State Innovation Model Operational Plan

Model Test Year 3 (Award Year 4)

February 1, 2018 – January 31, 2019

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A. Project Summary

A.1. Summary of Model Test

Award Year 4 (AY4) is the final year of Delaware's SIM grant, and our operational plan for this year reflects both the culmination of lessons learned and our efforts to lay the ground work for continued progress after the end of the grant.

Our previous year began with state leadership transition, resulting in a number of changes and new directions. The year ended with the launch of several new programs. In AY4, we will look to use our experience and learnings to continue to cultivate the support of our stakeholders and to make substantial progress on our initiatives. The attached work plan looks a little different from previous plans in that we have homed in on a few key activities, in an effort to make more visible and coherent progress. We also intend to work with stakeholders and vendors across work streams so that we find connections and exploit opportunities for collaboration and progress. This effort to integrate is an important strategy for sustainability.

This year's work plan is centered on Healthy Neighborhoods, payment reform, behavioral health integration, and others –all supported by Health IT—and continue our efforts to transform health and health care for all Delawareans.

- Payment reform and related activities will be a major focus of our work this year. The Health Care Commission (HCC) will continue to support the Department of Health and Social Services in their efforts to construct and launch a health care benchmark. New models for payment will be developed in collaboration with Delaware payers, providers, and consumers. The HCC and its vendors will also continue to forward transparency and quality efforts through payment reforms on many fronts—linking with DHIN and the practice transformation efforts under SIM.
- Behavioral health integration will be the backbone of our practice transformation work. Founded on the plan developed in AY3, HCC will work with practices across the state to improve their capacity to address behavioral health needs alongside primary care. The HCC will also continue to support other practice transformation activities, and seek ways to support provider engagement in Delaware's Health Information Network (DHIN).
- Our Healthy Neighborhoods initiative was launched in the fall, and will propel population health efforts through the three county-based HN councils. In this year, the HCC will conduct a mini-grant program that allows these local councils to implement critical, evidence-based programs to improve population health. The HCC will also support population health through several other consumer-based efforts, including the state employees' programs and elsewhere.
- Health IT and health information exchange and transparency underpin the success and sustainability of all of these efforts. Without data, payment reforms can be lop-sided, practice transformation can be stymied, and local communities cannot target high-need issues and populations. Therefore, the HCC will continue to work with DHIN and invest in our HIT efforts—in concert with our other initiatives.

These four lines of work are of critical importance to the state of Delaware in achieving transformation. But they do not exist in a vacuum. Therefore, the HCC is working to closely manage and integrate across these initiatives, and to ensure a coherent program of work that facilitates improvement. Furthermore, the Health Care Commission will use this final year of the SIM grant to look forward and plan for the future. Our payment, practice and community transformation efforts will get the ball rolling across the state, but we must all work together to keep that momentum. We believe this plan sets the stage for Delaware to ultimately reach our SIM goal: The Triple Aim Plus One.

A.2. End State Vision

As we established in Year 1 of the Delaware SIM program, we are committed to achieving the Triple Aim Plus One—with the Plus One being focused on provider satisfaction and engagement. More recently, Governor Carney has made a public, specific commitment to transformation, outlined in a Road to Value for the Delaware health care system that more specifically articulates the pathway for achieving this vision, as it seeks to transform health care delivery and improve health outcomes through the following strategies: (1) Improve health care quality and cost; (2) Pay for value; (3) Support patient-centered, coordinated care; (4) Prepare and support the health provider workforce and health care infrastructure needs; (5) Improve health for special populations; (6) Engage communities; and (7) Ensure data-driven performance. The SIM grant work in AY4 will be an important next step for Delaware's progress toward these goals.

As we move forward in Award Year 4 on our Road to Value, we will seek to progress toward this vision by driving, leveraging, and working with stakeholders to move us along toward the following:

- Integrated systems of care competing on cost and quality
- Continuing to increase the proportion of payers and providers participating in value-oriented payment systems;
- An active use of purchasing and regulatory levers in public sector programs, through which we sustain momentum towards a value-based delivery system;
- Systems of care that are grounded in robust primary care and activated consumers, thereby improving provider engagement and reducing burden;
- Organized systems and neighborhoods that are responsive to community-specific health priorities, tailor care to special populations, and adapt to changing needs; and
- Creating governance and stakeholder engagement mechanisms that ensure Delaware is strategic, systematic, results-driven and collaborative in creating solutions to our health challenges beyond the period of the SIM award.

As of 2017, we reached an important milestone: more than 30% of payments for primary care for Delawareans are now "value-based."[1] In Award Year 4, we will further strengthen our foundation for a sustainable health transformation agenda. We will seek to accelerate the adoption, and broaden the

[1] Note: Delaware uses the CMS construct for "value-based" to mean payments that recognize quality rather than being only volume-based. Furthermore, we designate as value based payment structures those that adhere to "Category 3 or 4" as defined by CMS' Learning and Action Network

scope of value-based payment in Delaware, and continue our program of practice transformation assistance, while also aligning with the evolving Medicare ACOs and other health plan-provider partnerships. We also seek to learn from payer and purchaser strategies outside of Delaware that support transparency and consumer decision-making, and drive better outcomes at a lower cost trend. Bringing all of these new tools and learning to bear on our work, we intend to move forward and make real progress in AY4 toward this vision.

In each of the sections below, our Award Year 4 Plan lays out our approach and activities to move our state closer to achieving our vision, and set us on that Road to Value for years to come.

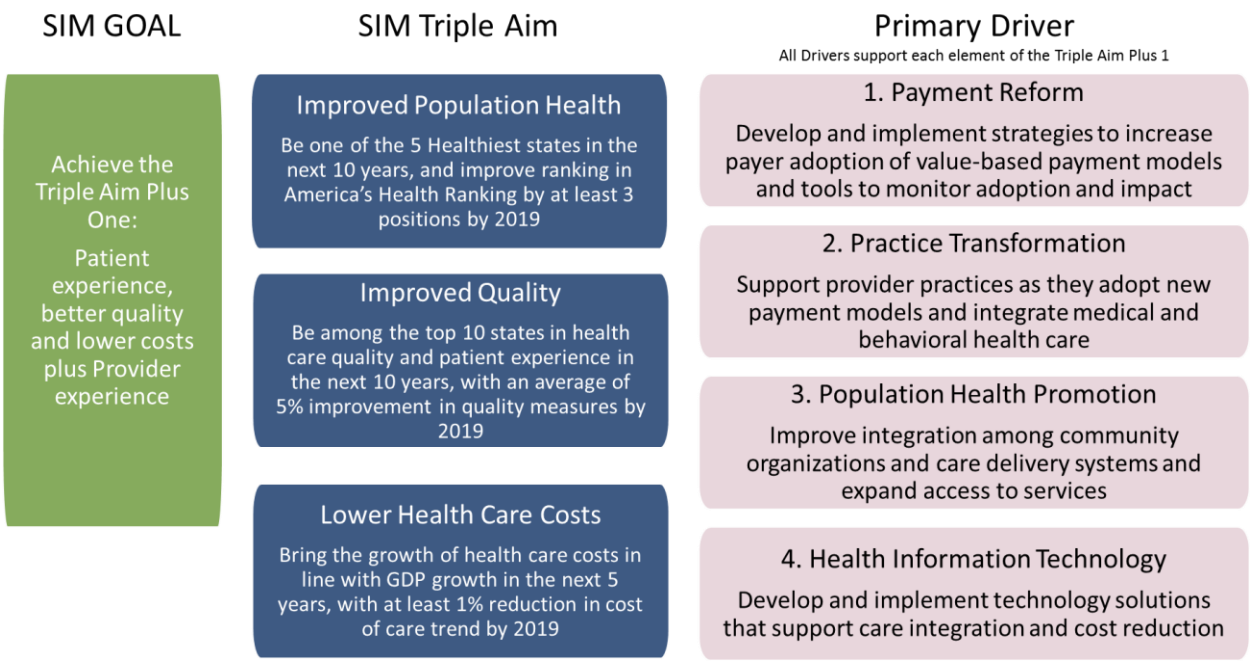
A.3. Updated Driver Diagram

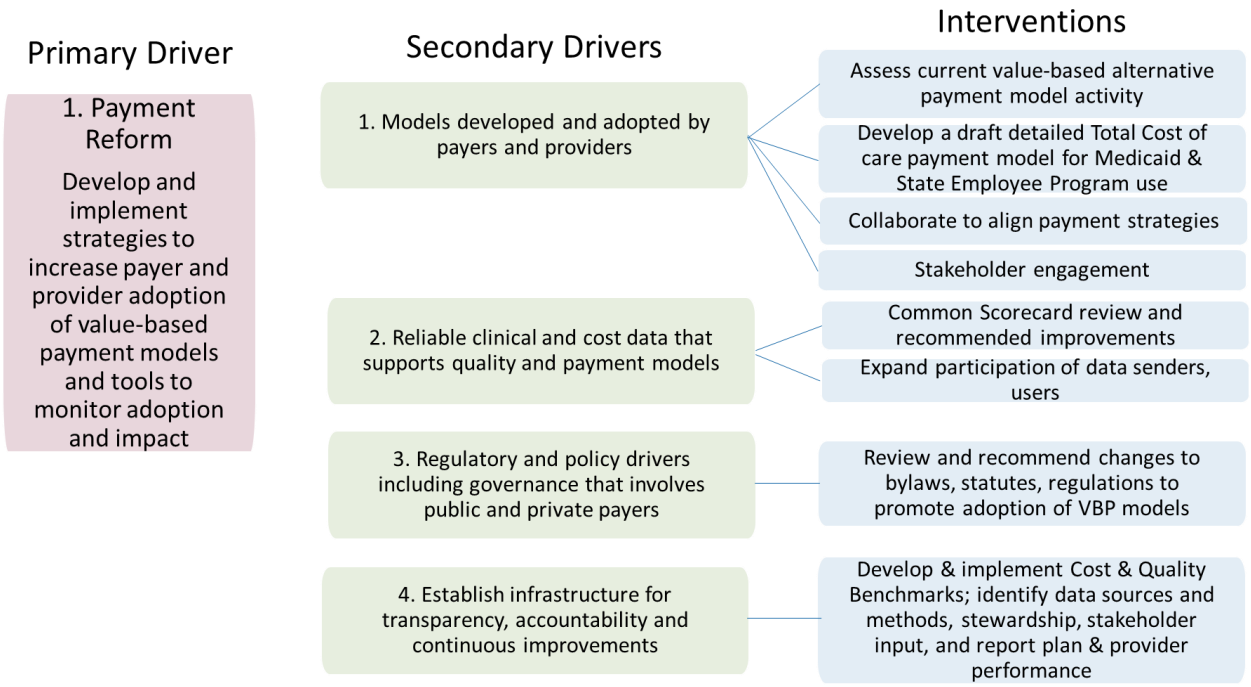
The Delaware Award Year 4 (AY4) Driver Diagram refreshes and reframes our SIM Grant work for the coming year—drawing on lessons learned and our continued development in these various pathways. It does not reflect a change in direction. Rather, the AY4 Driver Diagram clarifies our plan by detailing and homing in on the specific interventions that are required to carry out health system reforms forward throughout and beyond the grant period.

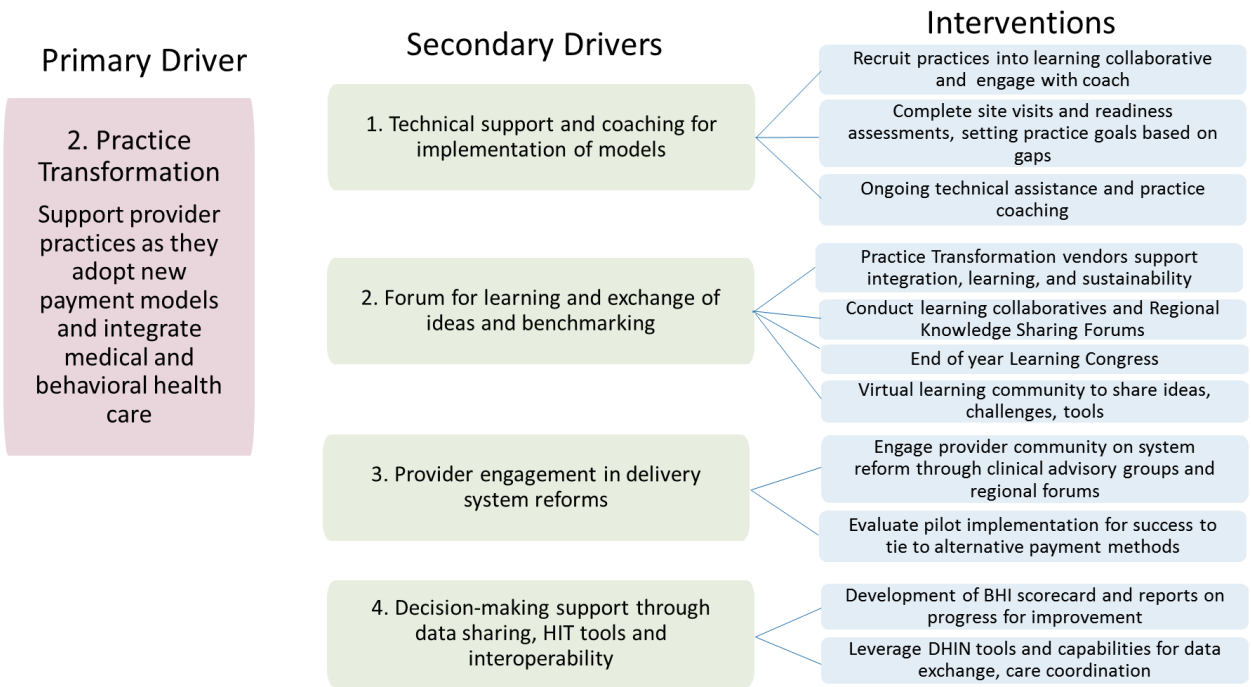
This year's Driver diagram is different from our previous depictions. We have combined and integrated drivers to represent our renewed focus on the most specific and essential drivers that we need to tackle, better integrate activities across the SIM effort, better support sustainability planning and better align with the Governor's end state vision for health system transformation. The AY4 Driver Diagram includes the specific secondary drivers and interventions that will lead us to our sustainability goals.

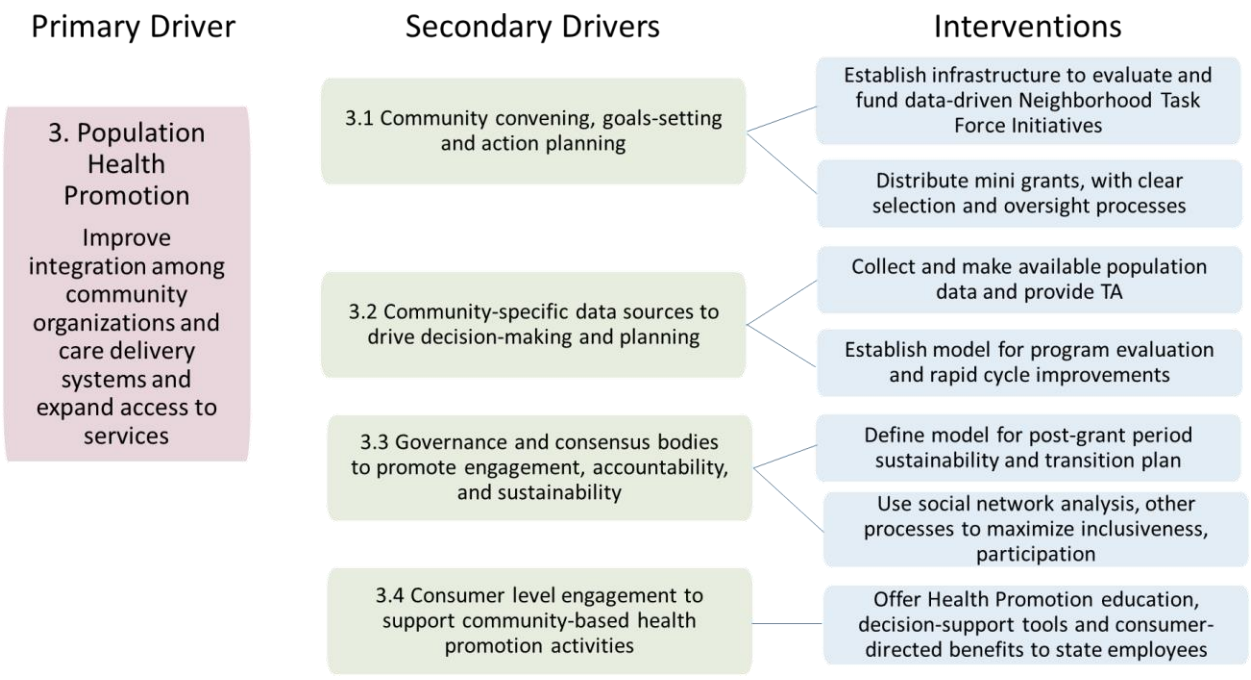
The AY4 Driver Diagram clearly reflects the alignment of SIM efforts with Governor Carney's Road to Value for the Delaware health care system. Governor Carney's approach remains consistent with Delaware's original SIM proposal while putting a greater emphasis on value and accountability. The AY4 Driver Diagram more clearly maps interventions and more effectively shows cause and effect.

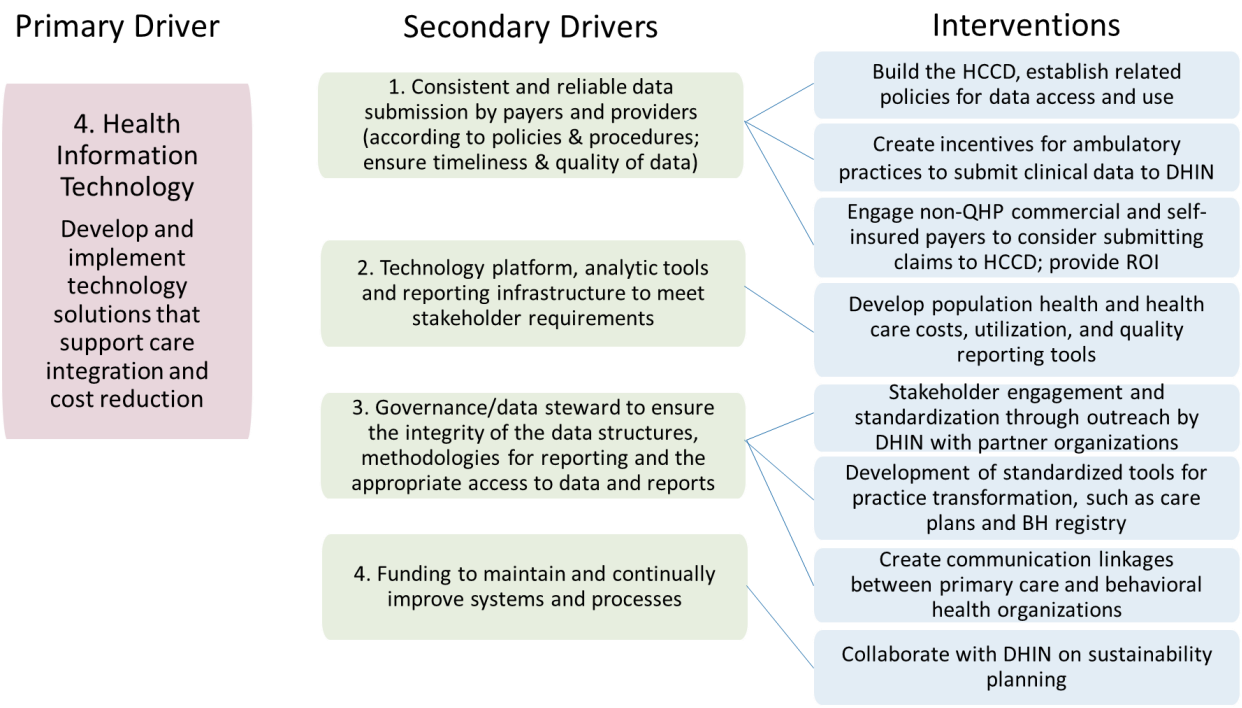
DE SIM Driver Diagram is provided below and attached as Appendix F.1. A detailed mapping of the specific changes from Award Year 3 is provided as Appendix F.2.


SIM GOAL
SIM Triple Aim
Primary Driver
All Drivers support each element of the Triple Aim Plus 1
Achieve the Triple Aim Plus One:
Patient experience, better quality and lower costs plus Provider experience
Improved Population Health
Be one of the 5 Healthiest states in the next 10 years, and improve ranking in America's Health Ranking by at least 3 positions by 2019
Improved Quality
Be among the top 10 states in health care quality and patient experience in the next 10 years, with an average of 5% improvement in quality measures by 2019
Lower Health Care Costs
Bring the growth of health care costs in line with GDP growth in the next 5 years, with at least 1% reduction in cost of care trend by 2019
1. Payment Reform
Develop and implement strategies to increase payer adoption of value-based payment models and tools to monitor adoption and impact
2. Practice Transformation
Support provider practices as they adopt new payment models and integrate medical and behavioral health care
3. Population Health Promotion
Improve integration among community organizations and care delivery systems and expand access to services
4. Health Information Technology
Develop and implement technology solutions that support care integration and cost reduction


Primary Driver
Secondary Drivers
Interventions
1. Payment Reform
Develop and implement strategies to increase payer and provider adoption of value-based payment models and tools to monitor adoption and impact
1. Models developed and adopted by payers and providers
Assess current value-based alternative payment model activity
Develop a draft detailed Total Cost of care payment model for Medicaid & State Employee Program use
Collaborate to align payment strategies
Stakeholder engagement
2. Reliable clinical and cost data that supports quality and payment models
Common Scorecard review and recommended improvements
Expand participation of data senders, users
3. Regulatory and policy drivers including governance that involves public and private payers
Review and recommend changes to bylaws, statutes, regulations to promote adoption of VBP models
4. Establish infrastructure for transparency, accountability and continuous improvements
Develop & implement Cost & Quality Benchmarks; identify data sources and methods, stewardship, stakeholder input, and report plan & provider performance


Primary Driver
2. Practice Transformation
Support provider practices as they adopt new payment models and integrate medical and behavioral health care
Secondary Drivers
1. Technical support and coaching for implementation of models
2. Forum for learning and exchange of ideas and benchmarking
3. Provider engagement in delivery system reforms
4. Decision-making support through data sharing, HIT tools and interoperability
Interventions
Recruit practices into learning collaborative and engage with coach
Complete site visits and readiness assessments, setting practice goals based on gaps
Ongoing technical assistance and practice coaching
Practice Transformation vendors support integration, learning, and sustainability
Conduct learning collaboratives and Regional Knowledge Sharing Forums
End of year Learning Congress
Virtual learning community to share ideas, challenges, tools
Engage provider community on system reform through clinical advisory groups and regional forums
Evaluate pilot implementation for success to tie to alternative payment methods
Development of BHI scorecard and reports on progress for improvement
Leverage DHIN tools and capabilities for data exchange, care coordination


Primary Driver
3. Population Health Promotion
Improve integration among community organizations and care delivery systems and expand access to services
Secondary Drivers
3.1 Community convening, goals-setting and action planning
3.2 Community-specific data sources to drive decision-making and planning
3.3 Governance and consensus bodies to promote engagement, accountability, and sustainability
3.4 Consumer level engagement to support community-based health promotion activities
Interventions
Establish infrastructure to evaluate and fund data-driven Neighborhood Task Force Initiatives
Distribute mini grants, with clear selection and oversight processes
Collect and make available population data and provide TA
Establish model for program evaluation and rapid cycle improvements
Define model for post-grant period sustainability and transition plan
Use social network analysis, other processes to maximize inclusiveness, participation
Offer Health Promotion education, decision-support tools and consumer-directed benefits to state employees



A.4. Updated Master Timeline

The Master Timeline for Delaware's SIM initiative has been updated to reflect completed activities and milestones as well as planned activities and milestones for Award Year 4. The Master Timeline is attached as Appendix F3.

B. SIM Policy and Operational Areas

B.1. SIM Governance

The Governance and Management structure for this final year of the SIM grant is designed to renew, refresh, and continue to grow the commitment, support and engagement of stakeholders as a vital strategy for sustainability.

Delaware underwent a number of changes in Award Year 3—including a change in leadership, the passage of legislation calling for a Health Care Spending Benchmark and migration toward a Total Cost of Care reform, as well as an evaluation and recalibration of our infrastructure, governance, and engagement strategies under SIM. To reflect and adapt to these changes, our AY4 approach to health care transformation governance and SIM oversight has shifted and expanded to reflect new direction and emphasis, and to expand the level of engagement of our public and private sector leaders. Our new Governor has demonstrated his commitment to payment reform as a strong part of the state's health care transformation agenda, and is looking to optimize public program's contributions in this effort. At

the same time, the state is seeking to expand and add to the foundational stakeholder work already conducted, with enhanced infrastructure and expanding circles of input and engagement.

a. Governance and Management Structure

A new state Administration often begins with an assessment of the evolution and current status of critical areas of state policy. Governor Carney and Secretary Walker soon laid out a new vision for moving forward in health reform, and the state legislature contributed several new ideas to the table. These new directions will build on the existing infrastructure, but call for accelerated progress and the greater involvement of the state in its capacity as a health care purchaser. They also reflect the need for the state to bring its full leverage to transformation efforts. The revised governance and management plan for AY4 reflects those needs and demonstrates the continuing commitment to stakeholders.

In the Governance Structure below, we show our new consolidated process for SIM oversight, public input, and stakeholder engagement with the Health Care Commission. The HCC will continue to serve as the state's sounding board and a primary conduit for stakeholder input, and will continue to work closely with all of the other "enablers" and contributors to health system transformation.

Figure 1. SIM Governance Structure

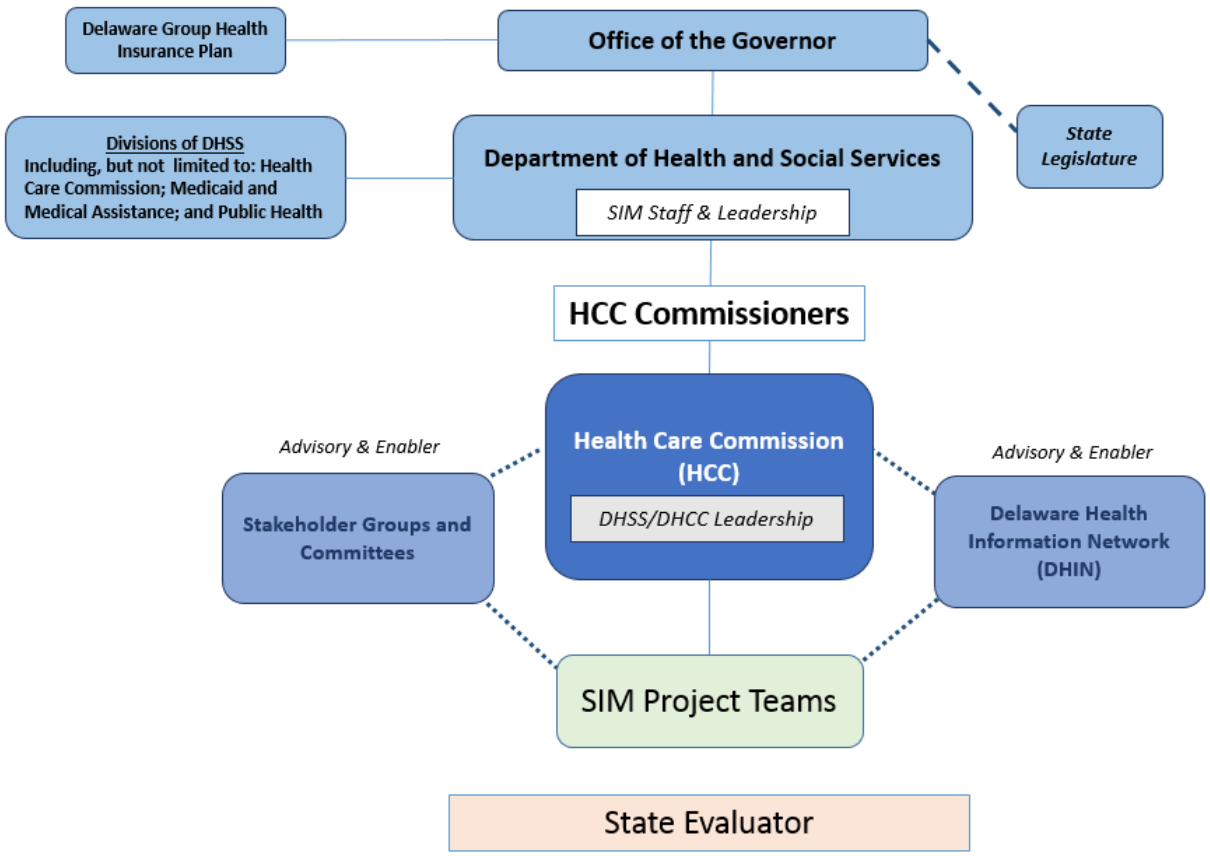


Figure 2 describes the Management Structure in place to oversee the day to day administrative and program activities of the DE SIM initiatives. Through the use of the Project Management Vendor, Health Management Associates (HMA), the Health Care Commission (HCC) is able to coordinate planning across AY4 program implementation activities and align stakeholder engagement and sustainability planning efforts across contracted vendors and local organizations such as Delaware Center for Health Innovation, the Delaware Health Information Network, Medicaid, and the state employee Group Health Insurance Plan (GHIP).

Figure 2. SIM Management Structure

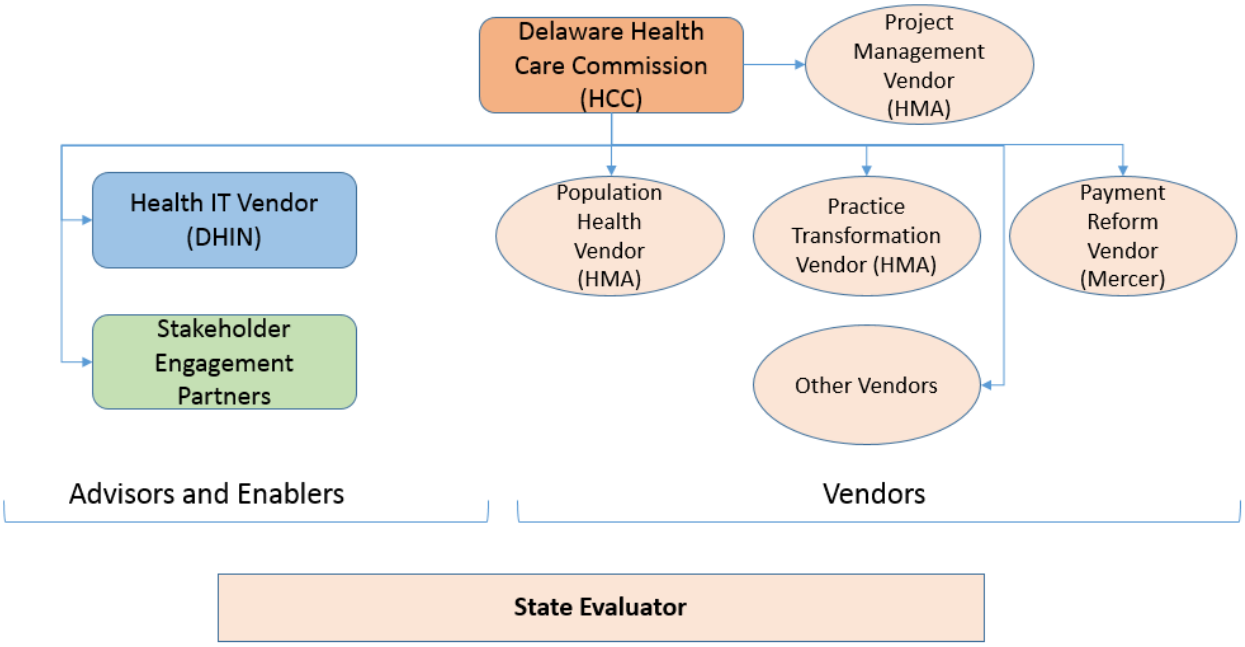


Table 1. Directory of SIM Key Contacts

SIM Component/Project Area Key Contacts Directory					
SIM Component/ Project Area	**Component/Project Lead**			**Contact Information**	
	Position/ Title	**First Name**	**Last Name**	**Phone Number**	**Email Address**
Establish Infrastructure	Executive Director, HCC	Ann	Kempski	302-739-2731	Ann.Kempski@state.de.us
	Deputy Director, DHSS	Molly	Magarik	302-598-2756	Molly.Magarik@state.de.us
	Health Management Associates, Managing Principal	Kathleen	Nolan	202-601-7749	Knolan@healthmanagement.com

SIM Component/Project Area Key Contacts Directory					
SIM Component/ Project Area	**Component/Project Lead**			**Contact Information**	
	Position/ Title	**First Name**	**Last Name**	**Phone Number**	**Email Address**
Technology & Data	CEO, Delaware Health Information Network	Jan	Lee, MD	302-678-0220	jan.lee@dhin.org
	Health Management Associates	Chad	Basham	202-601-7750	Cbasham@healthmanagement.com
Population Health	Co-Chair, Healthy Neighborhoods Committee	Matt	Swanson		matt@dehealthinnovation.org
	Principal, Health Management Associates	Liddy	Garcia-Bunuel	202-601-7751	lgarciabunuel@healthmanagement.com
	Executive Director, HCC	Ann	Kempski	302-739-2731	helen.arthur@state.de.us
Workforce and Education	DE Health Care Commission	Eschalla	Clarke	302-739-2738	Eschalla.Clarke@state.de.us
Clinical	Co-Chair, Payment Committee, DCHI	Tracy	Bolander, PsyD	302-224-1400	tbolander@midatlanticbh.com
	Co-Chair, Clinical Committee, DCH	Nancy	Fan, MD	302-598-7459	nfanssmith@yahoo.com
	Health Management Associates	Nancy	Jaeckels Kamp	312-641-5007	nkamp@healthmanagement.com
	Health Management Associates	Jean	Glossa, MD	201-601-7747	jglossa@healthmanagement.com
Payment	DE DHSS Director of Health Reform	Steve	Costantino	302-255-9041	Steven.Costantino@state.de.us
	Mercer	Frederick	Gibison	602-522-8592	Fred.Gibison@mercer.com

SIM Component/Project Area Key Contacts Directory					
SIM Component/ Project Area	Component/Project Lead			Contact Information	
	Position/ Title	First Name	Last Name	Phone Number	Email Address
	Director, DE Division of Medicaid & Medical Assistance	Stephen	Groff	302-255-9663	Stephen.Groff@state.de.us
	DE Director, Statewide Benefits Office, DHR	Brenda	Lakeman	302-739-2261	Brenda.Lakeman@state.de.us
Patient and Consumer	DHSS Director of Communications	Jill	Fredel	302-255-4429	Jill.Fredel@state.de.us
	HCC Community Outreach Officer	Kiara	Cole	302-739-2733	kiara.cole@state.de.us
Other					

b. Decision-Making Authority

Decision-making authority for SIM activities rests with the Governor and Department of Health and Social Services leadership, supported and advised by the Delaware Health Care Commission (HCC). The Health Care Commission's structure and charge—as detailed in state statute--is ideally suited to the purpose of health system transformation, including a public-private advisory body to enable cross-sector action and stakeholder input. A key component of its charge includes that: "[The HCC shall] Serve as the policy body to advise the Governor and General Assembly on strategies to promoting affordable quality health care to all Delawareans and assuring policies are in place to maintain an optimal health-care environment, analyze all aspects of the health-care landscape, including, but not limited to, population and health outcomes, service delivery infrastructure, quality, costs, accessibility, utilization, insurance coverage and financing." The HCC also has the statutory ability to develop, launch and oversee pilot programs, coordinate and collaborate with DHIN and other state partners, and conduct other work necessary to meeting its charge. The breath of this charge aligns with Delaware's SIM efforts, and encapsulates the critical tools and levers for health care transformation in the state.

The HCC meetings are open to the public and provide a forum for stakeholder engagement that will continue to be supplemented by the work of advisory groups and subcommittees, as well as the Delaware Center for Health Innovation and the Delaware Health Information Network. Should any new decision-making authority be endowed with health system responsibilities—under the Benchmark effort, for example—the HCC will coordinate and incorporate that work into its approach and decisions.

c. Leveraging Regulatory Authority

State government has vital tools in its arsenal for promoting health system transformation. Delaware's approach to leveraging its regulatory and public program authority seeks to balance the interests of stakeholders while still seeking to accelerate progress by optimizing its public role. This is a delicate balance. Our approach is to work with stakeholders to develop the approach and then use our tools to amplify an aligned strategy. Our Health Care Commissioners (representing all sectors) help us to ensure we achieve this balance.

In AY4, Delaware seeks to ensure that our use of public tools is designed to promote and advance our transformation initiatives. Here are the key tools we plan to use to promote and sustain our efforts.

1) Purchasing Authority

Delaware plans to advance value-based payment model adoption throughout the state, with Medicaid and the state employee benefits program (GHIP) playing a key role in this agenda. The recent Medicaid MCO procurement outlined a pathway for VBP. As we develop models for value-based payment under the SIM grant, we work to ensure they are applicable to Medicaid. And we will work with the Medicaid agency to support them as needed in adopting these models. (For detail on the VBP model development work effort, please see Sections B2 and related sections).

Public employee coverage is another lever for supporting transformation. Like with Medicaid, the HCC will reach out to leaders of our state employee plan (GHIP) to support conversion to value-based payment systems. Furthermore, the GHIP environment is an important tool for promoting population health. Last year, the Delaware state employee plan (GHIP) added a new value-based HMO option, which includes shared provider risk and promotes population health and increased consumer engagement. The Delaware General Assembly also passed budget language (Section 23 of House Substitute 1 for House Bill 275) that requires public employees to more actively participate in the open enrollment process. Our AY4 plan includes work with GHIP to develop decision-support tools for state employees, including personalized and confidential communications and online decision tools, as described in the work plan for population health improvement in section B.2c.

2) Regulatory Changes

Delaware has a Certificate of Public Review law (i.e. "certificate of need") relative to managing health care purchases. In Year 3, Delaware finalized revisions to the Health Resources Management Plan (HRMP) that include a greater emphasis on value, using this regulatory tool among the many other levers for this work. In Year 4, HCC will continue to develop this mechanism through collaboration with Health Resources Board (HRB) members around the models for payment reform and related transformation work described in the next section. In particular, this collaborative dialogue between the HCC and the HRB will support use the revised criteria to evaluate new proposals that come before the Board. (See Section B.2 for more discussion of our payment reform efforts).

3) Data Transparency

Beyond the regulatory and purchasing authorities of a state, government can use transparency as a lever to drive and support a reform agenda. In health transformation, that is an incredibly important

mechanism given the many owners and purveyors of health care data in the public and private sector. In Year 3, Delaware took a number of steps to further data transparency, and in AY4 will continue to support the transformation agenda through transparency.

The Benchmark effort is a major effort in this area. In 2017, the Delaware General Assembly asked DHSS to study and provide guidance on the establishment of a health care benchmark. In follow-up to the report DHSS delivered to the General Assembly's Joint Finance Committee's leadership in December 2017, the HCC will continue to assess data sources and transparency methods for this important accountability tool. These are described in more detail in the payment reform activities in B.2. As part of that work, the state will examine the levers and authorities available to it in promoting data transparency, reporting, and oversight, potentially considering new authorities and governance structures.

The Delaware Health Information Network (DHIN) is an invaluable tool and essential partner in data transparency efforts. While DHIN was recently authorized by the Delaware General Assembly to build a health care claims database (HCCD) and is in the process of doing so, the limitations of a voluntary reporting approach are becoming apparent. Similarly, DHIN's model of voluntary provider and plan participation in other data reporting activities may limit its ability to provide an accurate picture for data users and limit the potential utility in payment reform and practice transformation. As detailed in the Health IT plan and other transformation efforts in B.2, Delaware recognizes that DHIN needs to be appropriately resourced and optimally governed and authorized to conduct important data efforts. As part of the AY4 agenda, we will examine the authorities and approach of DHIN to ensure that tools like the Common Scorecard and the newly launched Health Care Claims Database (HCCD) support the transformation agenda. See Section B.2e for more detail on these activities.

d. Stakeholder Engagement

The engagement of stakeholders in Delaware's healthcare transformation efforts is critical to its success and sustainability. As we move forward in year four of our SIM project, we are looking to refresh our engagement strategy and to expand and augment our current base of involved leaders. In AY4, we will continue to drive a strong agenda of stakeholder dialogue and commitment. We will actively work to maintain the involvement of our current stakeholders and conveners, even as we continuously seek to expand our base. As we detail in the work-area sections below, we have specific plans for involving and cultivating stakeholders. These plans are based on a three-part strategy: 1) maintain what is working, 2) develop new stakeholder engagement opportunities and linkages, and 3) integrate and communicate across projects to ensure stakeholder support that continues well beyond the SIM grant period.

Maintain Current Connections: The Delaware Health Care Commission (HCC) and DHSS leadership will continue to seek input and advice from SIM stakeholders already committed to this agenda. In particular, the Delaware Center for Health Innovation's Healthy Neighborhoods and Clinical Committees will continue to advise our activities in practice transformation and population health. As a public/private entity, HCC has the ability and obligation to engage closely and openly with a variety of players within Delaware's health arena, from providers to payers to community organizations to consumers.

Expanded Outreach: As we carried out SIM Year 3, the new Administration heard from evaluators, CMMI feedback, stakeholder surveys, and one-on-one discussions about the strengths and gaps in the SIM stakeholder engagement process. While the Delaware Center for Health Innovation (DCHI) has brought committed experts to the table to share their knowledge, experience, and perspective, input revealed gaps in our engagement efforts that limit our potential success. Specifically, payer and consumer voices needed to be cultivated more actively. Our AY4 plans seeks to address these gaps.

To address the payer input, we plan to support employer purchaser dialogues. The HCC is organizing a payer-purchaser summit for January 26, with Highmark as a co-host. The HCC has become a member of the Greater Philadelphia Business Coalition on Health, and they will assist with employer engagement. We will seek their payer-purchaser feedback on specific activities, such as adoption of the Common Scorecard metrics or other report card tools, and the contribution of their claims data to DHIN, for example. At the direction of the governor and General Assembly, we may conduct additional meetings on the establishment of the health care benchmark. We will also consult with economists and experts, including a team at the University of Delaware (with Mercer as primary responsible partner) in economic forecasting and development to inform the next phase of our benchmark activity.

To ensure the consumer and patient voices, our stakeholder strategies under practice transformation and health neighborhoods initiatives must be augmented. We will supplement the existing Healthy Neighborhoods Committee with additional stakeholders from the community. We also must involve special populations in the discussions more directly. Specifically, we will convene a patient council to guide the BHI model roll out, we will facilitate peer-to-peer learning from other states with our state employee consumers, and we will solicit the feedback from advocates and consumers focused on the prevention and treatment of chronic disease, and representatives of the frail elderly and disability communities. All of these new efforts are detailed in the topical sections below.

Stakeholder Communications: We understand the need for a sustainable approach to stakeholder engagement beyond AY4. To ensure the continuation of stakeholder engagement activities by the HCC beyond the SIM Grant, it is of the utmost importance to integrate communication and engagement with stakeholders into the HCC's everyday practices. In addition, the Secretary of DHSS does many meetings directly with stakeholders, which is a tradition in our small State, and she has also created a process for frequent, formal public comment on the Benchmark and other SIM related activities.

The leadership of DHSS and HCC took steps in Year 3 to seek additional stakeholder input and participation through public meetings and benchmark "summits", social media, smaller meetings, and formal public opportunities to comment on drafts of the road to value and the benchmark reports. This work will continue, but we intend to have a more proactive and flexible communications plan. In a collaborative effort with organizational partners, we will create a formal plan, with calendar and content for sustained engagement. It will incorporate the need to reach different audiences and provides an engaging entry point for the wide range of health transformation activities in Delaware. By having a cross-activity plan, we can ensure that stakeholders understand the integrated, inter-dependent nature of this transformation agenda.

The decisions made and the pathways established in this year will drive Delaware's success beyond the SIM grant period. As you see throughout this operational plan, our focus is on sustainable efforts. This focus crystalizes the essential nature of stakeholder engagement so Delawareans can carry the work beyond this grant year. In addition to our centralized approach to stakeholder engagement through the HCC, each core component of our major SIM activity areas will cultivate buy-in and a sustainability plan grounded in Delaware stakeholders' vision for the future of health care transformation. Below is a brief description of these component-specific engagement plans.

1) Payment Reform

Involvement of payers and adoption of new models of paying for care are pivotal to Delaware's transformation strategy. Adoption will come from stakeholders who believe that their voices have been heard and that the models are reflective of, and tailored to, local organizational structures and market dynamics. SIM work to develop models and assess the impact of these new models will be conducted in a transparent fashion, with regular engagement with the HCC, state decision makers, and private sector leaders essential to the strategies.

Payment reforms must also be integrated into other transformation efforts. Stakeholder dialogue around practice transformation, Healthy Neighborhoods and health IT will include and incorporate the payment reform connections as needed. The tandem development of payment models will require close coordination and a clear communications pathway so that all stakeholders are kept informed and committed to this branch of the SIM work.

2) Practice Transformation

There are many initiatives and much focus on practice transformation across the state of Delaware and even more specifically within behavioral health integration and practice transformation. Delaware will have a multi-faceted engagement approach that plays an important role in aligning the initiatives in order to make significant progress in better health care quality and experience while being good stewards of resources and efforts across the provider practices and across the state.

First and foremost, vendor teams will work closely together for seamless communication and transitions of the work that has been started in many primary care practices over the last two years. Specifically, the behavioral health integration (BHI) team will work with the vendors to recruit as many practices to participate in the BHI pilot to address that milestone. Practices will be divided into two cohorts of practices over the year working collaboratively to implement and share and learn from each other for successful BH integration and better care of Delawareans with behavioral health needs. We will hold stakeholder engagement learning sessions called, Regional Knowledge Sharing Opportunities twice during the year, and an end-of year Learning Congress to share more broadly across the state, the work done and progress completed.

In addition, the BHI team will continue to meet with the existing DCHI clinical committee, re-establishing it as a BHI clinical advisory group. All practice transformation vendors will work closely with DHIN to develop standardized metrics and tools to help sustain these models long-term, and conduct other efforts to drive practice recruitment, including attending and updating state and local meetings that are

connected to the practice transformation and BH integration work. This work will also be closely aligned with the value-based payment approach/model in order to truly sustain an evidence-based standard model of care and gains made through the pilot phase. Finally, as noted in the introduction to this section, we will have a patient council to support our BHI efforts.

3) Population Health Promotion

Stakeholder engagement is critical in the Healthy Neighborhoods initiative. A social network analysis is currently underway to identify key agencies, and community-based organizations currently not engaged. Through active recruitment in year four, neighborhood task forces, local councils and the statewide Healthy Neighborhoods Consortium will have representation of cross-sector organizations, including community-based organizations, community health centers, hospital/health systems, payers, and consumers. It will be a bottoms-up approach, ensuring community entities working to address the social determinants of health have a voice and become valued members of the delivery system.

As noted in the Practice Transformation section above, the Healthy Neighborhoods team will be in regular contact with all relevant stakeholder groups—sharing information and data, eliciting feedback and supporting cross-driver coordination and transparency.

4) Health Information Technology

To better integrate SIM interventions and activities, Delaware's Year 4 plan places new emphasis on building engagement of practices and other data users in the HIT work plan. Specifically, we will ask Practice Transformation partners to help convene practices to learn about the benefits of becoming DHIN data senders, to help inform the next phase of quality metrics activities, and to provide feedback on other current DHIN supported tools. We will explore partnerships with provider organizations to co-sponsor CME sessions on HIT tools. Working with the Greater Philadelphia Business Coalition on Health, Delaware will engage with self-insured payers on becoming claims senders to the HCCD, and we will engage the DHIN Board of Directors on longer term sustainability challenges.

B.2. Health Care Delivery Transformation Activities

In this section, we highlight the specific transformation work streams, centered around the four drivers—payment reform, practice transformation, health IT and population health. The Operational Plan for Award Year Four is designed to address several important goals:

- Continue our progress in Transformation,
- Make a concerted effort to integrate and align across programs of work,
- Cultivate and sustain stakeholder engagement, and
- Develop strong, clear approaches to sustaining progress after the SIM award ends.

In the final quarter of Award Year 3, the state secured through a competitive procurement the services of a vendor (Health Management Associates) to assist in project management, stakeholder engagement and general support for these branches of this work. This Vendor is charged with helping to support the Health Care Commission, as well as all of the vendors and enablers described in the Governance Section. A strong program management focus will improve transparency for stakeholders, assist in coordination among work streams, manage data and documents, and take the lead in driving the sustainability

discussion so that we produce a coherent strategic plan for continuing beyond the SIM grant. In addition, program management function will incorporate learning and evaluation from external evaluators. Each of our Transformation Activities detailed below incorporate these goals.

Later in this plan, we describe our project management approach to AY4. We will use a centralized Project Management Office structure to oversee and conduct the SIM activities. While a PMO has clear operational benefits, it is also a key feature of our transformation agenda for AY4. The activities described in this section are not independent, and will not be successful in isolation. Therefore, our work plan includes a strong element of integration, and ensuring inter-dependencies are noted and optimized. To support integration, we will conduct regular "cross-track" meetings, ensure our stakeholder efforts are coordinated, and coordinate work plans and vendor activities to build on related outputs.

Sustainability planning is another responsibility for our project management team to support. Throughout the narrative section below and the following work plan by driver, we discuss how each work stream will address sustainability and support sustainability planning during AY 4. In the final section on project management, we discuss how the sustainability efforts will be consolidated, integrated, and presented to the HCC and other stakeholders for validation.

Below is a brief description of each of our relevant transformation activities in AY4, with an appendix that details the work plans, milestones and time table for each area of work.

a. Service Delivery and Payment Models

1) Practice Transformation and Integration of Behavioral Health and Primary Care

Delaware recognized in its State Health Innovation Plan that it would be necessary to foster close integration of primary care and behavioral health to transition to effective models of coordinated care. Timely intervention and available community based care can reduce reliance on emergency department and other crisis services. These coordinated interventions may be most important for individuals not currently well-engaged by the mental health system. Delaware recognizes that an integrated Primary Care/Behavioral Health practice may be the optimal treatment setting for most individuals, particularly those with Severe Mental Illness (SMI). Delaware has two primary strategies for accomplishing primary care/behavioral health integration: 1) promoting adoption of electronic records by behavioral health providers and 2) supporting new models of integrated care between primary care and behavioral health providers.

Recent Activity. In Quarter Four of the current award year, Delaware launched the Behavioral Health Integration Initiative, and began practice recruitment. During a webinar in November, a number of practices participated to understand the program of support offered through the initiative. Throughout Q4, BHI team members have met with and otherwise engaged with stakeholders to maximize practice participation in the initiative. Practice coaching and learning collaboratives will begin before the start of AY4. Details of the BHI initiative are available in Appendix A.7. BHI Overview. On the Practice Transformation front, the four vendors have continued to work across the state.

Delaware has paused our Year 3 behavioral health electronic health record initiative and assessed its limitations. We anticipated that larger practices would have greater capacity to devote the time and make workflow changes to integrate the EHR into their practice and begin connecting electronically with other providers and with DHIN, and that has been the case. Small practices had more difficulty. In addition, due to federal and state procurement rules, we had to establish a contracting approach with practices which was not well received. Initial interest expressed by providers diminished after they read and understood the contracting terms.

As HCC partners with HMA to roll out the BHI pilots, we anticipate consultation with CMMI and ONC on options related to electronic health records in BH practices, and broader BH HIT issues (see Driver 4.3).

Approach for AY4. The practice transformation effort of the previous years has laid a foundation for a focused initiative on behavioral health integration. As we move into Year Four, Delaware seeks to build on the momentum, while focusing more specifically on BHI. Leveraging the input and experience of the practice transformation (PT) vendors and the DCHI Clinical Committee, the BHI team will recruit practices, assess their readiness and plans for integration, channel them into one of three possible integration pathways, and create a system of support to drive integration. The three possible practice integration pathways include: referral networks, co-location, and full team-based integration. The BHI team from HMA will provide practice coaching and learning collaborative opportunities designed to support each practice as it moves forward in its integration pathway. In addition, the BHI team will convene a patient advisory committee to guide and inform the integration work.

Also in AY 4, the PT vendors will complete their support engagements with practices in primary care improvement, and assist with integration, learning, and sustainability activities that reflect the importance of the foundational work and relationships established by PT. We will as the PT vendors and select practices to assist in refreshing our data related to primary care, to recruit and facilitate practice and ACO engagement with DHIN, and to conduct robust survey and evaluation. In addition, some may continue forward with BHI. For all of these transformation efforts, Health IT is an important part of the work. HMA and the practice transformation vendors will work with DHIN to maximize the existing tools and connect providers to the HIE. Payment models that reflect the BHI and PT goals will also ensure sustainability past the end of direct support, requiring close coordination and exchange of ideas between practice-level efforts and the response of the payer community.

2) Value-Based Payment Models

Like in many other states, Delaware public and private payers are seeking to implement value-based arrangements. In AY4, Delaware will take the next steps in articulating specific payment models that will support other transformation goals and engaging payers to adopt models that advance Delaware toward total cost of care accountability models. By the end of AY 4, Delaware will have a clear, deliberate strategy for driving model adoption beyond the SIM grant period.

Recent Activity. In December 2017, the Delaware Secretary of Health and Social Services provided a report to the legislature outlining a strategy for establishing a health care benchmark as part of the state's value-based payment reform strategy. Creation of a statewide health care spending benchmark will bring public attention to the rate of health care spending growth in Delaware, as will the quality benchmarks bring focus to important quality priorities. A spending benchmark will also foster transparency of payer and provider performance of managing health care cost growth. Such transparency should inform and support progress on payment and delivery system reform within the State. For example, components of the benchmark that are under consideration, such as cost and utilization data by provider type and/or setting, can reveal opportunities for providers to become more efficient, and inform payment models that would support such efficiency without compromising quality.

The report detailed five actions the state should take:

I. Establish state health care spending and quality benchmarks
II. Analyze and report on variation in health care delivery and cost and facilitate data access for providers
III. Implement Medicaid and state employee total cost of care risk-based contracting utilizing alternative payment methodologies and delivery models that share risk and accountability with providers
IV. Support care transformation and primary care
V. Address underlying social and environmental issues affecting health outcomes and prioritize and address them with appropriate strategies.

Payment reform efforts in AY4 will support and contribute to Delaware's momentum on the benchmark efforts and recognize the importance of interfacing/coordination with interventions highlighted in the other drivers addressed under the SIM program. Collectively, all SIM vendors and activities will help move the state toward the end goals of a value-based health care system.

Figure 3. Key Drivers of Payment Reform

Approach for AY4. For more than a decade, payers in Delaware have been slowly moving to change payment methodologies to reflect the need for improved value and efficiency of the health care system. Through broader stakeholder engagement, in this final year of the SIM award, Delaware seeks to align across these disparate efforts and, with ongoing transformation work, lay out more coherent and strategic pathways for all stakeholders in moving toward these models. With technical assistance from the payment reform vendor, Mercer, Delaware will conduct a rigorous program of assessment, model development, and stakeholder engagement to drive deployment. This work will be grounded in a firm understanding of progress to date, advancing to an exploration of different models and best practices, and economic forecasting of the impact of adoption. Finally, the Mercer team will assist with an exploration of the regulatory and legal implications of different pathways forward. A particular focus will be on the levers and needs of the state's public payers—specifically Medicaid and the Government Health Insurance Program for public employees.

The feasibility plan for a health care benchmark, requested in July 2017 by Delaware policy makers, signals to all stakeholders a desire for more deliberate and measurable efforts to slow the growth of per capita health care spending. Activities to establish the benchmark, while a significant part of Year 4 work plan, are complementary to and reinforcing of efforts to accelerate payment reform. With the committed engagement of DHSS senior leadership, aligned with our state employee benefits and Medicaid leadership, and assistance from Mercer in multiple domains (legal, economic modeling, open data transparency strategies), we expect to catalyze new interest from providers who are seeking additional opportunities to expand their VBP participation beyond the Medicare ACO program. By announcing the development of a total cost of care model, we will reinforce the important role of data, the strong role for primary care, team care, and the advantages of low cost appropriate settings of care, and the need for organizations that enable risk to be shared across providers and facilitate care coordination and care management.

We plan to use the reports of our Practice Transformation vendors, along with formal interviews and survey mechanisms, to evaluate provider readiness for and interest in VBP models, and to understand better our dynamic and consolidating marketplace for physician practices. Delaware enjoys both hospital-based and non-hospital based Medicare ACOs. We seek greater insight into recently formed organizational models that may support and sustain risk sharing payment across small practices.

As noted elsewhere, the transformation work of the SIM grant is reliant on payment reforms as a part of its sustainability strategy. As the payment reform team moves forward, Mercer will connect with other teams and with Delaware stakeholders to ensure continuity beyond the SIM grant cycle. And as the benchmark effort progresses, Mercer's models and engagement strategies will adjust as needed to align with that work.

b. Quality measure alignment

Quality measure alignment and transparency is a key strategy for transformation and imperative for the "Triple Aim Plus One" goal of Delaware's SIM grant. In AY4, the state will continue its efforts to focus on coherence of strategy and public-private collaboration that ensures alignment of quality measure and other issues. We are sensitive to provider burden issues related to quality measurement, and the Common Scorecard metrics represent a consensus-based set of measures across quality domains that have a high degree of alignment with HEDIS, PCMH, and CMS program measures. We are also aware that providers trust clinical data more than claims data. In our HIT agenda for Year 4, we will explore a role for DHIN in enabling eCQM for our provider community. We will also move forward with a public reporting agenda for a subset of Common Scorecard measures.

Recent Activity. The Common Scorecard developed by DHIN has been launched, as have several private-sector initiatives to measure and report on quality. Also in Q3/4, the state began the important work of launching a health care claims database. These and other efforts in HIT will continue the move toward aligned and transparent measures of quality and cost.

Approach for AY4. Quality measure alignment will be implemented through several activities, as well as integrated into transformation activities.

a. Benchmark. As noted earlier, the Delaware Secretary of Health and Social Services has produced a report that outlines a pathway for the state to achieve a "total cost of care" approach and a statewide benchmark of health care spending. Inherent in this approach is standardization of measures for delivery system performance and costs. The process of creating the benchmark and standard measure set requires the input and engagement of all health care stakeholders. The Health Care Commission—or whatever entity will ultimately have stewardship of the benchmark—together with Mercer's payment reform team, HMA's practice transformation team, and other stakeholder groups—will identify opportunities to align quality and cost metrics.
b. The Common Scorecard and other DHIN products. In every aspect of work by DHIN, they seek to support providers and patients with useful information. An inherent part of this work is the sharing of information that can be useful in decision making by key groups. The Common

Scorecard was launched and has been useful. In AY4, DHIN and the HCC will identify the next natural steps for this work, and the potential need for other alignment/transparency efforts.

c. Plan to Improve Population Health

The primary emphasis of Delaware's population health efforts is the Healthy Neighborhoods initiative. Under this initiative, local communities come together to collaborate and identify opportunities to impact health outcomes across one of four Healthy Neighborhood priority areas: Behavioral Health, Maternal and Child Health, Healthy Lifestyles, and Chronic Disease Management and Prevention. Each local community is eligible to receive financial support for specific activities through mini-grants administered by the HCC's contractor, Health Management Associates.

Recent Activity. Leveraging the infrastructure put in place during Delaware's previous SIM grant award years, at the end of Award Year (AY) 3, HMA developed and began disseminating a Healthy Neighborhoods model designed to quickly move towards funding community initiatives focused on the four Healthy Neighborhoods priority areas, while also ensuring accountability for the funds through our structured process. In Q4, HMA launched the program, convening each of the healthy neighborhood taskforces and transitioning certain responsibilities from DCHI's Healthy Neighborhoods Committee. The HN vendor, HMA, will put a strong emphasis on local leadership development for long-term sustainability.

Approach for AY4.A major focus of AY4 will be promulgating the model to promote cross-sector stakeholder and community engagement, as well as implementing the model's three step process for funding community initiatives developed by the Healthy Neighborhood Task Forces. Delaware seeks to align and leverage its nonprofit hospitals' responsibilities and activities to conduct Community Health Needs Assessments. This will be instrumental to sustainability and integration of efforts within and across geographies.

During AY4, HMA will support the current Healthy Neighborhood Local Councils in 1) Wilmington/Claymont, 2) Dover/Smyrna, and 3) Sussex to build their infrastructure, ensuring cross-sector community participation and engagement, a common agreed upon agenda and shared intent, as well as concretized processes and structures that are documented in Local Council By-Laws. Each Local Council will be comprised of a diverse group of community providers and stakeholders, and each will have associated Neighborhood Task Forces that develop and carry out initiatives aimed at impacting at least one of four Healthy Neighborhood priority areas. In addition to the Local Councils and Tasks Forces within each Healthy Neighborhood, there will be a single Statewide Consortium comprised of Local Council Co-chairs, statewide leaders, advocacy organizations from communities, and the Statewide Fiscal Agent (initially HMA, but will be replaced by a local entity during AY4). HMA will provide the neighborhoods—collectively and individually—a strong program of technical assistance in setting their agenda, selecting evidence based efforts, and managing the flow of funds to HN programs.

To support the communities in their work, the HCC will provide mini-grant funds to the local communities across Delaware. To ease the process, HMA will use a standardized, three-step process for funds disbursement in AY4. Through this process, which involves the completion of a standardized

readiness assessment, presenting and receiving feedback from the Statewide Consortium, and getting approval from the Local Councils, the Statewide Fiscal Agent will distribute money directly to the lead agency implementing the approved Healthy Neighborhoods initiative.

Like other transformation activities, the HN initiative will have a particular focus on sustainability. Key to this will be securing the services of a fiscal agent that can continue to solicit and manage funding for local innovation after the end of the SIM award.

d. Health Information Technology

There is a strong and longstanding commitment to HIT in Delaware, including from the Governor's office, and an understanding of the important role HIT has in the success of its SIM initiative. The Delaware Health Information Network (DHIN) has been closely coordinated with the HCC since the inception of the SIM initiative and continues to work closely with HCC to define strategies and implement specific initiatives to support transformation activities, including but not limited to the following:

Existing activities:

- Common Provider Scorecard
- Encounter Notifications
- Community Health Record
- Health Care Claims Database
- Personal Health Record
- Population Health and Healthy Neighborhood Performance Analytics
- Telehealth

Potential new SIM supported activities:

- Electronic Clinical Quality Measures (eQMs)
- Healthcare Utilization, Practice Variation, and Quality Analyses
- Provider Outreach and Education

HIT solutions are a key factor in achieving sustainability for many of the SIM initiatives detailed in this plan. Essential to any decision and process is information; one must have the right information, at the right time, and in a usable and understandable way—this is the goal of HIT solutions.

While HIT solutions contribute to the sustainability of SIM initiatives, the sustainability of the HIT solution itself must be considered and addressed as well. Delaware is fortunate to have a statewide health information exchange with a successful business model, DHIN. DHIN is a financially self-sustaining operation. Revenue generated from DHIN's products and services cover the operation expenses and reserves. Sound business practices allow for the organization to prepare for growth with investments in new technology platforms and infrastructure. While this financial model allows for sustained operations, its ability to implement new solutions and incur stand-up costs is dependent on grants and other funding opportunities.

Delaware has taken a business-minded approach with HIT. There are very limited legislative or regulatory mandates for participation in HIT solutions, therefore health care stakeholders need a business-case incentive to participate. The critical driver of sustainability for Delaware's HIT solutions is the ability to develop functionality that end users want to use and are willing to pay for. The HIT plan illustrates Delaware's understanding of the desired HIT solutions and the incentives and perceived value required to drive adoption.

The full Health Information Technology Operation Plan is provided as Appendix F.4, DE SIM AY4 HIT Ops Plan.

e. Workforce Capacity

The primary vehicle for improving workforce capacity is in the practice transformation and payment reform sections (see 2.a). In prior SIM award years, the state attempted several specific initiatives to engage and train the workforce around health care improvements. In AY4, the state has reoriented to better align workforce engagement strategies through seamlessly integrating workforce supports into the technical assistance programs of each transformation activity. This change also frees up resources to devote to accelerated payment reform, HIT, and practice transformation priorities.

Delaware remains committed to the "plus one" component of our Triple Aim plus One goals, and we look to learnings from our PT efforts, as well as peer reviewed studies, on the impact of certain enhanced primary care models on provider satisfaction and engagement. As we refresh the data on our primary care landscape in Year 4, we will explore metrics that reflect provider satisfaction (particularly primary care), supply, retention in Delaware, and retention in clinical care.

B.3. SIM Alignment with State and Federal Initiatives

Delaware's model testing proposal builds from a strong foundation of innovation. We are building on previous CMMI programs in Delaware, including Christiana Care's "Bridging the Divide" and Nemours/A.I. duPont's PCMH model for optimizing health outcomes for children with asthma. Delaware has multiple Medicare Shared Savings Program ACOs as well as a TCPI grant to Health Partners Delmarva, LLC. Delaware now has a new and growing PACE program sponsored by St. Francis Hospital. 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 and returns to Clearinghouse at the beginning of each Award Year to review the funding.
- 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 Healthcare 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 will also been important to identify opportunities to align community benefit programs and community needs assessments in the future.
- Strong coordination and alignment within DHSS and its member agencies. The leadership of DHSS and HCC will re-commit in Year 4 to continued coordination and identification of alignment opportunities among the SIM drivers and activities and other Departmental initiatives. In Year 4, as we welcome new leadership in certain roles and roll out both Healthy Neighborhoods mini-grant funding and BHI technical assistance and model development, we will be more deliberately including leadership and subject matter experts from the DE Department of Public Health, Delaware Medicaid and Medical Assistance, and Delaware Substance Abuse and Mental Health. The ongoing opioid crisis in Delaware, and the availability of additional federal funding through SAMSHA from the 21st Century Cures Act provides an opportunity to align with the SIM BHI work to support innovative screening and treatment models that expand our capacity in primary care to identify, intervene and refer to appropriate treatment settings.
- Active leadership by DHIN and DHSS. The CEO of the DHIN and the Secretary of Health and Social Services are both members of the HCC 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, including referring practices to the correct funder when approached. In Year 2, HealthPartners Delmarva and one of the SIM-funded practice transformation vendors held a joint learning collaborative and throughout the year, we have worked to inform each other's communications strategies, and shared lessons learned regarding vendor reporting and collecting information on practices' progress on milestones. This collaboration will continue in Year 3.

a. CMCS (waivers, SPAs, etc.)

Delaware has not yet determined if it will need to seek any new Medicaid waiver authorities or file any SPAs related to SIM generated reforms. We expect to determine the need for any such approvals by end of Year 4 Q2.

b. CMMI (e.g., CPC+, AHCs, TCPI, ACOs, etc.)

As we enter Year4, Delaware is taking a closer look at the Delaware Medicare ACOs and their results through 2016. We have at least 5 MSSP participating entities, but none has generated savings as yet. The MSSP is of interest because it captures total cost of care for Medicare Parts A and B, and Delaware is exploring TCC models.

c. CDC, ONC, HRSA, etc.

Delaware will continue to use CDC data and available technical assistance in our population health activities. In addition, we want to optimize our use of ONC support for our HIT activities.

d. State Initiatives (e.g., state-funded, private initiatives, etc.)

The University of Delaware recently launched a Partnership for Healthier Communities which aligns with the SIM Healthy Neighborhoods initiative. In addition, a state based program known as Stand by Me, started under the Markell Administration, offers lessons for Healthy Neighborhoods on working successfully with community partners. A meeting is planned with the leader of Stand by Me to discuss effective partnerships.

C. Detailed SIM Operational Work Plans by Driver

B.4. Delaware SIM Award Year 4 Operational Work Plan by Driver

a. Primary Driver 1

Primary Driver: 1 Payment Reform: Total SIM Expenditure Level = $1,200,000			
Secondary Driver: 1.1 Models developed and adopted by payers and providers			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Completed assessment of current value-based alternative payment model activity	Review prior SIM documentation of general value-based payment readiness and adoption, with a focus on total cost of care models and downside risk assumption, in the commercial and Medicare markets	Q4 AY 3 – Q1 AY4	SIM Expenditure: $200,000 Responsible: Mercer
	Identify stakeholders to interview re: current VBP adoption and readiness to accept/administer risk-based total cost of care models for Medicaid and State employees: a. payers (Medicaid, State employee benefit staff, commercial plans); b. providers (hospital systems, physician networks, PCPs, FQHCs. medical society), and c. purchasers (business coalition representatives)	Q4 AY 3 – Q1 AY4	
	Develop interview tools	Q4 AY 3 – Q1 AY4	
	Conduct interviews, focusing questions specifically on willingness and readiness to contract for Medicaid and State employees (independently) on a shared risk basis	Q4 AY 3 – Q1 AY4	

	Compile interview results, develop report identifying existing VBP strategies and readiness analysis, and implications for future state contracting activity	Q4 AY 3 – Q1 AY4	
Draft detailed Total Cost of Care payment model for Medicaid and State Employee program use completed	Develop recommendations regarding total cost of care risk-based model implementation for Medicaid and State employees, including but not limited to: a. covered services; b. covered populations; c. multi-year phase-in of increasing provider risk assumption; d. risk adjustment and outlier protection; e. role of quality measure performance (including those in the Common Scorecard) in the payment model; f. provider participation requirements; g. timeframe, and h. performance assessment and evaluation for quality and cost impact	Q1 AY4 – Q2 AY4	SIM Expenditure: $200,000 Responsible: Mercer
	Model fiscal impact	Q1 AY4 – Q2 AY4	
	Identify whether models would fit MACRA criteria to qualifying participating professionals for an “Other Advanced” APM model.	Q1 AY4 – Q2 AY4	
Collaborate to align payment strategies	Identify state and/or federal barriers and strategies to implement total cost of care VBP models in State purchasing environment, including:	Q2 AY4 – Q3 AY4	SIM Expenditure: $100,000 Responsible: Mercer

	a. review of relevant federal and state statutes, regulations and policies; and b. develop matrix with recommendations to mitigate potential barriers.		
	Facilitate collaboration between Medicaid and Employee Benefits plan to align multi-year VBP strategy to the greatest extent possible to leverage state purchasing power, identifying points of alignment and of necessary divergence.	Q2 AY4 – Q3 AY4	
	Identify possible contract and procurement vehicles for advancing implementation of total cost of care contracting, and select the preferred means. Consider, at a minimum, the following options: a. Utilize existing state MCO (Medicaid) and third-party administrator (TPA) (state employee) contractors to contract with providers b. Procure providers directly, and then direct MCO/TPA to effectuate contracts using state-procured terms.	Q2 AY4 – Q3 AY4	
	Identify opportunities to leverage commercial implementation of VBP strategy, including through employer purchasing coalitions. For more detail, please see Section E: Sustainability Plan.	Q2 AY4 – Q3 AY4	
Stakeholder engagement	Identify the key capabilities that contracting risk-bearing providers will need to possess to qualify to contract to serve State employees	Q2 AY4 – Q3 AY4	SIM Expenditure: $150,000

	and Medicaid beneficiaries and to succeed in total cost of care VBP implementation.		Responsible: Mercer
	In collaboration with HCC and HMA, assess where candidate provider contract partners are most in need of capacity development (e.g., health informatics, care management). Consider how existing state resources (DHIN) might be utilized to at least partially address those needs.	Q2 AY4 – Q3 AY4	
	Engage stakeholders in discussing details regarding the VBP multi-year strategy (HCC, providers, plans, employers, beneficiaries/consumers), including by soliciting feedback on the draft payment model. Use DHIN data capabilities where appropriate.	Q2 AY4 – Q3 AY4	
	Engage advisory committees supporting the implementation and management of the quality and cost benchmark to provide insight into the impact of payment models on total cost of care as well as other drivers such as primary care utilization and uptake, inpatient and ambulatory costs.	Q4 AY4	
	Modify the payment model, as appropriate, based on stakeholder feedback.	Q2 AY4 – Q3 AY4	
Secondary Driver: 1.2 Reliable data that supports quality and payment methods			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Recommendations made for Common Scorecard improvements	Assess components of the Common Scorecard measure set and, if appropriate, propose different/additional nationally recognized measures.	Q1 AY4 – Q2 AY4	SIM Expenditure: $50,000 Responsible: Mercer

	Assess the availability of resources (including multi-payer data collection) and system support to implement and understand quality measurement and reporting.	Q1 AY4 – Q2 AY4	
	Engage stakeholders to assess and make recommendations regarding improvement in the current state of quality, outcome and health metric reporting.	Q1 AY4 – Q2 AY4	
	Determine appropriateness and approach to public rating and reporting.	Q1 AY4 – Q2 AY4	
Data strategy and deployment plan	Develop action plan for enhanced public reporting including multi-payer data collection. Collaborate, consult with DHIN where appropriate.	Q2 AY4 – Q4 AY4	SIM Expenditure: $100,000 Responsible: Mercer
	Develop proof of concept/model of public reporting.	Q2 AY4 – Q4 AY4	
	Develop statewide data strategy deployment plan including goals, key steps, and potential barriers to success in statewide and multi-payer implementation.	Q2 AY4 – Q4 AY4	
Secondary Driver: 1.3 Regulatory and policy drivers including governance that involves public and private payers			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Review and recommend changes to statutes and regulations	Review and recommend changes to DHIN access rule	Q4 AY 3	SIM Expenditure: $100,000 Responsible: Mercer
	Review and recommend amendments to statutes, regulations and policies to further support the benchmarks and as necessary payment reform, data collection and reporting	Q1 AY4	

Secondary Driver: 1.4 Established infrastructure for transparency, accountability and continuous improvements			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Cost and Quality benchmark developed and implemented; data sources and methods identified, stewardship confirmed, plan and provider performance reporting	Stakeholder engagement (convene advisory committee)	Q1 AY4	SIM Expenditure: $300,000 Responsible: Mercer
	Establish Subcommittee on Spending and Subcommittee on Quality	Q1 AY4	
	Identify opportunities and measures	Q1 AY4	
	Identify data sources	Q1 AY4	
	Discuss and recommend benchmarks	Q1 AY4 – Q2 AY4	
	Summative discussion of advice to HCC	Q2 AY4	
	Implementation	Q3 AY4 – Q4 AY4	
	Establish 2019 Benchmarks	Q4 AY4	
	Develop advisory committee to support the ongoing implementation of the quality and cost benchmarks including providers and payers to monitor benchmark performance particularly around drivers of cost and quality data.	Q3 – AY4	
	Develop process for continuous evaluation and improvement, dissemination of cost and quality data supporting transparency and highlighting alignment and/or misalignment with payers providers and patients.	Q4 – AY4	

b. Primary Driver 2

Primary Driver: 2 Practice Transformation: Total SIM Expenditure Level = $1,700,000			
Secondary Driver: 2.1 Technical support and coaching for implementation of models			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party

Practices recruited, engage with coaches	Kick off webinar x2 for each cohort	Nov, 2017 for cohort 1 and June 2018 for cohort 2	SIM Expenditure: $400,000 Responsible: HMA
	Outreach to key stakeholder groups	Dec, 2017 for cohort 1 and Jun, 2018 for cohort 2	
	Site visits around the state for recruitment	Dec, 2017 and Jun, 2018	
	Practice coaches introduced to participating practices in each cohort	Jan, 2018 for cohort 1 and June, 2018 for cohort 2	
Site visits and readiness assessments completed, setting practice goals based on gaps	Practice coaches conduct Site visits with readiness assessment and help teams identify gaps and set goals	Feb, 2018 for cohort 1 and Jun, 2018 for cohort 2	
	Assessments and gaps and goals will align practice teams into learning tracks	Feb, 2018 for cohort 1 and Jun, 2018 for cohort 2	
Ongoing TA and practice coaching	Frequent coaching sessions with practice team; in person, telephonic and video conference capability	Jul, 2018 for cohort 1 and Dec, 2018 for cohort 2	
	Content- specific webinars will be offered to enhance their implementation and additional SME's can provide individually TA as each practice team needs	Jul, 2018 for cohort 1 and Dec, 2018 for cohort 2	
	Tool kits with action plans, implementation guide book, tools, such as care plans, scripts, and education materials, will be given to each practice team and with coaching guidance	07/01/18 for cohort 1 and 12/31/18 for cohort 2	
Secondary Driver: 2.2 Forum for learning and exchange of ideas and benchmarking			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party

AY 3 Practice Transformation vendors to provide 1 additional quarter of PT TA, and support integration, learning, and sustainability	PT vendors to assist to recruit practices to DHIN webinar to discuss data sending, common scorecard, eCQMs; to participate in Mercer interviews on provider readiness; to assist with BHI rollout; to encourage final survey responses by practices.	By June 1, 2018	PT Vendors, DHIN, HMA, HCC, data vendor $500,000
Conduct learning collaboratives and regional knowledge sharing forums	Two learning collaborative training sessions will be held for each cohort. One in February and one in March for cohort 1, and one in August and one in September for cohort 2	Cohort 1 by Mar, 2018 Cohort 2 by Sep, 2018	Expenditure: $400,000 Responsible: HMA
	Regional knowledge sharing forums will be held once for each cohort. One in May and one in November	Cohort 1 by May, 2018 and Cohort 2 by Nov, 2018	
	PT vendors and BHI teams will continue to meet regularly, and share best practices.	Q1 and Q2	
End of year Learning Congress	All participating practices from both cohorts will come together in January 2019 for a learning congress to share their progress and success stories and discuss ongoing work and sustainment	Jan, 2019	
Use of a virtual learning community to share ideas, challenges, tools, and questions with all participants on line	A virtual learning community will be set up for each cohort to access online calendar of events, register for webinars and other activities, chat with coaches, SMEs and other practice team members, and access tools and resources in a central location	VLC is active during the entirety of each cohort	
Secondary Driver: 2.3 Provider engagement in delivery system reforms			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Engage provider community on system reform through clinical advisory groups and regional forums	Continue to engage key provider leaders through ongoing meetings and updates to the clinical advisory group, the HCC, the	Throughout AY4	Expenditure: $400,000 Responsible: HMA

	Delaware BH Consortium, DHIN, and other forums as applicable		
	Engaging providers through the regional knowledge sharing forums; discussing progress towards transformation, and building towards models supported through alternative payment methods	May and November 2018	
Evaluate pilot implementation for success to tie to alternative payment methods	Multi-faceted Evaluation plan; 1) pre- and post-practice assessment– evaluating implementation progress of BHI models and towards gaps/goals set, 2) evaluation of learning events and activities such as evaluation of learning collaborative, webinar content, and coaching/technical assistance, 3) process and outcome measures per scorecard (see next driver 2.4)	Evaluation data will be analyzed monthly and reported on quarterly, with an end of cohort and end of year final report – Jan, 2019	
PT vendors will close out with a final report and assessment of next steps	The practice transformation vendors will provide the HCC with a final assessment of their progress and remaining barriers/opportunities. While BHI is a continuation of the work, the PT vendors will speak with HIT/HIE issues and payment reform readiness. For more detail, please see Section E: Sustainability Plan.	Q2, AY4	
Secondary Driver: 2.4 Decision-making support through data sharing			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party

Development of BHI scorecard and reports on progress for improvement	Coordination between DHIN & BHI: Working with DHIN and the clinical advisory committee to form a BHI scorecard for Delaware. Scorecard would cover measures meeting the triple aim plus one. Reports would be quarterly and final report in January with a sustainability plan with DHIN and HCC.	Quarterly reports with final report by Jan, 2019	Expenditure: $400,000 Responsible: HMA
Using evidence-based models and measures as standards of care (see Driver 4.3 HIT for BH EHR plan)	Creating metrics within the scorecard that have a measurement steward and/or are based on evidence based standards of care, such as Choosing Wisely and NQF.	04/31/18	

c. Primary Driver 3

Primary Driver: 3. Improved Population Health: Total SIM Expenditure Level = $1,244,519			
Secondary Driver: 3.1 Community convening, goals-setting and action planning			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Infrastructure established to evaluate and fund data-driven Neighborhood Task Force initiatives	Create HN Model – DONE	Q4 AY3	SIM Expenditure: $644,711 (Includes $375,000 in Mini-grants to be distributed to Healthy Neighborhoods) Responsible: HMA
	Promulgate the HN model to 3 Local Councils	Q4 AY 3 – Q1 AY4	
	Provide TA to establish the Local Council and Neighborhood Task Force in their roles	Q1 AY4 – Q3 AY4	
	Act as Interim Fiscal Agent until sustainability plan is in place and local fiscal agent has been established.	Q4 AY 3 – Q2 AY4	
Mini – grants distributed	Support Task Forces in using data to identify and prioritize initiatives and convening the right people to participate in the discussion.	Q1 AY4 & ongoing through Q4 AY4	
	Task Force selects an initiative to pursue.	Q1 AY4 & ongoing through Q4 AY4	

	Task Force completes three step readiness process; HMA provides TA and facilitation of workshops.	Q1 AY4 & ongoing through Q4 AY4	
	Get input from Statewide Consortium and request approval from Local Council for disbursement of funds.	Q1 AY4 & ongoing through Q4 AY4	
	Complete disbursement form (unrestricted funds request) to draw down funds.	Q1 AY4 & ongoing through Q4 AY4	
	Funding by Fiscal Agent to Entity implementing Task Force initiative.	Q1 AY4 & ongoing through Q4 AY4	
Secondary Driver: 3.2 Community-specific data sources to drive decision-making and planning			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Population data collected and made available	Work with DPH to create community-based data portal.	Q3 AY4 – Q4 AY4	Expenditure: $89,904 Responsible: HMA
	Define data requirements (including standard reports specifications)	Q1 AY4	
	Work with DHIN to define data source, rules for submission and access and distribution mechanisms	Q2 AY4	
Technical assistance provided to Local Councils on use of data to prioritize initiatives and make rapid cycle improvements	Identify and compile data sources for Local Councils to understand the problem and decide on metrics that will drive activities	Q1 AY4 – Q4 AY4	
	Provide training and capacity building concerning data use and analysis.	Q1 AY4 – Q4 AY4	
	Create evaluation framework for mini-grantees to include logic model and reporting requirements	Q1 AY4 – Q4 AY4	
	Provide support to Local Councils to review and analyze data	Quarterly through Q4 AY4	

	Provide course corrections as needed	Quarterly through Q4 AY4	
Secondary Driver: 3.3 Governance and consensus bodies to promote engagement, accountability and sustainability			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Model defined for post-grant sustainability. For more detail, please see Section E: Sustainability Plan.	Identify key participants and solicit participation of statewide HN Consortium	Q1 AY4	Expenditure: $89,904 Responsible: HMA
	Identify and inventory resources (actual and potential funding streams and other resources) to support/sustain/strengthen HN infrastructure and projects	Q1 AY4	
	Convene group	Q1 AY4	
	Work with group to establish charter	Q1 AY4 – Q2 AY4	
	Transition group facilitation to chairs of committee	Q4 AY4	
	Identify “back bone” organization while HMA acts as interim.	Q4 AY4	
	Identify possible funding sources post SIM grant, e.g. Health Promotion Trust, SIB.	Q1 AY4 – Q4 AY4	
Transition plan created	Develop transition plan	Q3 AY4	
	Execute transition plan	Q4 AY4	
Social network analysis used to maximize stakeholder inclusiveness and participation at the local council and task force level	Create survey monkey survey tool	Q1 AY4	
	Distribute link to all HN contacts	Q1 AY4	
	Analyze results	Q1 AY4	
	Use results enhance stakeholder engagement at the local council and task force level	Q1 AY4	
	Recruitment	Q1 AY4 – Q2 AY4	
Secondary Driver: 3.4 Consumer Level Engagement to support community-based health promotion activities			

Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Patient and consumer engagement in their health and health care decisions	Communications strategy for cost and quality benchmark targeted to consumer, stakeholder audiences	Q1 AY4 –Q4 AY4	Expenditure: $200,000 Responsible: HCC & vendors
	Integrate consumer outreach and engagement at ChooseHealthDE, with accompanying social media tactics	Q1 AY4-Q4 AY 4	
Promote consumer decision tools for state employees to support active, value-informed plan selection in OEP 2018; including online (MyHealthMentor); personalized mailings (w/claims, prescription history); in-person assistance; mobile computers for workers w/out access at worksite.	Develop comprehensive outreach and engagement plan for OEP 2018 to increase % of workers who make active choice of plan	Q1 AY4	Expenditure: $220,000 Responsible: Delaware Group Health Insurance Plan (DE GHIP)
	SIM supported activities to test multi-modal outreach and materials for workforce segments w/out work computers, shift workers facing additional socio-economic barriers to engagement	Q1 AY4	

d. Primary Driver 4

Primary Driver: 4. Health Information Technology: Total SIM Expenditure Level = $520,000			
Secondary Driver: 4.1 Consistent and reliable data submission by payers and providers (according to policies and procedures; ensure timeliness and quality of data)			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
HCCD built; policies for data access and use developed	Complete proof of concept using state employee, Medicaid claims	Q1 AY4	Expenditure: $200,000 Responsible: HMA, DHIN
	Deploy to production	Q2 AY4	
	Mandate reporting	Q2 AY4	
	Develop use and access Policies	Q2 AY4	
	Explore eCQM reporting and platform	Q1 AY4	

Incentives for ambulatory practices to submit clinical data to DHIN created	Review DHIN subscription fees	Q2 AY4	
HCC and Mercer collaborate to recruit self-insured purchasers to submit claims to HCCD	Develop value proposition for participation	Q3 AY4	
	Explore policy and requirement possibilities	Q3 AY4	
	Illustrate the need and gap analysis	Q4 AY4	
Secondary Driver: 4.2 Technology platform, analytic tools and reporting infrastructure to meet stakeholder requirements			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Population Health reporting tools developed	Identify data sources	Q1 AY4	Expenditure: $150,000 Responsible: HMA, DHIN
	Explore reporting tools	Q2 AY4	
	Acquire data	Q2 AY4	
	Perform Initial Analyses	Q2 AY4	
	Platform Implementation Plan	Q3 AY4	
Cost, Utilization, and Quality Analytics tools developed	Explore analytics platforms	Q2 AY4	
	Perform Initial Analyses	Q2 AY4	
	Develop Platform Implementation Plan	Q3 AY4	
Secondary Driver: 4.3 Governance/data steward to ensure the integrity of the data structures, methodologies for reporting and the appropriate access to data and reports			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Stakeholders engaged and standardization achieved through outreach by DHIN	Present plan to stakeholders and solicit feedback	Q2 AY4	Expenditure: $170,000 Responsible: HMA, DHIN
	Develop outreach materials	Q2 AY4	
	Conduct outreach	Q3 AY4	
Develop tools for practice transformation, such as care plans and BH registry	Develop Care Plan Business and Functional Requirements	Q3 AY4	
	Explore Care Plan Solutions	Q3 AY4	
	Implement Care Plan	Q4 AY4 and into 2019	
	Explore Electronic Consent solutions for sharing behavioral health data within the Community Health Record	Q2 AY4	

	Submit BH data to CHR with consent	Q4 AY4	
Linkages between primary care and behavioral health organizations established	Work with BH providers to adopt EHRs; learn from Year 2-3 pilot, seek TA from ONC	Q1-Q4 AY4	
	Educate BH providers and PCPs on the use of DIRECT messaging and the CHR	Q1-Q4 AY4	
Secondary Driver: 4.4 Sustainability plan for funding to maintain and continually improve systems and processes			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Collaborate with DHIN on sustainability plans	Analyze options and funding sources, request TA from ONC and experiences from other states. For more detail, please see Section E: Sustainability Plan.	Q1 AY4	Expenditure: N/A Responsible: HMA, DHIN
	Research viability of user fee options; statutory or regulatory options to allocate costs broadly and fairly across system participants.	Q1 AY4	

e. Infrastructure

Project Management and Oversight (Infrastructure) $900,000			
Milestone/Key Accomplishment (Outcome Oriented) (maps to Intervention on DD)	Activity – Critical to the success of the milestone; may not be tied directly to budget items (lower level than DD)	Timeline for Completion	Expenditure and Responsible Party
Support the Health Care Commission and Stakeholder groups	Organize presentations and prepare review documents for meetings	Ongoing	SIM Expenditure: $900,000 Responsible: HMA ($650,000); Concept Systems ($250,000)
	Carry out HCC recommendations	Ongoing	
	Support opportunities for the vendors to regularly engage with stakeholders	Ongoing	
	Carry out administrative/project management functions (e.g., reporting, project risk management/issue resolution, etc.)	Ongoing	
	Optimize technical assistance opportunities from CMMI and the TA partners. To do this, we will track TA requests, work with stakeholders to identify and	Ongoing	

	articulate TA needs, and incorporate TA results into our work plans and planning activities.		
Develop a formal sustainability plan that cuts across SIM work streams and lays out a multi-year strategy for Delaware to continue progress post grant.	Establish a process for developing and vetting a sustainability plan that maps a path for continued progress after the end of AY4	Q1 AY4	
	Identify needed changes (e.g., new regulatory structures, partnerships, authorities) that will support sustainability.	Q2 AY4	
	Conduct a sustainability conference, pulling together the stakeholders from each work for sustainability discussion. Include payer, provider, public program leadership, and consumer perspectives and possible funders. For more detail, please see Section E: Sustainability Planning. a. Assemble preliminary plans from Healthy Neighborhoods, practice transformation and payment reform initiatives b. Conduct a day-long meeting to discuss interactions and mutual supports, and to identify potential collaboration activities. c. Produce a report that lays out a multi-year, multi-pronged strategy for sustainability	Q3 AY4	
	Develop driver-specific details for continued progress	Q3 and Q4	
	Submit a complete plan and driver-specific measures for sustainability to the HCC for validation.	Q4 AY4	
State-led Evaluation	Evaluate DE SIM infrastructure and initiatives to advance SIM program of system transformation; conduct interviews, develop recommendations for course corrections, inform sustainability efforts, produce regular narrative reports	Ongoing	
Align among SIM programs	Convene cross-program teams and stakeholders to identify cross-over issues and avoid undue stakeholder burden.	Ongoing	

	a. Conduct bi-weekly conference calls with all key vendors b. Discuss stakeholder interactions. c. Regularly report on all activities to the full group, and find common needs and barriers.		
	Streamline oversight and decision making through the HCC or other groups established to direct policy.	Q3 AY4, per the sustainability plan	
	Conduct regular meetings among action teams to identify interactions, prioritize barriers and models, and align where needed.	Ongoing	

D. Program Monitoring and State-Led Evaluation

D.1. State-Led Evaluation

a. Plans for Year 3

In Year, the evaluation team intends to continue the implementation of the evaluation approach as detailed below. In terms of a general schedule of evaluation activities, the first quarter of Year 4 (Feb-Apr) will focus on engagement with HCC to review the following: (1) appropriateness of the evaluation questions, (2) data collection targets and tools, and (3) review of the AY4 Operational Plan. In cases it is determined that adjustments need to be made to the evaluation focus and approach, revision to the evaluation questions, data collection targets, and tools will occur. A review of the current stakeholders, their role, and level of engagement, as well as anticipated stakeholders and plans for their engagement will be considered. Regular meetings with HCC will occur throughout AY4 with the purpose of soliciting feedback and approval of the data collection targets, procedures and tools and providing opportunities for rapid cycle improvement based on evaluation results. Data collection and analysis will begin in Q1 and continue through the remainder of AY4. Quarter four (Nov-Jan) activities will focus on reviewing results from the data collection and analysis and working with HCC to develop course correction recommendations for the system as a function of the continuous quality improvement approach.

The state-led evaluation is being facilitated by a collaborative team lead by Concept Systems, Inc. and supported by the University of Delaware's Center for Community Research and Service. The team has actively worked over the course of the year to design and implement the state-led evaluation. As agreed upon and framed by the key partners in the DE SIM initiative, the purpose of the evaluation is to engage stakeholders in a continuous improvement approach to examining the processes and outcomes of the DE SIM. In collaboration with DE SIM stakeholders, the evaluation approach is designed to provide input on and inform stakeholders of progress towards unique, state-specific implementation milestones and model outcomes. This approach is intended to create a feedback loop for Delaware to track implementation, make mid-course corrections, and meet program goals. It is anticipated that the evaluation activities will lead to the development of a sustainable evaluation infrastructure for examination of health care related activities within the state. This will allow opportunity for the state to examine its own data for improvement on a continuous basis. CSI and UD established an evaluation system for DE SIM that is flexible, modifiable, generates timely feedback, and emphasizes efficiency.

b. Evaluation Approach

To meet the purpose of the evaluation, CSI and UD are employing an integrated, mixed-methods evaluation approach where qualitative and quantitative techniques for data collection and analyses are used. For each of the broad evaluation questions stated below, multiple qualitative and quantitative data points are expected to provide answers. Integration involves subjective and objective sources of information and occurs at several levels, including data collection, analysis, and reporting. The evaluation approach emphasizes quality and strives to meet evaluative standards set forth by the evaluation field related to accuracy, propriety, feasibility, and utility.

IMPLEMENTATION/PERFORMANCE MONITORING

Primary Objective: Design and facilitate an implementation/performance monitoring process that will examine how DE SIM is meeting its objective and milestones as per the AY4 Operational Plan. The approach will emphasize process monitoring to generate information that can expedite feedback on progress and performance through a more rapid turnaround of evaluation findings. This results-based feedback on performance on a quarterly basis will accommodate the need for rapid-cycle utilization of findings to produce course correction recommendations for the system as a function of continuous quality improvement and accountability.

Key Performance Monitoring Questions: How is DE SIM implementation proceeding relative to the drivers and milestones outlined in the AY4 Operational Plan? What are the conditions or situations that inhibit or expedite meeting the milestones? How are these acted upon? What differences, if any, between the plan and the implementation were identified? What were the causes for these differences? What are the key processes for achieving the intended results of the DE SIM initiative? What are the effects (intended and unintended) on the achievement of results if those processes do not take place as foreseen?

SYSTEM EVALUATION

Primary Objectives: Design and implement a series of analytical studies that guide understanding of how major systems changes are unfolding, where it may be delayed or expedited, or how the innovation may need to be changed and adapted as it is scaled. This approach will seek to document the perceived effect of implementation of DE SIM upon the emerging system, methods and questions are sensitive to understanding the initial conditions and how the initiative is evolving as it is taking shape. In particular, a set of outcome evaluation studies (3) will be designed and conducted to examine short-term outcomes of specific DE SIM activities, consistent with their intended effect.

Key Outcome/Impact Evaluation Questions: How has the sustainability (i.e., durability) of DE SIM infrastructure and activities been addressed? How is stakeholder engagement being operationalized? What are the limitations and barriers to engagement? How are these being addressed? How have major changes in the DE SIM strategy impacted engagement? How have major changes in the DE SIM strategy impacted what is perceived as success? What evidence is there that specific DE SIM components (sp. practice transformation, payment model adoption, neighborhood processes and infrastructure) are resulting in change?

c. Data Collection Tools and Analyses

The instruments and methods for collecting the needed information to address the evaluation questions have included a combination of surveys, document review, observations and key informant interviews. The evaluation questions, data collection tools and analyses are focused on the overall DE SIM implementation, viewing DE SIM as a systems change initiative made up of multiple interacting components. In addition, variation in the implementation across the different components (i.e., driver activities) will be examined in an effort to provide information that allows for specific adjustments in needed areas. The focus of the evaluation is on the interaction and coordination among the driver activities and less so on any one specific activity.

D.2. Federal Evaluation, Data Collection, and Sharing

During Year 3, Delaware actively and regularly participated with the selected CMMI SIM Evaluator, RTI, to support evaluation activities. This includes:

- Participating in monthly conference calls with the federal evaluation team
- Providing RTI with lists of providers and beneficiaries impacted by SIM efforts within the state including a list of Medicaid providers, a list of Medicaid beneficiaries living in specified geographic areas, and a list of State Employees living in specified geographic areas
- Establishing procedures for the secure transmission of requested data and complying with the correct specifications of the files
- Collaborating to provide state-specific feedback on the location and timing of focus groups
- Providing RTI with a list of stakeholders involved with the SIM initiative

Delaware will continue to cooperate fully with any data and information requests necessary for the federal evaluator's work throughout the rest of the grant period.

D.3. Program Monitoring and Reporting

a. Program Management Structure

The Delaware Health Care Commission (HCC), as the governor's designated award recipient, has oversight and project management responsibility for the State Innovation Model Cooperative Agreement. The Principal Investigator for the agreement is HCC Executive Director Ann Kempski, who oversees all aspects of the grant and all vendors associated with it and monitor's overall progress. Other HCC staff assist with vendor management and monitoring as well as grant management functions.

HCC has engaged Health Management Associates to support its project management efforts. The SIM Grant Project Management Office (SIM PMO) is organized to maximize Delaware's potential progress toward its goals across the drivers of health delivery system transformation. The SIM PMO performs the following functions:

- ***Strategic planning.*** Changes in the DE administration and DHSS/HCC leadership offers both challenges and opportunities for AY4. Specifically, the focus on efforts in alignment with the Governor's Road to Value and the engagement with new vendors for several components of the SIM Grant require the PMO to not only set direction for each of the individual work teams but also coordinates efforts so that they collectively progress towards goals. Further, in AY4, it is critical that the PMO provide strategic guidance across vendors, enablers and stakeholders to ensure a cohesive foundation for sustainability with support of DHSS leadership.
- ***Project management support for the grant activities to meet state expectations and federal requirements.*** The SIM PMO has ultimate responsibility for communication of progress and measuring impact of SIM activities. It is also responsible for all required reporting and has established a mechanism for information-sharing and reporting of progress and risks and mitigation of barriers to success.

- ***Stakeholder engagement and transparency.*** A core requirement for success in AY4 is ensuring openness, transparency and inclusiveness so there is meaningful participation across diverse stakeholder communities. The SIM PMO has built an effective mechanism for ongoing stakeholder engagement through standing meetings, web postings, individual discussions when warranted.
- ***Research and analysis.*** Cross-SIM initiative data requirements both vary and overlap. By centralizing the data and analytics discussions through the SIM PMO, we are better able to identify the data needs, seek out all relevant sources, use appropriate analytic tools, and present timely and accurate information and recommendations in a way that allows for a systematic and thoughtful decision-making.
- ***Organizing technical assistance.*** With a cross-SIM perspective, the SIM PMO has the ability to secure, manage and maximize the output of technical assistance available from CMMI and its partners.

b. AY4 Risks

In addition to the risks identified in the Year 2 and Year 3 Operational Plans and reported on in each subsequent QPR, below are additional risks Delaware has identified for its SIM work in Award Year 4:

- **Inability to maintain focus on strategic priorities outlined in the plan:** In Award Year 4, in order achieve the necessary cross-initiative integration, DE is consolidating authority for the SIM program. Expanding the scope of authority introduces a risk of losing focus on any single initiative while addressing issues emerging in another area. Further, due to the implications of introducing a cost and quality Benchmark, we expect that this single priority intervention may require significant time and attention of program leadership. To mitigate these risks, we will rely on a proven project management infrastructure including meetings and standard reporting in project management tools and a culture of transparent communication between and among the SIM PMO and initiative team leads to maintain focus on all key priorities.
- **Inability to entice payer and provider participation in data sharing:** Health delivery system transformation relies heavily on information-sharing. The critical data elements are primarily sourced from payers and providers. Until now, payer and provider participation has been slow to grow. To mitigate the risk of not achieving the levels of participation desired, we have developed a plan to use practice transformation vendors as well as BHI and payment reform vendors to recruit and encourage participation by providers.
- Related to the barriers inherent in voluntary data sharing is the risk that the HCCD, Common Scorecard, and other DHIN delivered datasets and tools do not provide data that is representative of the entire State's delivery system or it sub-sectors, sub-populations, and sub-geographies. We plan to work with vendor Mercer to engage employer purchasers outside of the public sector to determine if there is a value proposition that can be created for them. We know that other states have had some success in engaging these purchasers, and seek to learn from that experience.
- **Inability to build the constituency support needed to build the foundation for sustainability:** Similar to the above item, in order to build a sustainable system of reform, key stakeholders

must be engaged in the process of transformation, which is a challenge given that most people and organizations are reluctant to change without a strong case for change—economic, political, and organizational. To mitigate this risk, we are using a multi-year plan, driven by data, for progressing on the path toward payment reform. Further, through our PMO infrastructure in AY4, we will build a foundation of integration across drivers that will be required for sustainability.

- **Inability to effectively support the implementation of the package of health delivery system reforms in AY4 and ongoing:** To be successful in delivering the transformation activities outlined in AY4 Operational Plan and beyond, the HCC must have sufficient infrastructure and authority to be effective. Through discussions with DHSS and the Governor's office early in 2018, we will begin to address these concerns. Effective, ongoing partnerships with the Department of Public Health, Medicaid, and State Employee Benefits are critical, and those functions must be resourced and supported. Further, we will leverage targeted TA support requests to CMMI and their partners to gather best practices and develop the appropriate internal infrastructure that will enable our success.

The most recent Quarterly Progress Report outlines other project risks and mitigation strategies identified earlier and currently being employed, and is available at "Q3 DE SIM QPR as Submitted 11-30-17.pdf".

D.4. Fraud and Abuse Prevention, Detection and Correction

Delaware takes the prevention, detection and correction of fraud very seriously. With any contracts Delaware enters into for services using SIM funding, HCC has incorporated reporting and data collection procedures that will allow us to review all activities in detail to ensure oversight and the proper use of funds. HCC has also established regular monitoring calls with each contracted vendor to assess project progress and identify any areas of risk. HCC is also currently engaged with the state's auditor to review Year 1 of the SIM Cooperative Agreement and has built this function into its annual budget during the entire project period. In addition, HCC is coordinating with other federal grantees (e.g. DHIN and HealthPartners Delmarva, LLC) to ensure that activities are aligned and that federal funds are not used for duplicate activities. At all levels, Delaware seeks to maintain transparency of all project operations through reporting at public meetings and sharing of information on state websites.

Delaware will continue to work with payers and providers to identify issues of concern as they develop and implement their new payment models. HCC and DCHI continue to maintain an open dialogue and seek to identify and overcome these barriers in collaboration with the payers, inclusive of the state's Medicaid and State Employees Health Benefits.

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.

E. Sustainability Plan

As noted throughout this operational plan, Delaware will be focused on developing and implementing a coherent, integrated sustainability strategy. The work conducted under each driver will include stakeholder engagement and planning that extends beyond the end of AY4.

As described in the guidance from CMMI, a major focus of this year's work will be on planning for and articulating a pathway for sustainability beyond the end of the SIM grant. This pathway for continued progress will require assessment of organizational capacity and interest, stakeholder buy-in and commitment, as well as a strong value proposition. It may vary for the different driver areas, as will the barriers and facilitators for specific work streams to continue. The goal of Year 4 is to hit milestones and demonstrate successes that will have a ripple effect for years after. In each area of work, we seek to move the agenda forward several steps so the momentum can continue beyond the SIM grant period. The sustainability effort will catalog options, value statements, and barriers to sustainability, building on what is working to date.

DHSS will task each of its vendors to identify opportunities, pathways, and possible barriers around sustainability. By the close of Q1, Delaware will have outlined this strategy and vetted it with the HCC. And at multiple points in the grant year, stakeholder input and commitment to strategies will be cultivated. Dialogue with public and private payers and our provider and stakeholder communities will be a key focus, and we look forward to engaging with CMMI on sustainability planning and related tools. The Work Plan by Driver section outlines the steps we intend for assembling and vetting this consolidated, multi-year approach. Below is a general outline of how this will work by driver and combined.

1) Payment Reform. Sustainability efforts for payment reform will focus on incorporating and embedding new payment models with public payers—specifically the Government Health Insurance Program and Medicaid. The HCC and its vendors will work closely with leadership in the public sector to provide guidance and support on instituting new payment models through these venues. Furthermore, the benchmark process will serve as a baseline against which payment reforms can be measured and their impact tracked. Other input—from public and private payers, health plans, consumers, and communities—will play a critical role in shaping the future payment reform agenda.
2) Practice Transformation. Sustaining the practice changes that Delaware has and will achieve through the various PT efforts is incumbent on continued provider commitment as well as health information exchange and payment reforms that support these practice improvements. To support the development of a sustainability framework for PT, we are conducting a readiness assessment for Behavioral Health Integration and evaluating practice reforms that come from the BHI initiative over the year. This will help us to understand what is needed to replicate this kind of behavioral health integration statewide. Also, in Q2, the practice transformation vendors that have been working on primary care reforms for the past few years will produce a summary report and next steps—a useful guide on gaps and pathways for continued improvement. These

ideas will be discussed by the Clinical Committee, and vetted and honed by HCC (see the Section on Governance for more information).

3) Healthy Neighborhoods. As laid out above, the identification of a fiscal agent as well as cementing the role and functionality of local councils are key components of sustainability. The HCC will work with other stakeholder groups to establish a framework for continuing community-level organization and activity. The HN sustainability plan will be reviewed by the Healthy Neighborhood Committee, and vetted and by HCC (see the Section on Governance for more information).
4) Health Information Exchange and HIT. Sustainability of HIE/HIT is grounded in the development of a strong use case and cultivating the demand for data in other reforms. Please see the enclosed HIT plan as to how we will develop a path forward. The DHIN Board and the HCC will work together to shape the HIT sustainability plan as it related to SIM driver continuity.
5) Pulling the pieces together. There are two key areas where cross-over and coordination around sustainability will be vital. The first is the interaction between practice transformation and payment reform. The HCC will gather input and develop a plan for how to support the continued progress and fill gaps that will link these two drivers. Using the assessments of providers generated this year and last year, the HCC will assess how different payment models and their adoption will affect this work. The second area of cross-over is Health IT will the other 3 drivers. For example, practice transformation is dependent on data exchange, and data exchange is dependent on practice participation. As Delaware plans for post-SIM reforms, attention will be given to strategize that build on and mutually support multiple drivers.

As noted above in the work plan, Delaware will do driver-specific planning efforts followed by a process to weave together and build on these ideas with a single, coherent plan for continued stakeholder engagement and reform development and implementation. A stakeholder convening in Q3 will be the launch of the next stage of Delaware's work, followed by final confirmation of the plan by the HCC in Q4.

F. Required Operational Plan Update Appendices

F.1. Driver Diagram

Attached as Appendix F.1

F.2. Rationale for Changes to the AY4 Driver Diagram

Attached as Appendix F.2

F.3. Master Timeline

Attached as Appendix F.3

F.4. Health IT Plan

Attached as Appendix F.4

F.5. Risk Assessment and Mitigation Strategies

Link to AY 3 Q3 QPR Risk and Mitigation Strategies

F.6. SIM Metrics

For the most recently submitted metrics submission see attached Appendix F.6 – SIM Metrics.xls.

Delaware has been using the CMMI developed metrics for tracking SIM progress, and using the definitions as provided in the spreadsheet. Please see the attached Metrics Tables from the Q3 QPR.

Delaware is facing a gap in reporting due to a change in Medicaid MCOs from United to AmeriHealth Caritas. United is no longer complying with quarterly submission reporting, and AmeriHealth is in the process of finalizing agreements with network providers.

Separately, Delaware is struggling to find a way to accurately report on the percentage of primary care practices participating in Value Based Payment models, due to the fact that health plans have overlapping networks. This overlap causes providers to be counted multiple times and artificially inflating our percentage.

The various efforts outlined throughout this plan—in particular the Health IT initiatives—will go a long way toward improving Delaware's reporting, analytics, and metric tracking capabilities. Until these various solutions have been fully implemented and Delaware has the data and tools necessary, Delaware will take advantage of any technical assistance and best practices CMMI can offer to help fill the reporting gaps.

F.7. BHI Overview

Appendix F.7. BHI Overview describes the pilot process and integration models that practices will work towards achieving through coaching and learning collaboratives. The specific model targeted for the practice will be determined based on a readiness assessment conducted by practice coaches.