce in the skills needed to deliver integrated care.

The core concept for Delaware's approach to retraining the current workforce is to develop a two-year learning and development program. This program builds from the ideas generated at Delaware's Workforce Symposium on April 8, 2014, including developing common simulation-based learning modules, facilitating local workshops on "team-based care," developing core competencies for new roles (e.g., for care coordinators), and hosting symposia twice yearly to highlight innovative approaches to integrating care and identify cross-state retraining needs.

Delaware does not currently have a model to regularly assess the state's workforce requirements. Past assessments have typically required a special one-time project to compare Delaware's current workforce with its current and future needs. The Workforce and Education Committee has responsibility for developing a sustainable model for workforce planning and identifying the organizations needed to carry forward this work over time.

In parallel with retraining the current workforce, Delaware also needs to ensure that Delaware is able to educate, attract, and retain new members of the workforce that have the skills and capabilities required to deliver team-based, integrated care. The

Workforce and Education Committee's responsibility over the next several years is to partner with the state's and regional educational institutions to set out a comprehensive strategy for training that ensures a sustainable pipeline for Delaware health care workforce.

There are four primary components to Delaware's workforce and education strategy that collectively aim to ensure there is an adequate health care workforce to meet state residents' needs and that providers can perform at the top of their license and board certification. First, Delaware plans to implement a learning and re-learning curriculum for individuals currently in the workforce to develop the competencies needed to coordinate care. The DCHI recently adopted a consensus statement² for this learning and re-learning approach, and the Delaware Health Care Commission will issue an RFP for support to develop and implement the curriculum in 2016. Over time, Delaware will develop approaches to ensure that the next generation of the health care workforce is trained with these skills. As identified in the Learning and Re-Learning Consensus Paper, the curriculum will specifically strengthen workforce competencies within the following six areas:

- 1) Communication and Counseling Skills
- 2) Collaborative Report Writing
- 3) Interprofessional Practice
- 4) Navigation and Access to Resources
- 5) Care Decisions and Transition-of-Care Planning
- 6) Health Information Technology

Second, Delaware intends to develop an ongoing workforce capacity planning capability that provides insight into workforce needs and accounts for how these needs may evolve as providers transition to value-based payment and care delivery models. DHCC intends to issue an RFP for support for this capacity planning in 2016. The Workforce & Education Committee has recently begun planning for the development of a Workforce Capacity Planning Consensus Paper. Committee members are charged with reviewing the outline in order to inform the first draft of the Consensus Paper, which is scheduled to be finalized in Q3 2016 according to the Workforce & Education Committee Charter. An RFP will then be released after the Consensus Paper is finalized and approved.

Third, Delaware intends to develop an approach to streamlining licensing and credentialing in the state and has already begun discussion with payers, providers, and the Division of Professional Regulation to identify potential approaches for how to accomplish this goal.

² See <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-Workforce-Learning.pdf>

Fourth, Delaware intends to expand graduate health professional training in the state through an innovative Health Professionals Consortium. In Q4 2015, HCC issued an RFP for the Curriculum Development and Implementation as well as the Graduate Health Professional Consortium Facilitation. The RFP is structured so that vendors have the opportunity to bid on one or both scopes of work. The HCC will select a vendor(s) in Q1 2016.

Delaware has sequenced the rollout of the different elements of the model to align with the broader health care transformation. For example, Delaware prioritized the learning curriculum as an early focus, since that will be one of the mechanisms to provide individuals currently in the workforce with the skills and competencies needed for team-based, coordinated care. The outreach approach for the curriculum has not yet been developed.

E. Payment and/or Service Delivery Model(s)

Delaware's State Innovation Model will catalyze the adoption of alternative payment models that reward quality and efficiency of care delivery for all Delawareans, with a particular emphasis on Advanced Primary Care. Our strategy is to encourage all payers, across Medicare, Medicaid, and Commercial segments, to offer both a Pay-for-Value option as well as a Total Cost of Care option to primary care providers (or affiliated ACOs, systems, and networks), accessible to providers who differ in scale, capabilities, and readiness to accept risk. While our strategy allows flexibility for payers to operationalize these models in different ways, there are several design parameters that we encourage all payers to adopt in the design of their models:

- **Pay-for-Value (P4V) – “Category 2”:** Payers will offer primary care providers the opportunity to earn bonus payments, incremental to fee-for-service payments, based on performance against a combination of both quality and efficiency targets. For Commercial and Medicaid Managed Care payers, measures of quality and efficiency shall be drawn primarily from a Common Scorecard established by the Delaware Center for Health Innovation and operationalized by the Delaware Health Information Network based on performance data provided by participating payers.
- **Total Cost of Care (TCC) – “Category 3”:** Payers shall offer primary care providers (or affiliated accountable care organizations, clinically integrated networks, and/or integrated delivery systems) the opportunity to earn a percentage of savings achieved relative to a target budget for total cost of care, as long as providers also achieve targets for quality of care, based on a set of quality measures drawn primarily from the DCHI Common Scorecard. In some cases, participating providers may be at risk to repay a portion of any costs in excess of the target budget.

Further details can be found in DCHI's “Outcomes-based payment for population health management” white paper which is in final draft and was reviewed at DCHI's January Board and Payment Committee meetings and is available upon request. The paper, which will be put up for

formal adoption at DCHI's February 2016 board meeting, lays out 12 principles for payment models across dimensions such as measure choice, risk adjustment, and patient attribution.

Delaware's further goal is that all payers will offer funding for care coordination—preferably in the form of a risk-adjusted per-member-per-month payment, but potentially including alternative forms such as the Chronic Care Management model adopted by Medicare—in conjunction with the P4V and/or TCC options, or as a more universal form of payment available to all primary care providers. Operational details concerning care coordination are outlined extensively in a DCHI Consensus Paper on Care Coordination, which was formally adopted in the January 2016 board meeting and is available at <http://www.dehealthinnovation.org/Health-Innovation/Publications>.

Both P4V and TCC variations of alternative payment, as established in the Delaware SIM Model are meant to match the CMS definition for “Category 3” payment models. As providers in Delaware gain experience with these models, some may progress to global capitation (“Category 4”). However, we know of no current plans for providers to accept capitation.

In some cases, payers and primary care providers may enter into “Category 2” payment models, involving modest bonus payments tied to quality. In some cases, adoption of these “Category 2” payment models may provide a path for beginning to engage providers in processes around performance measurement and value-based payment and provide a transition to “Category 3”.

The State is catalyzing adoption of value-based payment in several ways: 1) requirements for adoption of value-based payment were incorporated into contracts with the State's two Medicaid Managed Care Organizations (Highmark and United), including goals for adoption consistent with Delaware's State Health Innovation Plan; 2) similar requirements were incorporated into Qualified Health Plan standards for 2015 and 2016, and will be further reinforced in updates to these standards in successive years (Highmark and Aetna being the two carriers currently offering QHPs); 3) the State Employee Health Plan has communicated similar expectations to its two carriers (Highmark and Aetna); 4) the DCHI periodically formalizes its perspective on design principles and select operational details underpinning value-based payment in formal white papers that are available to local health care organizations and the public; 5) DCHI regularly monitors the availability and adoption of value-based payment models for consistency with the principles reflected in Delaware's State Health Innovation Plan and SIM Project Narrative and further detailed in white papers publicly adopted by DCHI; 6) leaders from DCHI, the Delaware Health Care Commission, the State Employees Health Plan, and Delaware Medicaid regularly meet with the major Medicaid and Commercial payers in the State to understand the financial and operational details of value-based payment models and coordinate communication to the provider community surrounding these models; 7) State leaders regularly meet with leaders of five ACOs and CINs in Delaware who have organized to participate in the Medicare Shared Savings Program (MSSP), and have also indicated interest in supporting provider adoption of value-based payment for Commercial and Medicaid populations; and 8) DCHI and HCC are collaborating in the rollout of SIM-funded and TCPI-funded practice

transformation support, in the process communicating to providers about value-based payment in conjunction with practice transformation.

Over the past year, the number of Delaware MSSP ACOs has grown from two to five. As of 1/1/16, Delaware has become the first state in the U.S. where all Medicare-participating hospitals are part of the Medicare Shared Savings Program, in addition to two other Medicare ACOs sponsored by independent physician organizations. Delaware has submitted a request to CMMI for Medicare to offer a per-member-per-month care coordination payment similar to that used in the Comprehensive Primary Care initiative, for consistency with the model of care coordination funding being adopted by the leading Medicaid and Commercial payers in the State. Unless and until Medicare chooses to do so, Delaware primary care providers may fund care coordination for Medicare beneficiaries through the Medicare Chronic Care Management model, and/or other investments that MSSP-participating ACOs may make in care coordination based on the potential to achieve shared savings. Medicare Advantage penetration in Delaware is very low—less than 10%—and is therefore not a significant focus on the State’s efforts to drive adoption of value-based payment.

Highmark has recently met with the State to detail a new Pay-for-Value payment model which will be rolled out to primary care providers during SIM Test Year 1. Highmark is targeting an effective date of 1/1/17 or sooner for their Medicaid members, Commercial members including those in Qualified Health Plans, other fully insured populations, the State Employee Health Plan, and other self-insured employers. Self-insured members will include both local employers as well as out-of-state Blue Card PPOs with members in Delaware who are attributable to primary care providers in Highmark’s Delaware provider network. The details of the new model thus far appear to be consistent with many of the design principles adopted by the State and by DCHI, including bonus payments tied to quality, utilization, and total cost of care in a manner consistent with CMS “Category 3” payment models; it also incorporates a risk-adjusted PMPM care coordination fee. Highmark also offers an alternative “CMS Category 3” shared savings model available to primary care providers through Highmark’s partnership with MedNet for Commercial members. Highmark has also shared with the State its plans to enter into a total cost of care risk sharing agreement with Christiana Care Health System (CCHS) for a panel of Medicaid members attributed to CCHS-employed PCPs, targeting an effective date early in SIM Test Year 1.

United has also met with the State to detail both a CMS “Category 2” quality incentive model as well as a CMS “Category 3” payment model, the latter of which is tied to quality, utilization, and total cost of care, and also incorporates a risk-adjusted PMPM payment for care coordination. These models will be introduced to primary care providers in United’s Delaware Medicaid network during SIM Test Year 1 with effective dates beginning in the same year.

For Highmark’s Commercial membership, patients will be attributed to primary care providers using a retrospective attribution methodology similar to the one used for the Medicare Shared

Savings Program. For both Highmark and United, Medicaid members will be attributed to PCPs using prospective PCP selection or auto-assignment.

Aetna has shared with the State some of the value-based payment models available to local providers. However, to date, participation in CMS “Category 3” payment models consistent with the State’s SIM goals has been very low for Aetna based on very low patient panel sizes given Aetna’s small Commercial membership in Delaware.

F. Leveraging Regulatory Authority

The State has a variety of tools at its disposal to enable and empower health care transformation—from information aggregation and purchasing to regulation and legislation. Some specific examples of how the State will use this leverage include the following:

- Delaware will use its purchasing authority through its Medicaid program and its State employee benefits program to require any payers in either program to implement value-based payment models and has made progress toward this goal, as detailed in Section III.E above.
- Delaware will explore a variety of steps to streamline the current credentialing process, including reducing duplicative background checks among payers, providers, and the Department of State, and leveraging the common CAQH credentialing application to simplify the process.
- The Health Resources Management Plan (HRMP), which is used by the Health Resources Board (HRB) in the State’s Certificate of Public Review process for new or expanding health facilities and significant capital or equipment expenditures, will be revised and updated to align with the goals of the SIM initiative. The first draft of the HRMP was reviewed by the HRB at its December 2015 meeting. The goal is to complete the revisions and statutorily mandated comment and approval process by July 2016.
- The Health Care Commission adopted state-specific standards for the Qualified Health Plans sold on the state’s Health Insurance Marketplace that include specific goals for the adoption of value-based payment models, use of the Common Scorecard, data submission requirements, and participation on the DCHI board. These standards are in effect for Plan Years 2016 and 2017.
- Delaware is better positioned to support innovative means of delivering care since the legislature passed House Bill 69 in July 2015. The bill mandates that insurers reimburse remote telemedicine services the same way they do for in-person equivalents. The state’s Department of Insurance is currently formulating regulations related to the bill’s implementation and expects to publish them in mid-February 2016. Delaware’s QHP standards also reinforce and mirror the telehealth legislation for those plans sold on the Marketplace.
- During the 2015 legislative session, the General Assembly eliminated the need for Advanced Practice Registered Nurses to practice under a collaborative agreement. This

will increase the availability of PCPs throughout the state and will enable APRNs to function as a distinct part of the care team.

G. Quality Measure Alignment

Delaware has made significant progress in aligning quality measures across all payers in the state. Delaware intends for all value-based payment models to be based on a common scorecard for primary care providers that includes measures of quality, experience, utilization, and cost. Delaware has received commitments from its three largest payers across Commercial and Medicaid to report on these measures beginning in 2016. Delaware expects payers to link their payments to these measures as models are introduced in 2017. Delaware currently has a “beta” version of this scorecard that is being tested with 21 primary care practices representing approximately 120 primary care providers across the state. In the pre-implementation phase, Delaware invested significant time and effort (including interviewing nearly all of the 21 testing practices) to ensure that the Scorecard could achieve significant alignment with individual payers’ scorecards and that it limited administrative burden for providers and payers. On the basis of the feedback from the providers and the payers, Delaware developed a version 2.0 of the Scorecard (see the exhibit below) and intends to launch this statewide in 2016. These measures are consistent with the proposed measures in Delaware’s original submission, but have been refined to accomplish four goals: 1) improve focus on women’s health; 2) add additional focus on population health management; 3) reduce administrative burden by removing several measures that required CPT II codes; and 4) updating measures that had been changed or dropped by the national measure stewards. Delaware aspires for Medicare data to be included in this scorecard as well and has begun a conversation with CMS about how to accomplish that goal.

Exhibit 4: Common Scorecard v2.0

PRELIMINARY PREDECISIONAL WORKING DOCUMENT: SUBJECT TO CHANGE

Common Scorecard Version 2.0

Category	Measures	Measure type	Data source	Type
Quality of care	1 Diabetes: HbA1c control	HEDIS (CDC) ¹	CPT-IV/ Lab	Reporting
	2 Diabetes: Medical attention for nephropathy	HEDIS (CDC) ²	Claims	Accountable
	3 Medication adherence in diabetes	NQF #541 ³	Claims	Accountable
	4 Medication adherence in high blood pressure: RASA	NQF #541	Claims	Accountable
	5 Adherence to statin therapy for individuals with cardiovascular disease	HEDIS (SPC)	Claims	Accountable
	6 Medication management for people with asthma	HEDIS (MMA)	Claims	Accountable
	7 High risk medications in the elderly	HEDIS (DAE)	Claims	Accountable
	8 Colorectal cancer screening	HEDIS (COL)	Claims	Accountable
	9 Cervical cancer screening	HEDIS (CCS)	Claims	Accountable
	10 Breast cancer screening	HEDIS (BCS)	Claims	Accountable
	11 BMI assessment	HEDIS (ABA)	Claims	Reporting
	12 Screening and follow-up for clinical depression	NQF #418	G-code	Reporting
	13 Avoidance of antibiotic treatment in adults with acute bronchitis	HEDIS (AAB)	Claims	Accountable
	14 Appropriate treatment for children with URI	HEDIS (URI)	Claims	Accountable
	15 Childhood immunization status	HEDIS (CIS) ⁴	Claims	Accountable
	16 Developmental screening in the first three years of life	NQF #1448	Claims	Reporting
	17 Fluoride varnish application for pediatric patients	Custom	Claims	Reporting
	18 HPV vaccination for female adolescents	HEDIS (HPV)	Claims	Accountable
	19 Adolescent well-care visits	HEDIS (AWC)	Claims	Accountable
	20 Well child care: 0-15 months	HEDIS (W15)	Claims	Accountable
	21 Well child care: 3-6 years	HEDIS (W34)	Claims	Accountable
Utilization	22 Follow-up within 7 days after hospital discharge	Custom ⁵	Claims	Reporting
	23 Plan all-cause readmissions	HEDIS (PCR)	Claims	Accountable
	24 Inpatient utilization	HEDIS (IHU)	Claims	Accountable
	25 Emergency department utilization	HEDIS (EDU)	Claims	Accountable
Total cost of care	26 Total cost of care per patient	Payer defined	Claims	Accountable

¹ One component of the Comprehensive Diabetic Care specification; modified HEDIS definition: HbA1c < 9%
² One component of the Comprehensive Diabetic Care specification
³ Proportion of Days Covered (PDC) specification for diabetes, renin-angiotensin system antagonists
⁴ Combination 10 is used for this measure
⁵ Conditions included in this measure: CHF, COPD, pneumonia, and ischemic vascular disease

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H. SIM Alignment with State and Federal Initiatives

Delaware’s model testing proposal builds from a strong foundation of innovation. Currently, Delaware’s CMMI programs include Christiana Care’s “Bridging the Divide” and Nemours/A.I. duPont’s PCMH model for optimizing health outcomes for children with asthma. Delaware also has multiple Medicare Shared Savings Program ACOs. Delaware also has a TCPI grant to Health Partners Delmarva, LLC. Five CMS Marketplace grants have been awarded in Delaware: one Planning Grant, three Level One Establishment Grants, and one grant for Federal in-person Navigators. HHS grants include a focus on eligibility and IT gaps, as well as the Maternal, Infant, and Early Childhood Home Visiting program. Delaware also has a series of other federal programs, including funding for the DHIN and CDC funding for public health initiatives (e.g., assessment and planning for DPH’s State Health Improvement Plan). There are many external initiatives across the state, including Smart Start / Healthy Families America, Healthy Women Healthy Babies, La Red’s Parkinson’s Telemedicine Clinic, Million Hearts Delaware, Beebe CAREs, Christiana Care’s Independence at Home and Medical Home without Walls programs, and the Statewide Telehealth Coalition.

Delaware has taken significant steps to ensure that its SIM efforts align with ongoing health care innovation programs and do not duplicate activities or supplant current federal or state funding. In particular, Delaware has pursued the following steps to achieve these goals:

- **Presenting to the Delaware State Clearinghouse.** The State reviewed its SIM approach with the Clearinghouse Committee of the General Assembly to ensure alignment across Delaware’s grants.
- **Active engagement with health system leaders.** Delaware will continue this active engagement, since many of these institutions lead other significant health care innovation programs. Delaware has engaged these leaders through the DCHI Board and Committees, through regular meetings with the Delaware Health Care Association, and by convening meetings with Delaware’s Clinically Integrated Networks and ACOs. These meetings have been very important for aligning with Delaware’s two HCIA grant programs, its MSSP programs, and its TCPI program. It has also been important to identify opportunities to align community benefit programs and community needs assessments in the future.
- **Active leadership by DHIN and DHSS.** The CEO of the DHIN and the Secretary of Health and Social Services are both members of the DHCC and of the DCHI Board. The DCHI Committees and advisory groups also include leadership from the Division of Public Health and the Division of Substance Abuse and Mental Health (both of which are part of the Department of Health and Social Services). This joint leadership has helped ensure coordination with Meaningful Use and HITECH, CDC and SAMHSA grants, and other local public health initiatives (e.g., the Governor’s Council on Health Promotion and Disease Prevention).
- **Specific coordination with TCPI grant recipients.** Delaware’s SIM leadership has established regular and on-going communications with HealthPartners Delmarva, a recipient of TCPI funding. HCC has communicated with its practice transformation vendors regarding expectations for coordination and cooperation between SIM-funded efforts and TCPI-funded efforts. We have also collaborated to host a meeting for providers in Delaware to learn about the various options available for practice transformation support.

I. Workforce Capacity Monitoring

Delaware does not currently have a model to regularly assess the state’s workforce requirements. Past assessments have typically required a special one-time project to compare Delaware’s current workforce with its current and future needs. The Workforce and Education Committee has responsibility for developing a sustainable model for workforce planning and identifying the organizations needed to carry forward this work over time.

In parallel with retraining the current workforce, Delaware also needs to ensure that Delaware is able to educate, attract, and retain new members of the workforce that have the skills and capabilities required to deliver team-based, integrated care. The Workforce and Education Committee’s responsibility over the next several years is to partner with the state’s and regional educational institutions to set out a comprehensive strategy for training that ensures a sustainable pipeline for Delaware health care workforce.

1. Stakeholder Engagement

Delaware has a dedicated committee of subject matter experts focused specifically on workforce matters related to health innovation. The committee includes representation from both the medical and educational communities, in acknowledgment of the importance of both re-training the current workforce while developing the appropriate skills and capacity in the upcoming workforce. This group meets monthly and performs ad hoc work between meetings to ensure that continued progress is made on the committee's established tasks and deliverables.

On a continual basis, Delaware engages with critical stakeholders in the state whose work has direct implications for particular facets of workforce transformation efforts. Key players on academic and health education topics include the University of Delaware and its Healthcare Theatre and the Delaware Health Sciences Alliance, whose founding partners include both private healthcare provider systems and universities. Delaware also plans to leverage the expertise of faculty at all of Delaware's academic institutions to develop a common curriculum for team-based care and develop competencies for new roles in the healthcare workforce.

With regard to credentialing and licensure, Delaware has and will continue to engage with stakeholders impacted at all stages of these processes. These include providers and employers who must provide the firsthand information necessary to secure licensure and appropriate credentialing; credentialing entities including healthcare facilities and payers; and regulatory entities including Delaware's Division of Professional Regulation. Delaware has also collected detailed information from the national and state level to offer examples of how Delaware may wish to proceed in streamlining its licensing and credentialing efforts. The extensive nature of these efforts will require sustained engagement with all of these stakeholders to ensure comprehensive understanding and buy-in of system changes.

2. Data Collection

Delaware has already made significant progress in understanding and documenting key issues and statistics impacting workforce capacity and better defining workforce needs for the future. This has included reviewing available information and statistics and developing resources to better define workforce issues not previously explored in great depth.

To better understand the current and future healthcare needs of the state, Delaware has examined population and demographic trends as well as provider statistics including HRSA statistics about health professional shortage areas (HPSAs.) Currently, multiple geographic areas within Delaware have been designated as HPSAs for primary care, mental health and dental health services. For primary care, the entire counties of Kent and Sussex and numerous census tracts within New Castle County have been designated

as HPSAs. This information is a key driver of efforts to increase the participation of providers at all levels in Delaware’s workforce.

Delaware recently undertook a close examination of population projections between the years 2012-2040 to better understand anticipated shifts in the overall population and demographics of the state. Chief among the findings was an expected significant increase in the state’s Hispanic population, which projections show will roughly double from 8.2% in 2010 to roughly 16% in 2040. This increase will undoubtedly require the addition of Spanish-speaking and culturally competent providers to the workforce during this time period and Delaware must consider how to factor this need into determinations about workforce training and development needs. Other considerations include Delaware’s aging population and the shifting of the population, particularly retirees, into more rural areas of the state, which will ostensibly require an even greater number of providers in areas already facing shortages.

Beyond simply understanding the healthcare needs and challenges of the state, Delaware has made strides in identifying and documenting a path forward in addressing them. The Division of Public Health’s extensive feasibility study explored the use of Graduate Medical Education (GME) programming to increase the primary care workforce in Delaware and included several concrete recommendations that are helping to shape the workforce and education committee’s current efforts.

In the near future, Delaware will undertake a more extensive effort to capture detailed information about its healthcare workforce in concert with its public and private state partners. The intent of these efforts will be to better understand gaps in the existing provider network and to identify opportunities both within and outside of the existing workforce to increase capacity and best meet the healthcare and related needs of Delawareans.

Delaware has collected data on its health care workforce from the Delaware Department of Labor, which categorizes the workforce into a number of job titles and projects the employment level for these job titles in 2016. Please see below for a sampling of this data:

Job Title	Number of Providers - 2014	Projected Number of Providers - 2016
Physicians and Surgeons, All Other	1,477	1,529
Registered Nurses	10,428	10,874
Nurse Practitioners	529	558
Home Health Aides	2,762	3,000

Medical Assistants	1,921	2,007
Family and General Practitioners	599	612
Physician Assistants	426	452

3. Removing Barriers with Legislative, Regulatory or Executive Action

Delaware is beginning to explore the potential role of the Legislature, executive office and other regulatory bodies in facilitating achievement of its aims related to workforce development. The workforce and education committee has identified licensing and credentialing as two critical areas in which regulatory changes may be required in the interest of improving provider workflow. A consensus paper currently in development by the committee outlines challenges faced by providers and credentialing entities in completing accurate and efficient credentialing checks that are vital to a provider’s ability to practice within his or her specialty area.

The primary challenge for Delaware with regard to credentialing largely mirrors that of other states: unique credentialing requirements at the hospital, payer and state licensing division create redundancy within the system, requiring the provision of detailed provider information to multiple sources with much overlap of content but no streamlining of collection processes. This creates a high degree of complexity in the system while placing an unreasonable burden on administrative staff at providers’ offices, who ultimately bear the responsibility for collecting and disseminating this information.

Delaware is actively examining information from the Council for Affordable Quality Healthcare (CAQH) and from other states to understand how the challenges of provider credentialing have been addressed elsewhere. It is anticipated that the final analysis may very well point to the need for legislatively mandated use of a standardized credentialing application and/or a shared credentialing database in order to best address simplification and streamlining of credentialing processes. Delaware is similarly beginning to examine licensure through this lens in order to identify impediments to efficient completion of licensing procedures and to determine whether regulatory changes are required in order to realize significant improvements.

4. Workforce Capacity Programs

Delaware has already assembled a solid body of research and information regarding programs in the state that offer education and training to the current and future healthcare workforce and will continue to do so as new offerings are developed. In order to compile this body of information, Delaware leveraged existing communication channels to engage with stakeholders in both the public and private sectors to better

understand how they were addressing the goal of providing quality, value-based care through targeted workforce training and support.

Example programs that Delaware has documented and highlighted thus far include efforts varying in scale, geographic reach and area of focus, but themes include:

- Using telemedicine to teach PCPs about specialty care for complex conditions
- Piloting Patient Centered Medical Homes with dozens of practices statewide and providing practice transformation coaching with focus on change management, process and culture change to support the PCMH model
- Co-located services for individuals with behavioral health needs to more readily access primary care
- Utilizing care coordinators to:
 - Manage care and educate patients, families and caregivers regarding the patient's care plan and self-management responsibilities
 - Guide patients through cancer testing and treatment and offer advice, emotional support and practical help
- Interdisciplinary care teams focused on:
 - Mentoring graduate students in health sciences
 - Coordinating care to better empower patients to self-manage chronic illnesses
 - Providing home/shelter visits and transportation and addressing other factors impacting health such as hunger, addiction and domestic violence

Delaware is also actively examining ways to better leverage and increase the effectiveness of its existing graduate medical training offerings. The graduate health professionals consortium is expected to serve as the umbrella under which a wide array of health professional training programs will be carried out, all with the intent of bolstering the reach and quality of healthcare services in Delaware. An RFP for establishing the consortium was issued in Q4 2015 by the HCC; a vendor will be selected for this work in Q1 2016. Additionally, Delaware will continue to explore how its Institute of Medical Education and Research (DIMER) and related partners can best collaborate and encourage innovation that yields the greatest number of medical professionals committing to practice in Delaware.

As previously mentioned, the Workforce and Education Committee identified six core competencies that should be built into the curriculums which will guide provider training across the state. They are as follows:

- Communication and Counseling Skills
- Collaborative Report Writing
- Interprofessional Practice

- Navigation and Access to Resources
- Care Decisions and Transition-of-Care Planning
- Health Information Technology

Additionally, the DCHI Board made the following recommendations regarding the development and implementation of the curriculum:

Audience: Initially, the audience of the curriculum should include any member of the primary care team with primary responsibility for coordinating clinical care. The DHCI envisions expansion over time to include other members of the health care team, as well as the potential for the learning components designed for patients (e.g., how to maximize care visits, tips for asking care-based questions, when to seek specialist care). The new curriculum will also acknowledge the growing cultural diversity of Delaware’s health workforce.

Core Topics: Core topics should directly address competencies identified earlier in this document and should include Standards of Practice, Care Planning, Care Team Leadership, Communication Skills (e.g., patient engagement, motivational interviewing and behavior change strategies), use of health information technology (e.g., risk prediction software, population health management tools), and cross-system integration (e.g., social service, community-based programming).

Format/Channels: The curriculum should be delivered through a variety of channels and designed to meet the needs of a variety of professionals. Learning should occur in individual and group settings and should include actual and simulated patient interactions, didactic and clinical experiences, and fully incorporate technology including telemedicine.

Alignment with other Practice Resources: The duration of the curriculum should be 24 months. Participation should be available to team members of any practice receiving practice transformation support and be aligned with primary care practice transformation activities as recommended by DCHI.

An RFP for designing the curriculum was issued in Q4 2015 by the HCC; a vendor will be selected for this work in Q1 2016.

J. Health Information Technology

1. Rationale

Delaware’s approach to health information technology (HIT) consists of three major elements in support of statewide health transformation: (a) Transitioning to value-based payment models and transforming the healthcare delivery system to improve outcomes, (b) Engaging patients and consumers in their care, and (c) Research, evaluation and

planning — for the SIM program overall and at the individual community-level (e.g., Healthy Neighborhoods).

The approach is summarized in the below table and also described in detail in the subsequent subsections.

Exhibit 5: Overview of Delaware Health IT strategy

Elements of DE strategy	Supporting health IT topics
Delivery system and payment model	<ul style="list-style-type: none"> ▪ Aggregate claims-based information ▪ Increase clinical data access ▪ Generate Scorecard measures from clinical measures ▪ Enable event notifications across healthcare system ▪ Provide EMR adoption incentives for behavioral health ▪ Increase direct secure messaging
Patient and consumer engagement	<ul style="list-style-type: none"> ▪ Develop public tools to increase health literacy ▪ Enable consumer transparency into cost and quality information ▪ Ensure equity and access for telemedicine ▪ Enable patient access to their health information
Research, evaluation and planning	<ul style="list-style-type: none"> ▪ Conduct public health planning through multi-payer claims aggregation ▪ Use datasets to support SIM dashboard ▪ Use datasets to support community-level health goals for Healthy Neighborhoods

a) *Delivery system and payment model*

(1) *Aggregate claims-based information*

Delaware will develop a multi-payer claims database using data from Medicare FFS (pending release of data by CMS), Medicaid, and the State Employee Benefit Program. These datasets represent 55-60% of the state’s insured; the plan is to eventually include commercial insurers as the benefits of the multi-payer claims database are proven. Building this database will enable the generation of insights from claims-based information for providers, consumers, employers, and public health planning.

Providers will be able to use data from the multi-payer database to help them participate in value-based payment models. Larger providers (e.g., ACOs, hospital systems) may use the data directly, while less

sophisticated providers may choose to engage third parties to conduct analytics if they are unable to do so on their own. Such arrangements will enable providers to understand costs by patient segment (e.g., per member per month cost for diabetic hypertensives in a particular geography) and help them establish the baseline levels of cost and utilization, thus helping develop total cost of care agreements between payers and providers.

Delaware expects that the claims database will leverage the existing data warehouse capabilities of Truven, a vendor with whom the Division of Medicaid & Medical Assistance (DMMA) and the State Employee Benefit Program both partner. Both DMMA and the State Employee Benefit Program have expressed their support for creating a multi-payer claims database. The State expects to work with CMS to obtain regular, current Medicare claims information to supplement the other data sets.

In the third quarter of 2016, Delaware will begin the formal planning process, including design, vendor acquisition, and developing formalized data release policy and processes (e.g., establishing terms such as frequency of claims refresh, rules for data release)³, followed by implementation of the database and initial release to approved subscribers. We believe that the formal implementation planning should wait until later in 2016 to ensure that we can successfully execute other elements on the HIT roadmap (e.g., version 2.0 of the scorecard). However, we are already assessing whether legislation would be required to establish an APCD and plan to gain approval during the 2016 legislative session if needed.

Throughout this planning and implementation process, Delaware will consider incorporation of commercial claims in the database. The required infrastructure for initial data senders will be developed with the eventual incorporation of commercial data in mind.

(2) Increase clinical data access

Delaware will facilitate the submission of a clinical data via a portable data format, the continuity of care document (CCD) as defined by HL-7⁴, into a common repository to support care transitions and care coordination.

³ APCD Council

⁴ See: Implementing Consolidated-Clinical Document Architecture (C-CDA) for Meaningful Use Stage 2

CCDs enable providers to access clinical information generated in other care settings. For example, CCDs allow primary care providers to respond to care decisions made during a planned or unplanned hospitalization. CCDs also allow hospitalists to base decisions on existing aggregated patient information (e.g., in case of medical emergency). Therefore, CCDs decrease manual work, increase patient safety, and enhance the quality of care as patients transition between care settings.

The DHIN currently plans to work with providers to enable the automatic submission of CCDs at the completion of an encounter, targeting 200 providers (12% of total in DE) within approximately two years from a baseline of 14 currently⁵.

Though CCDs contain information that is valuable for providers to deliver better care, data are most useful when integrated into the existing patient EMR. Without this integration, it is less likely that providers will be able to incorporate this information into existing workflow. Therefore, Delaware will offer funding for DHIN to work with EMR vendors to automatically pull CCD information from the community health record. This funding will be offered as early as mid-2017, with confirmation of best timing determined by the pace of adoption for CCD submission by providers.

In addition, the DHIN will also work with long-term and post-acute care (LTPAC) sites to automatically generate C-CDA (consolidated clinical data architecture) documents and submit them to the community health record. Such documents are consumable by EMRs in primary care and other settings. The DHIN will enable this conversion using the tool developed at the Keystone Beacon Community, which creates C-CDA files from the LTPAC minimum data set (MDS)⁶. The goal for participation is that within two years 80% of Delaware SNF and home health organizations will have been recruited and trained on creation and submission of C-CDA documents to the community health record.

In addition to CCD exchange, Delaware will explore the utility of additional centralization of clinical information that can improve care

⁵ DHIN ONC Grant (March 2015), revised October 2015

⁶ From CMS: “The Long-Term Care Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all residents in a Medicare and/or Medicaid-certified long-term care facility”

coordination and transitions of care, such as advance directives as per the Delaware Medical Orders for Scope of Treatment (DMOST) and a patient's care plan (i.e., one's health assessment that may include types of services required, what types of staff should provide them, one's health and personal goals)⁷. The Clinical Committee is exploring the potential to standardize care plans, and if that proceeds, centralization of the care plans may prove useful.

(3) Generate Scorecard measures from clinical data

At this time, Delaware's Common Scorecard is constructed using data primarily from claims contributed by individual payers. However, clinical quality measures can be enhanced by using data directly from the CCDs that are submitted to the community health record. This would address some of the limitations of claims-based measures and also increase the accuracy and completeness of data for providers to take action regarding quality performance. As an example, one would be able to ascertain exact body mass index (BMI), blood pressure, or blood glucose levels rather than relying on coding those into claims.

The DHIN is currently engaging with a vendor to enable the extraction of data CCDs from the community health record in order to conduct analytics. In versions 1 and 2 of the scorecard, we are relying only on claims data for the scorecard. As more clinical information comes into the DHIN, we will migrate to using more clinical data for practices that make it available. DHIN has already contracted with a vendor who can process the CCDs into discrete data elements, place it into a central data store, and then query and manipulate the data. That data can then be used in place of claims information to generate the metrics (the same vendor has been developing the common scorecard). Plans and funding (separate from the SIM grant) are targeting a release in Q2 2016 for the capability to ingest CCD data and store it in a clinical data mart. DHIN and DCHI will collaborate to generate Scorecard clinical quality measures from these aggregated CCDs, with a target to implement the capability for measure construction for submitting providers by Q2 2017.

(4) Enable event notifications across healthcare system

Delaware will expand its existing event notification system (ENS) to enable care coordination. Currently, the ENS, run by DHIN, is operating

⁷ CMS

for 150 eligible providers in Delaware, with a goal to increase this number to 475 within two years⁸. DHIN is sending ADT messages today.

In order to achieve this goal for level of adoption, the DHIN is working to automatically generate a list of patients for each primary care provider (PCP) for which alerts will be sent. DHIN is developing this functionality today and has been testing it with select practices. It utilizes existing patient information that DHIN has (e.g., CCDs, lab data, etc.) to dynamically generate patient lists. The DHIN today has capabilities to match patient information it receives from labs or imaging to the community health record that assembles information for each patient. This process helps to address a previous barrier of providers not having capacity to provide DHIN with the patients to track. So far, the feedback from testing practices with dynamic list generation has been positive, and DHIN expects to grow this capability.

Delaware also hopes to expand ENS to generate notifications from LTPAC facilities, using the CCDs generated by these organizations as described above. Alerts from these providers have been identified both by practicing Delaware providers as well as the ACOs and CINs as critical to enable care coordination and scheduling of follow-up visits as required in value-based payment models.

(5) Provide EMR adoption incentives for behavioral health

Delaware will offer incentives for behavioral health (BH) providers to adopt EMRs. BH providers are not eligible for Meaningful Use incentives and therefore have not adopted EMRs at the same rate as clinicians.

The targets for level of adoption of BH incentives are ~50 BH providers by end of 2016, an additional 30 by end of 2017 and another 20 by end of 2018. In early 2016, Delaware will begin outreach to BH providers to notify them that incentive payments will be made available. The State will design an enrollment process, develop required milestones for implementation, and suggest EMRs that would be compatible with the DHIN EMR integration roadmap.

(6) Increase direct secure messaging

Delaware will offer a standalone direct secure messaging platform to long-term and post-acute care (LTPAC) organizations through which to communicate with providers in other sites of care.

⁸ DHIN ONC Grant (March 2015), revised October 2015

Currently, the level of adoption of such communication by LTPAC facilities is quite low⁹. However, messaging services are important to enable better coordination among members of a patient's care team and to facilitate transitions of care. Example uses include notifying a primary care provider about an episode that took place while in LTPAC and an LTPAC organization clarifying an aspect of a patient's care plan with a primary care provider or other member of care team.

DHIN is already providing a standalone direct secure messaging application. The goal is that within 2 years, 75% of LTPAC organizations will have been recruited, enrolled and trained on the messaging application. Beginning in early 2016, DHIN will engage with LTPAC organizations to train relevant users on use for the messaging platform. DHIN will also develop a directory of Delaware providers, which will be supplied to LTPAC centers so that appropriate partners in primary care and other settings can be reached. DHIN expects to complete its directory for availability to providers by Q2 2016.

b) Patient and consumer engagement

(1) Develop public tools to increase health literacy

Delaware has identified increased health literacy as a strong need within the community, and therefore it will offer materials to support health literacy for all Delawareans. The opportunity to improve health literacy spans definitions of healthcare terminology and an understanding of the options for healthcare providers and services in the state.

Delaware will identify a set of concepts and terms that are important for individuals to understand in order to make use of their health insurance. Materials will include the definition of terms and aspects to address questions such as "what is a deductible", "how do I find out whether a procedure is covered by my insurance". The State will attempt to incorporate both Delaware-specific information and also best-in-class external resources, such as those from Kaiser Family Foundation, to make use of existing materials.

Delaware will also create a directory of health services and providers that will enable Delawareans to know where to seek appropriate care. The materials provided will include lookup of primary care providers,

⁹ DHIN ONC Grant (March 2015)

hospitals, and ambulatory clinics by geography, and could eventually include behavioral health and specialty care as well. We will utilize ONC guidance on this topic and consider HPD standard, pending confirmation on breadth of features by Q3 2016.

Both the health literacy overview and Delaware health services guide will be planned starting in early 2016. Once the set of information and services to provide is finalized, Delaware will expect to engage an outside vendor to develop and implement web-based materials for release.

(2) Enable consumer transparency into cost and quality information

Payers are scaling up availability of cost and quality information for consumers. Examples include:

- Highmark “Care cost estimator” reveals true costs of procedures and integrates with ongoing submitted claims to help patients manage their healthcare budget
- Highmark also offers “Physician Quality Measure”, which lists network provider’s status in national quality recognition programs
- Aetna offers a “Member Payment Estimator”, which enables comparisons between different facilities for common services

To enable further transparency for consumers, Delaware will use the multi-payer claims database to develop a consumer-facing website that includes information on total costs for common healthcare procedures and services, as well as comparative quality and indicators of quality, such as annual volume of a given service provided by a provider facility. This website will enable all consumers to search for common procedures and see the rates for providers and facilities, such as hospitals, imaging facilities, and outpatient care centers. Delaware will begin the development of this website following the implementation of the claims database in early 2018.

Delaware will also enable consumers to better understand their out-of-pocket costs for “shoppable” services. These services include episodes or procedures that are typically elective and have high price variation. Delaware plans to require payers to make out-of-pocket cost information available for top procedures and services. The set of procedures/services will be selected based on criteria such as annual Delaware-wide volume, variation in out-of-pocket cost, and variation in total payer cost. Delaware will begin the identification of the

procedures and services in mid-2016, also engaging payers on expected timeline to release this additional functionality on their websites.

(3) Ensure equity and access for telemedicine

Delaware will improve both access and equity for telemedicine. Recent legislation in Delaware, passed in July 2015, mandates that insurers reimburse remote telemedicine services the same way they do for in-person equivalents¹⁰.

The law formally defines telemedicine as involving real-time two-way communication via telecommunication or other electronic means and lays out different use cases that apply under this definition.

The law also regulates quality and consistency for telemedicine. For example, providers must complete similar procedural items as they would for in-person visits (e.g., documenting the visit through a record of care). In addition, with the exception of emergencies and episodic consultations by specialists, telemedicine must take place between those with an existing patient/provider relationship.

(4) Enable patient access to their health information

Delaware proposes to make the information in the DHIN community health record available to patients. This includes imaging, test results, discharge summaries, and eventually, the data contained in CCDs. This would allow patients to see their own health information and proactively be able to inform providers when tests and imaging have already been performed. Additionally, patients can be informed when providers have viewed their results in the community health record.

Currently, Delaware proposes to implement the DHIN patient portal by mid-to-late 2016. The DHIN will work with its existing community health vendor to make the information available to patients and initiate a direct-to-consumer marketing blitz to raise awareness and encourage adoption.

c) Research, evaluation and planning

(1) Conduct public health planning through multi-payer claims aggregation

In order to generate insights to support public health planning, Delaware will conduct analytics on aggregated multi-payer claims

¹⁰ House Bill No. 69: An Act to Amend Title 18 And 24 of the Delaware Code Relating to Telemedicine Services

through existing State capacity (e.g., Division of Public Health), contracting with external organizations, and partnerships with academic institutions. Examples of analysis include:

Healthcare access and services: By analyzing claims data, one can characterize Delawareans by geography, insurance type, condition type, and services received. This research can identify opportunities to reduce disparities, such as access to a certain type of care for a given geography or subpopulation, and also inform efforts to increase preventive care for a given condition. For example, an analysis may determine that there is a differential rate of preventive care (e.g., for tobacco cessation) between two populations and quantify the impact on health outcomes. This would inform broad public health awareness campaigns or community-level interventions.

Healthcare costs: Multi-payer claims information can also be used to quantify and segment costs by patient demographics, condition, insurer, and setting of care. Policy makers may use this information to inform regulation of health insurance, as well as to address opportunities to reduce cost through policy levers.

Clinical practice and outcomes: Claims data will be used to understand treatment patterns, patient behavior, and their associated impact on health outcomes. For example, policy makers will be able to characterize a particular aspect of patient behavior (e.g., follow-up appointments after discharge) and quantify impact on cost and outcomes. Having identified a clinical trend, the State may choose to respond by engaging with providers to develop improvement actions.

(2) Use datasets to support SIM dashboard

As part of the SIM program, an overall program dashboard will be created by the State to track progress against goals. Currently, the draft dashboard contains measures tracking overall SIM outcomes (e.g., public health, cost and quality of care) as well as progress in DCHI program areas (e.g., payment innovation, Healthy Neighborhoods).

Several of the proposed measures are built from existing sources, such as America's Health Rankings. Other measures may rely on the multi-payer claims database or additional sources, such as surveys that would be administered to providers and patients. The state plans to acquire this information by contracting with survey vendor(s).

(3) Use datasets to support community-level health goals for Healthy Neighborhoods

Analytics will also be used to support Healthy Neighborhoods identification of priorities, planning of initiatives, and for evaluation of progress. These analyses will be developed through partnership with academic institutions and contracts with other external organizations. Applications include:

- **“Hotspotting” of opportunities to improve outcomes:** Existing Division of Public Health data (e.g., Behavioral Risk Factors Surveillance System) and the use of multi-payer claims database will be used to identify opportunities for Healthy Neighborhoods initiatives. For example, a Neighborhood may leverage evidence around the incidence of depression in their community to support their choice of mental health as a focus area. Support provided by the DCHI to Neighborhoods to access and analyze data is discussed in Section III.C.
- **Planning of initiatives:** Analytics will enable Neighborhoods to design their work more effectively. For example, analysis of multi-payer claims could demonstrate that a certain subpopulation is particularly at risk for a given health condition (e.g., diabetes, asthma), therefore informing Community Councils to target Neighborhood interventions towards the subpopulation.
- **Evaluation of progress against goals:** Access to these data will also enable tracking of progress for a specific Neighborhood goal. For example, a Neighborhood may choose to track a decrease in unplanned healthcare encounters for diabetic patients over time as an indicator of whether a healthy lifestyles initiative may be impacting outcomes in the community.

d) Overview of proposed timeline and budgeting

Timing for proposed start and completion milestones of each of the HIT topics are outlined in the below tables:

Exhibit 6: Timing of Delaware HIT topics (1/2)

	Health IT topics	Start date	Milestones
A Delivery system and payment model	1 Aggregate claims-based information	Q3 2016	<ul style="list-style-type: none"> Implementation by Q1 2018 Availability of data to stakeholders by Q2 2018
	2 Increase clinical data access: Increase number of practices submitting CCDs	Ongoing	<ul style="list-style-type: none"> Increase automatic submission of CCDs from baseline of 14 eligible providers to 200 by Q3 2017
	3 Increase clinical data access: Provide funding for CCD import	Q2 2017 for CCD import funding	<ul style="list-style-type: none"> Target 5-15% of DE providers can automatically incorporate data from CCDs by Q2 2018
	4 Increase clinical data access: Send clinical data from LTPAC facilities	Ongoing	<ul style="list-style-type: none"> Recruit and train 80% of SNF and home health organizations on submission of C-CDA documents to the community health record by Q3 2017
	5 Generate Scorecard measures from clinical data	Ongoing	<ul style="list-style-type: none"> Implementation of clinical quality measures from CCDs for primary care practices submitting CCDs by Q2 2017¹
	6 Enable event notifications across healthcare system	Ongoing	<ul style="list-style-type: none"> Increase number of eligible providers receiving alerts to 475 from baseline of 150 by Q3 2017 Enable alerting from 80% of SNF and home health organizations by Q3 2017²
	7 Provide EMR adoption incentives for behavioral health	Q1 2016	<ul style="list-style-type: none"> 50 behavioral health providers with EMRs by end of 2016 Another 30 BH providers by end of 2017 and 20 by end of 2018
	8 Increase direct secure messaging	Ongoing	<ul style="list-style-type: none"> Complete database of direct addresses with functionality to add and remove entries by Q2 2016 Recruit, enroll, and train 75% LTPAC organizations on direct secure messaging by Q3 2017

Exhibit 6: Timing of Delaware HIT topics (2/2)

	Health IT topics	Start date	Milestones
B Patient and consumer engagement ¹	9 Develop public tools to increase health literacy	Q1 2016	<ul style="list-style-type: none"> Implemented and publicly available by Q3 2016
	10 Enable consumer transparency into cost and quality information: Develop public tool for consumer transparency into cost and quality information	Q1 2018	<ul style="list-style-type: none"> Public cost/quality tool implemented and available by Q3 2018
	11 Enable consumer transparency into cost and quality information: Ensure payer provision of consumer transparency into cost and quality information	Q1 2016	<ul style="list-style-type: none"> Top procedures and services are made available by each of the major payers by Q1 2018
	12 Enable patient access to their health information	Ongoing	<ul style="list-style-type: none"> DHIN patient platform implemented by Q3 2016
C Research, evaluation and planning ²	13 Conduct public health planning through multi-payer claims aggregation	tbd	<ul style="list-style-type: none"> tbd

1 No milestones for telemedicine priority area; 2 No milestones for community health planning or SIM dashboard

2. Governance

Delaware Health Care Commission

Overall role

The Delaware Health Care Commission (HCC) has overall responsibility for health policy in the state and has overall accountability for administering the SIM cooperative agreement.

Role in aggregating claims-based information

The HCC will facilitate the aggregation of data for the multi-payer claims database in coordination with the Division of Medicaid & Medical Assistance (DMMA), the State Employees Benefits Program (SEBP), the Delaware Center for Health Innovation (DCHI), and the Delaware Health Information Network (DHIN).

Currently DMMA and the SEBP have claims databases maintained through Truven warehouses. The current plan for aggregation of claims data includes the combination of Truven data with Medicare FFS, building on the existing data architecture and approach to management. As previously described, the centralization of claims will be done such that Commercial claims can also eventually be incorporated.

Role in supporting development of health literacy materials

The HCC will also support the development of health literacy materials and ensure that they are aligned with existing work on the Delaware health insurance marketplace, Choose Health Delaware. HCC will facilitate the development of health literacy materials (developed for Delaware specifically as well as general-purpose materials) that will be hosted on www.ChooseHealthDE.com and/or the DCHI website (www.dehealthinnovation.org). HCC may also choose to engage external organizations to develop additional health literacy materials (e.g., interactive map of Delaware hospitals and other sites of care).

Delaware Center for Health Innovation

Overall role

The Delaware Center for Health Innovation was established as a nonprofit, public-private organization to work with the HCC to carry forward Delaware's consensus-based process. The DCHI and its Technical Advisory Group will provide guidance on design and execution for Delaware's SIM health IT plan.

Role in sharing claims and clinical data

The DCHI Board of Directors, the Clinical Committee and the Payment Model Monitoring Committee will provide guidance on use cases for claims and clinical data in support of SIM.

Topics for claims and clinical data sharing that will be supported by the Board, Clinical and Payment Model Monitoring Committees include:

- Insights from claims-based information that will support public health planning
- Sharing claims data with providers through public use files and/or third-party generated analytics to enable population health management
- Sharing of clinical data (e.g., CCDs) across the care continuum to enable care coordination and transitions of care

Role in supporting development of health literacy materials

DCHI will provide input to the design and execution of health literacy materials, led by the Board and the Patient and Consumer Committee:

- **DCHI Board:** The Board will have the opportunity to provide input regarding the overall approach for development and rollout of materials, such as the timing and process for their design. The Board will also recommend sources of insight (e.g., other stakeholders from whom to gather feedback). The Board will review

the website materials prior to release and offer additional input on content overall.

- **Patient and Consumer Committee:** The Patient and Consumer Committee members represent different demographics within the state (e.g., age, geography, culture). It will support initial planning for health literacy materials, as well as provide feedback during design and rollout. Committee members will give input regarding whether materials address information gaps currently relevant to Delawareans, as well as whether the proposed presentation for the content will effectively engage the desired audiences.

Role in community-level health planning and Healthy Neighborhoods

The DCHI Board, the Healthy Neighborhoods Committee, and DCHI staff will provide input on needs for support of community-level health goals for Healthy Neighborhoods:

The DCHI Board and Healthy Neighborhoods Committee will make recommendations on analysis or data needed to design, manage, and monitor the programs. These recommendations may be executed in the form of a public white paper and/or direct actions to make the appropriate resources available (e.g., by DCHI staff).

DCHI staff will provide technical support including, but not limited to identification of existing data sources, plan for collecting supplemental data (e.g., community health needs assessment or community focus groups), data collection, data interpretation and translation of findings, selecting data-based outcomes, and determining impact of initiatives¹¹.

Delaware Health Information Network

Overall role

The DHIN runs Delaware's health information exchange, which includes a common repository of labs, imaging and care summaries that spans all hospitals and delivers results to primary care providers across the state. This repository is often referred to as the "community health record".

As described in the previous section, many components of the SIM HIT plan will be supported or led by DHIN. Specific areas for which DHIN will be the lead in planning and implementation include:

- Automating submission of CCDs from providers to the DHIN community health record

¹¹ DCHI Healthy Neighborhoods Operating Model (published September 2015)

- Enabling conversion of aggregated CCDs to clinical quality measures for the Common Scorecard. In versions 1 and 2 of the scorecard, Delaware is relying only on claims data for the scorecard. As more clinical information comes into the DHIN, we will migrate to using more clinical data for practices that make it available. DHIN has already contracted with a vendor who can process the CCDs into discrete data elements, place it into a central data store, and then query and manipulate the data. These features are planned to be in place by mid-2016.
- Providing “MDS to C-CDA” conversion capabilities for LTPAC
- Increasing the percent of Delaware providers receiving event notifications through the automatic generation of patient lists for providers. DHIN is already piloting this approach today by utilizing existing patient information that it has (e.g., CCDs, lab data, etc.) to generate patient to physician mapping. The DHIN today has capabilities to match patient information similar to a Master Person Index.
- Developing the ability for patients to access data in the community health record (e.g., labs, imaging, discharge summaries, data from CCDs)

Health Systems, Accountable Care Organizations and Clinically Integrated Networks

Current information exchange by ACOs and CINs

Delaware health systems, ACOs and CINs are scaling up information exchange capabilities in support of new delivery models:

- Beebe (Delmarva Health Network) is developing an internal health information exchange that includes employed providers, inpatient care and an LTPAC organization
- Bayhealth has partnered with a health IT vendor to build interoperability across its system in order to share clinical data among its employed providers and inpatient care EMRs
- Christiana Care Health System and its affiliated CIN, Christiana Care Quality Partners, are developing a suite of PHM and patient stratification tools on internal data, as well as specific clinical decision support/care flows that are targeted at different patient segments and care needs
- Nanticoke has partnered with an EMR vendor to increase interoperability between systems and enable care coordination across its inpatient care and employed providers

Impact of proposed Delaware plan on existing ACO/CIN data exchange

DHIN’s collection of CCDs will intersect with the existing health information exchange within individual health systems, ACOs and CINs. These provider organizations can

receive CCDs from the DHIN and integrate them with their existing care delivery processes to incorporate visibility into care that is delivered outside of the network. This process may be achieved at comparatively lower per-practice administrative burden and cost if the capability is coordinated across many employed providers within a given provider organization.

Role of the Division of Public Health (DPH)

Role in public health planning through multi-payer claims aggregation

As discussed in Section III.J.1.c), the DPH will support use of the multi-payer claims database to create insights for public health planning. The DPH has existing in-house analytic capacity that it may choose to use to support research, as well as the capability to enable projects through contracting and partnership agreements. The DPH also provides the capacity to link insights from claims data with other in-house resources, such as the Behavioral Risk Factors Surveillance System and mortality data.

Role in support of community-level health goals for Healthy Neighborhoods

The DPH will provide support for Healthy Neighborhoods through areas such as, but not limited to, inventories of health services in a Neighborhood, technical assistance (e.g., designing components of the Neighborhood's program) and development of scorecards (e.g., documenting progress for a Neighborhood against health goals)¹².

3. Policy

a) Policy and regulatory levers

Claims database: As discussed in Section III.J.1.a), Delaware will develop a multi-payer claims database, that may require updates to policies and regulations to use State data (i.e., Medicaid and State Employee Benefits Program claims) to enable aggregation and release of information for research and planning. In addition, Delaware plans to eventually incorporate commercial claims, which will require policies specifying the requirements for data submission. Such policy would provide criteria not only for the specific data elements, but also for the frequency and method of submission.

Consumer transparency into consumer cost information: Delaware may use regulation to establish guidelines for the procedures and services for which publicly available out-of-pocket cost information will be required from payers. Such regulation will be developed based on analyses of procedures and services

¹² Choose Health Delaware - State Health Care Innovation Plan (December 2013)

that have the most cost variation and volume. Delaware also expects to have a regular dialogue with payers to understand feasibility and timing constraints.

Common Scorecard: Delaware will incorporate measures from the Common Scorecard in both Qualified Health Plan (QHP) certification standards as well as requirements for the Medicaid Managed Care Organizations. Such regulation could include requirements to include Common Scorecard quality and efficiency measures as part of contracts with providers.

b) Methods to improve transparency and encourage innovative uses of data

Patient access to the community health record: Through DHIN, patients will have access to imaging, test results, discharge summaries, and eventually, the data contained in CCDs. This will allow patients to see their own health information and proactively be able to inform providers when tests and imaging have already been performed. Additionally, patients can be informed when providers have viewed their results in the community health record.

Cost information (from claims database and provided by individual payers): The multi-payer claims database will enable transparency for healthcare costs and utilization for providers, public health planning, academic researchers, universities, and other third parties. The multi-payer database can also enable a public-facing website that informs consumers of the total cost of care to the insurer. In addition, Delaware will require payers to provide consumers with out-of-pocket cost for a set of highest-volume, highest-cost variation procedures and services. Costs will be communicated at the individual facility as well as the individual health plan level.

Quality information: The multi-payer claims database will also enable public reporting on quality and indicators of quality, such as volume of a given procedure or service done by a given provider organization each year. This information will be provided on the same website as the public-facing cost data described above.

Common Scorecard: Delaware's Common Scorecard serves as a cross-panel view on cost and utilization for primary care providers. Currently, it is expected that the Scorecard will be used as the primary basis for reimbursement in value-based payment agreements. Therefore, through access to the Scorecard, providers are able to understand their performance and implications for reimbursement as they transition to new payment models.

Clinical data: The generation of clinical quality measures directly from CCDs in the community health record is one source of transparency for providers to understand care at other sites. Further, in addition to the point-of-care uses

described in Section III.J.1.a) for individual healthcare providers, the aggregation of CCDs may also enable public health planning based on aggregated analysis on clinical data.

c) Plan for promotion of patient engagement and shared decision making

Delaware will engage patients and consumers through health literacy resources, transparency into cost and quality of their healthcare, and the availability of their health information from the community health record.

Given that ownership of one's health data and healthcare decisions is the ideal end-state for patient and consumer engagement, Delaware must first address gaps in consumer understanding of how the health system works and of basic terminology that prevents such engagement.

Having enabled improved health literacy, availability of data from the DHIN will also enable further engagement. For example, patients (as well as that of caretakers and family members) can prepare questions for their providers based on viewing a hospital discharge summary in advance of the follow-up visit. Similarly, patients will be better prepared to discuss the options for treatment and for selection of provider facilities, specialists, etc. with their primary care provider, based on publicly available information on clinical quality and costs.

d) Multi-payer strategies to enable and expand the use of health IT

The multi-payer claims database and proposals for sharing of clinical data both serve as multi-payer strategies that will enable individual providers, provider organizations (e.g., ACOs), policy makers, academic researchers and others to generate insights from cross-panel, cross-subpopulation, and cross-Delaware perspectives and apply insights to improve healthcare quality and reduce cost.

4. Infrastructure

a) Analytical tools and data-driven, evidence-based approaches to coordinate and improve care across Delaware

Multi-payer claims database: Access to multi-payer claims data will enable providers to identify and act on opportunities to improve care, either through direct analysis of data or by engaging third parties to conduct analytics. For example, Delaware providers may use analytics to identify an opportunity to increase preventive care for a particular patient subset, which would inform the recommendations they make to participating PCPs, care coordinators and other members of the care team.

Sharing of clinical data: The submission of clinical data, such as CCDs, to a common repository will enable better coordination of care among providers as

patients transition from one care setting to another. For example, the DHIN community health record can enable hospitalists to have access to ambulatory data that may otherwise be unavailable.

Population health management tools (PHM) by individual hospitals and ACOs:

The multi-payer claims database and the aggregation of clinical data will support ongoing investments being made by individual ACOs and CINs. Multiple organizations are currently developing enterprise data warehouses and network-wide health information exchange capabilities. Access to data generated in other settings, such as claims, will enable more robust PHM analytics. Further, ACOs/CINs may be better-equipped to incorporate clinical data from other settings into provider workflow, given the investments they have made in system-wide EMRs and data management.

b) Plans to utilize telehealth and perform remote patient monitoring

As discussed in Section III.J.1.b), Delaware's July 2015 telemedicine law enacts regulation around quality, consistency and reimbursement, facilitating the adoption of telemedicine while maintaining standards of care for patients.

c) Plans to use standards-based health IT to enable electronic quality reporting

HEDIS: Delaware's Common Scorecard is a central component of delivery system transformation and an enabler for value-based payment. The current version of the Scorecard is primarily based on claims-based HEDIS measures to evaluate the quality of care and utilization levels for primary care providers.

HL-7: As discussed in Section III.J.1.a), clinical quality measures can be enhanced by using data directly from the CCDs that are submitted to Delaware's community health record. Delaware is enabling measure construction both from the automatic generation of CCDs at the end of an ambulatory encounter, as well as through the DHIN program to enable conversion from the LTPAC minimum dataset to a C-CDA formatted output.

d) Integration of public health IT systems

Multi-payer claims database: Claims data will be integrated with other sources of insights for research on by-population disparities, influences on health costs, and outcomes, and community-level analytics. For example, Delaware will consider the utility of incorporating claims-based information on treatment patterns and utilization with existing data in existing patient registries, such as the Delaware Cancer Registry.

Integration among Division of Public Health (DPH) datasets: The incorporation of multi-payer claims data will support ongoing work by the DPH to integrate

among datasets already owned and maintained by the Division. The DPH is currently working to improve the integration among existing datasets and create composite measures that are more descriptive of community-level health trends, similar to work done with the Connecticut Health Equity Index and the Florida Charts. Delaware will include information from claims data with DPH data integration and metric construction. For example, the DPH may incorporate differences in total cost of care as a component of by-geography health equity comparisons, alongside existing inputs such as hospital discharges, mortality and behavioral risk factors.

e) How support of electronic data will drive quality improvement at the point of care

The construction of clinical quality measures from automatically-submitted CCDs, as described above, will enable point-of-care quality improvement for Delaware providers because it will serve as a more real-time and specific view of performance than can be achieved through claims (e.g., due to the lag in claims adjudication and non-patient-level view available through claims rollup). For example, through clinically-derived measures, a practice may be able to identify a multi-patient trend driving lower performance on a Scorecard diabetes measure, also identifying which patients need follow-up to address in the near-term.

5. Technical Assistance

a) Targeted provider groups and services delivered

Delaware will provide technical assistance to providers through several channels:

- **Primary care practice transformation:** As part of Delaware’s primary care practice transformation, vendor support will be provided to primary care practices beginning in early 2016. The HCC expects that, where appropriate, technology and services provided by the Delaware Health Information Network will be utilized to support practice transformation¹³.
- **Regional Extension Center (REC):** The REC (via a grant to Quality Insights of Delaware) has been successfully supporting providers adopting EMRs. Delaware can build on these relationships and processes to deliver assistance to providers wishing to enroll in new payment models as the need arises. Quality Insights of Delaware is also currently partnering with a Medicare Shared Savings ACO to support

¹³ RFP for Practice Transformation Vendors (#HSS-15-030)

submission of quality metrics and aggregated analytics/reporting for its participating providers.

- **Funding for CCD data incorporation into EMRs:** Given the additional cost required to automatically incorporate CCD information in EMRs, Delaware will fund vendors to enable this capability and support practices to access CCD-derived information as part of their workflow. The proposed model for funding is that DHIN will contract directly with major EMR vendors to implement this capability across all Delaware practices that are using their EMR.
- **Connection to current and planned DHIN resources:** The DHIN will continue to engage with Delaware practices to understand their technical needs and enable connectivity to the community health record. In particular, the DHIN employs a team of provider relations staff who interface directly with practices. For example, provider relations staff are engaging with providers about expansion of the event notification system (ENS) and the process to automatically generate panels of patients for alerting.

b) Resources for providers ineligible for Meaningful Use incentive payments

Given that behavioral health EMRs are not a focus for Meaningful Use, Delaware plans to provide incentive payments for BH providers to adopt an EMR starting in 2016, with adoption targets of 50 providers by end of 2016 and an additional 30 by end of 2017.

K. Program Monitoring and Reporting

Delaware has outlined metrics in the attached Excel workbook “DE SIM Reporting Metrics 01-15-16.xls.” These metrics will assess the progress Delaware is making in addressing population health, the health care delivery system, and health care spending.

An important element of Delaware’s approach to health care delivery transformation has been to develop and refine, with input from payers and providers, a Common Scorecard for primary care providers across all payers that includes measures of quality, experience, utilization, and cost. It will help ensure that performance in quality and cost measures is consistently high. The Scorecard will be reported to providers on a quarterly basis so that providers can use data to drive health system processes and improvements. Delaware has received commitments from its three largest payers across Commercial and Medicaid to report on these measures beginning in 2016. Delaware expects payers to link their payments to these measures as models are introduced in 2017.

L. Data Collection, Sharing, and Evaluation

One of the tools that Delaware will use for regularly monitoring the impact of the work of the SIM initiative is the overall Program Dashboard. This technology solution will allow DCHI

committees and stakeholders alike to view the goals associated with each Committee and have an updated view into each's progress toward stated goals.

Currently, the draft dashboard contains measures tracking overall SIM outcomes (e.g., public health, cost and quality of care) as well as progress in DCHI program areas (e.g., payment innovation, Healthy Neighborhoods). Several of the proposed measures are built from existing sources, such as America's Health Rankings. Other measures may rely on the multi-payer claims database or additional sources, such as surveys that would be administered to providers and patients. The state plans to acquire this information by contracting with survey vendor(s). The Program Dashboard is targeted for implementation in Q2 2016.

Other data collection and sharing requirements will be determined in collaboration with the state's independent state-led evaluator. The procurement process is currently underway and it is anticipated that a vendor will be selected and onboard in Q4 2015. Delaware and its selected vendor will be committed to full cooperation and transparency with the federal evaluator.

M. Fraud and Abuse Prevention, Detection and Correction

Working with the state's Division of Medicaid and Medical Assistance and the State Employee Benefits Program, Delaware plans to assess its current procedures related to fraud and abuse and identify any areas which may pose a risk for new exposures.

Delaware anticipates that there will be some barriers to implementing the proposed innovation model, at least at the outset, due to the current structure of the fraud and abuse protection system. For example, for practices who are integrating behavioral health with primary care, claims that are submitted to a payer may be denied, since current systems dictate that the payer will not reimburse for two patient visits in one day. However, when examined on an individual basis, this integration is key to a transformed system of care.

Delaware will continue to work with payers and providers to identify issues of concern and maintain an open dialogue regarding best ways to overcome these barriers.