

Choose Health Delaware

Delaware's State Health Care Innovation Plan

December 2013



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INTRODUCTION TO THIS PLAN

Delaware is engaged in an effort to transform our health system, with the goal of improving the health of Delawareans, improving the patient experience of care, and reducing health care costs – the Triple Aim.

This document is Delaware’s State Health Care Innovation plan, which has been developed with support from the State Innovation Models initiative. This is designed to be a plan for all Delawareans – not the government or any individual stakeholder. It represents the coming together of the health care community, including consumers, clinicians, community health centers, health systems, payers, and the State to articulate a plan for how we can meet the challenges we face together. It is a State Health Care Innovation Plan for individuals and the health care community in Delaware and we are committed to implementing it. In order to implement it, we have examined the way care is delivered and received, the resources we have and those we need to build, and the way we work together today. This plan will also be the basis for a grant application to the Center for Medicare and Medicaid Innovation (CMMI), which may provide the opportunity to invest in some of the one-time costs of transformation.

To develop this plan, we have engaged the leadership of the entire health care community, as well as individual consumers. We have asked them to take off their hats and consider the best interests of all Delawareans. Our approach has been premised on transparency and openness. Over a hundred individuals have been active participants at the approximately forty meetings and working sessions and have collectively shaped this plan together. This plan reflects feedback from a broad set of stakeholders on two prior drafts. There was an extended public comment period during which many stakeholders shared their perspective on the second draft of the plan, during which we held three public discussions on the plan. There was also an opportunity to share feedback through an online survey.

Additional information about Delaware’s State Innovation Models work is available online at <http://dhss.delaware.gov/dhss/dhcc/cmml/>. We believe this is a tremendous opportunity, and we can build from our strengths as a state and from a foundation of ongoing innovation across Delaware.



Sincerely,

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Secretary, Department of
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EXECUTIVE SUMMARY

Delaware aspires to lead the nation in innovation and impact on each dimension of the Triple Aim: improving the health of Delawareans, improving health care quality and patient experience, and reducing health care costs. In order to achieve this vision, Delaware intends to move towards a more patient-centered, value-oriented, technology-driven, and simpler model of care that builds from Delaware's many strengths and ongoing innovation. In particular, Delaware aims to achieve the following specific goals by 2019:

- Delaware will be one of the five healthiest states in the nation; *and*
- Delaware will be in the top ten percent of states in health care quality and patient experience; *and*
- Delaware will reduce health care costs by 6 percent.

Success requires progress on ***each*** goal – this will create real value for the health system and, more importantly, improve health for all Delawareans.

In order to achieve this vision, we have reflected on the case for change and the unique characteristics of Delaware and worked through systematically the changes required in the delivery system, patient engagement, payment model, data and analytics, population health, workforce, and policy. In doing so, we have identified a number of critical changes that together will enable Delaware to transform its health system. These will require action by individuals, clinicians, hospitals, payers, employers, and the State in order to be successful.

Case for change

Delaware approaches health care transformation with a foundation of strength, including higher levels of insurance coverage than most states, strong infrastructure and health care institutions, and a wealth of ongoing innovation focused on improving quality and better managing cost for Delawareans.

Despite these strengths, Delaware still needs to improve on each dimension of the Triple Aim. The state spends more than the national average on health care at a level and rate of growth that is unsustainable. Health care outcomes and patient experiences remain average compared against peer states and fall short of leading states on many dimensions. Moreover, Delaware remains relatively unhealthy overall, with a growing burden of chronic disease and behavioral health, and persistence of underlying unhealthy behaviors. Given Delaware's strong assets



and higher levels of spending, the gap that remains versus the Triple Aim is surprising!

The inability to translate strong health resources and ongoing innovation into system impact results from three structural barriers in Delaware's health system. First, the prevailing payment model in Delaware incentivizes volume rather than quality and value. Second, while the delivery system for acute care is concentrated, the total experience is fragmented, which limits providers from delivering coordinated, team-based care. Third, the approach to population health does not integrate public health, community resources, and the delivery system in support of better health. These barriers are exacerbated by several operational challenges, including persistent workforce shortages across specialties, geographies, and skills; limited transparency about quality and cost; sustained preference for pilots (versus designing for longer-term improvements); community resources remain stretched thin across prevention and wellness efforts; and 10% of Delawareans remain uninsured (despite being well ahead of many states on this measure).

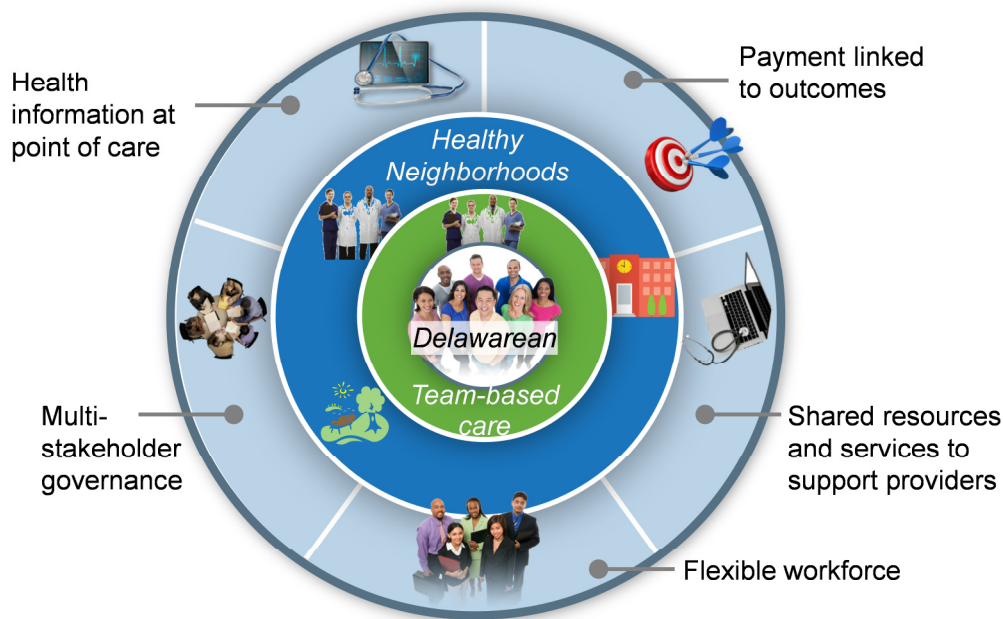
The case for change is clear. Delaware's plan proposes an approach to transformation that builds from all the great strengths existing across the state and breaks down the barriers that keep us from achieving the Triple Aim.

Plan for health system transformation

Delaware has identified an approach for the First State uniquely tailored to the strengths and needs of its diverse communities. This plan reflects the perspective of a broad set of Delawareans, and positions the state to lead the nation in impact and innovation in health and health care delivery. Delaware's plan creates a framework for transformation that enables more person-centered, value-oriented care and better population health. It supports change with aligned incentives, better access to information, support for providers to transform their practices, and a multi-stakeholder governance structure.



EXHIBIT 1: FRAMEWORK FOR DELAWARE'S HEALTH TRANSFORMATION



Core elements

Delaware's plan engages Delawareans as active participants in their own health. This will be achieved by implementing a technology-enabled patient engagement strategy that provides Delawareans with the access to information and resources they need to take greater accountability for their own health.

Delivery system transformation will focus on care coordination for high risk individuals (adults/elderly *and* children) who represent the 5-15% of the population in greatest need for intensive care coordination, with a particular emphasis on ensuring the integration of behavioral and medical care. Delaware will also concentrate its delivery system transformation on more effective diagnosis and treatment for episodic care— in particular, reducing unwarranted variation in care – for all population segments. This dual focus is important because while a small portion of Delawareans with chronic and behavioral health conditions represent nearly half of spending in the system, it is important to also address the other half of costs spread across the population.

In order to deliver care that better addresses these areas of focus, Delaware needs a system that is more person-centered, team-based, coordinated, and integrated than it is today. Delaware's plan calls for a simple, common scorecard of performance and outcomes measures (both quality and cost) to ensure a common focus on care delivered consistently with these principles. Delaware also



recognizes that many providers in the system today lack the scale and experience needed to transform their practices to deliver this type of care, so a set of shared services and resources will be developed to support providers in their transition (including a shared tool for stratification of care coordination needs, identifying care gaps, common clinical guidelines and protocols, support in identifying care coordinators, practice transformation support, and learning collaboratives). Preliminary categories for the clinical guidelines needed to focus on more effective diagnosis and treatment have already been identified.

Delaware will transition to outcomes-based payment models across all payers, achieving the goal of 80% of the state's population receiving care through value-based payment and service delivery models within five years. While the ultimate goal is for nearly all Delawareans to receive care from providers whose incentives are linked to outcomes, the transition paths will vary to account for differences in starting point experience with taking accountability for quality and cost outcomes. Delaware envisions two prototypical payment models for Medicaid and Medicare that vary in the amount of savings shared and amount of risk taken by providers for delivering high quality and better managing costs. Commercial payers may consider these models for their outcomes-based payment models as well. In order to maximize provider participation in these new payment models, providers can participate through flexible structures which support clinical integration and accountability for outcomes-based payment, with a preference for formal structures (e.g., Accountable Care Organizations) as the vehicle for change. Payers also will fund practice investment in care coordination.

Delaware will complement the care delivery and payment innovations with a new approach to population health that puts Delaware on a path to be one of the top five healthiest states in the nation. The core innovation is the "Healthy Neighborhoods" model, which integrates communities with their local care delivery systems, and better connects community resources with each other. Integration will be achieved through dedicated staff and a Neighborhood Council of community organizations, employers, and providers (including care coordinators and community health workers who lead care coordination in the community and across clinical settings). These connections will be reinforced with a set of common goals to ensure providers and community organizations share a focus on health, wellness, prevention, and primary care.



Enablers

These changes will be supported by three critical enablers. First, Delaware will build from its industry-leading Health Information Exchange – the DHIN – to create a single interface for providers and patients to access health information that supports care coordination, performance reviews and patient engagement. This will ensure that the right information is available at the right time and the right place for consumers and providers to promote better, more coordinated, and more team-based care.

Second, Delaware envisions becoming a “Learning State,” nationally recognized for innovation and a holistic approach to workforce development. Delaware will create transparency around existing resources to add capacity for new roles (e.g., care coordination, health IT), and will coordinate education and training programs across institutions to ensure that the entire workforce – including clinicians, care coordinators, social workers, behavioral health specialists, pharmacists, and others – receives the training needed to practice in teams and at the top of their license.

Finally, Delaware will invest in the policy changes needed for real transformation to happen (including, for example, tackling licensing barriers). Delaware will establish a Delaware Center for Health Innovation, which will be the governance structure tasked with operationalizing the transformation, monitoring progress, and making refinements and corrections along the way.

Financial impact

Delaware’s plan is ultimately about achieving the Triple Aim – better health, better health care quality and patient experience, and lower costs. Delaware’s plan positions the state to achieve all three goals. If successful, Delaware could save greater than \$700 million annually after sharing savings with providers and investment in transformation. The investment required is likely in the range of up to \$190 million annually in recurrent costs (investments in care coordination and shared savings) and \$160 million in one-time fixed costs over a ten year period, for shared services and resources to support providers, enhanced health information technology, workforce development, and integration of population health.



Distinctiveness: Delaware as a national model for transformation

Delaware's plan is distinctive in many respects. The flexible and inclusive framework creates an environment supportive of delivering coordinated, team-based care across all of Delaware's providers. The plan builds from strengths, leveraging, for example, Delaware's leading health information technology infrastructure. The breadth and depth of stakeholder engagement in co-designing the plan ensures that it reflects the real needs and challenges faced by Delaware's consumers, providers, payers, and employers. The State has been committed to this plan, serving as an active participant in its role as a convener, provider, and purchaser of care. Overall, Delaware's plan offers a scalable, replicable model for national health care transformation. This approach puts Delaware on a sustainable path to deliver on its goals for achieving the Triple Aim.

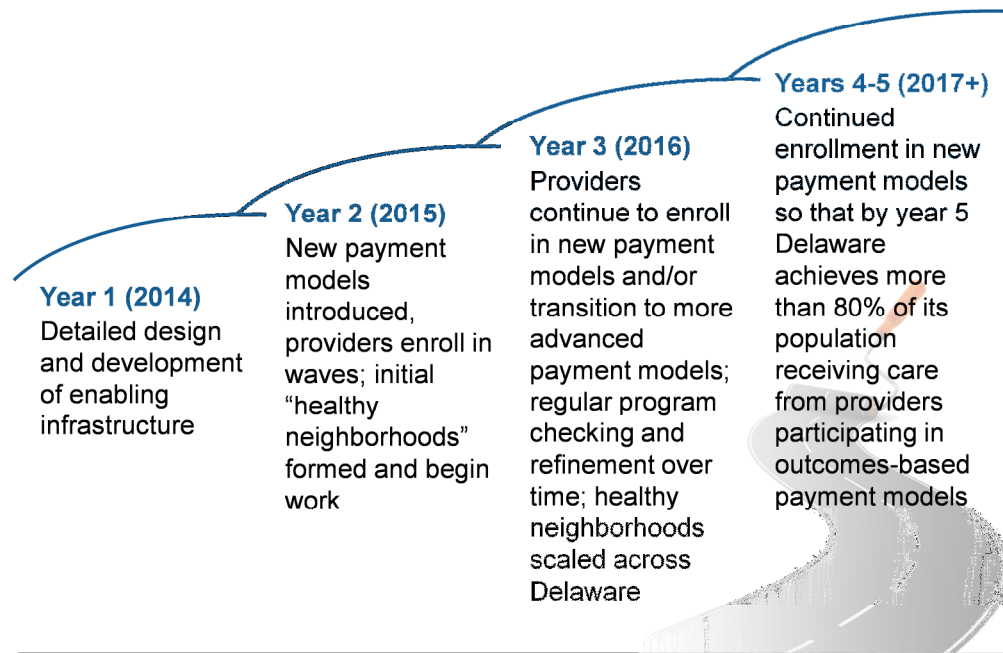
Path forward

Delaware has been unique in its comprehensive approach to integrate across federal programs, including funding for health information technology infrastructure, Medicaid expansion, implementation of the Health Insurance Marketplace under the Affordable Care Act and this State Health Care Innovation Plan. This integrated approach to health transformation will drive impact in Delaware and scalability nationwide. The emerging approach to health system transformation will position Delaware as a national leader in health innovation and impact.

The goal is for providers, payers, and the State to take steps toward implementation beginning in 2014. Over the next several years, Delaware envisions the following sequence of implementation:



HIGH-LEVEL IMPLEMENTATION ROADMAP



1.0 Case for Change

Delaware's health care system has many strengths – including leading clinicians and health care infrastructure, broad and increasing coverage, and continuous innovation. However, the state remains a long way from meeting aspirations for overall health, quality of care, or cost of care. Given the state's strengths and level of investment, this situation is surprising – and it indicates the impact of the structural and operational barriers which currently hinder change. Delaware's plan must address these barriers in order to achieve the health care transformation the state envisions.

1.1 DELAWARE'S STRENGTHS

Delaware's strengths include a long tradition of collaboration, as a small, compact state. The state has some of the nation's leading clinicians, community health centers, and health systems. Delaware also has a high level of health coverage (with just 10% uninsured, compared to 16% nationally), which is poised to improve further with the expansion of Medicaid and introduction of the Health Insurance Marketplaces. In particular, Delaware has the following health care assets:

Forums to bring together stakeholders

As a small state, Delaware has the unique advantage of being able to bring together stakeholders – public and private – to discuss and address the state's most pressing health issues. The following organizations are among those that foster this dialogue on health:

- *Delaware Health Care Commission (HCC)*: a public-private organization whose goal is to ensure quality affordable access to care. The HCC functions as the primary health policy forum in the state. Commission members include three cabinet secretaries, the Insurance Commissioner, and seven private citizens. Importantly, the HCC facilitates an integrated approach across federal and state programs, health information technology efforts, Medicaid expansion, and the new Health Insurance Marketplace.
- *Delaware Health Sciences Alliance (DHSA)*: an organization that fosters cross institutional collaboration, supports research and innovation, and supports educational programs across the University of Delaware College of Health Sciences, Christiana Care Health System, Nemours/Alfred I. duPont



Hospital for Children, and Thomas Jefferson University. The alliance fosters collaboration and cutting-edge biomedical research, focusing on improving health and improving education. The DHSA's collaboration spans across disciplines, including experts in medical education and practice, health economics and policy, population sciences, public health, and biomedical sciences and engineering.

- *Governor's Council on Health Promotion and Disease Prevention*: a council formed on May 20, 2010 to advise the State on a strategy to promote healthy lifestyles and prevent chronic and lifestyle-related disease.

Infrastructure

- **Technology**: the Delaware Health Information Network (DHIN), Delaware's health information exchange, provides Delaware with a nationally-leading health information technology infrastructure.
- **Workforce training**: The University of Delaware educates future and present health care professionals with an integrated team-based care delivery model. For example, the University of Delaware's Healthcare Theatre teaches communication skills to health professionals through interactive health care scenarios in which theatre students are trained to act as patients and family members.

Existing commitments to health

Delaware expanded coverage for Medicaid to 100% of the Federal Poverty Level (FPL) in 1996. This investment has contributed to Delaware's uninsured rate of 10%, which is significantly below the national average of 16%. Delaware's decision to expand Medicaid under the ACA to an effective rate of 138% FPL will provide even greater health coverage to Delawareans. Delaware also has better coverage for cancer screening and treatment compared with national averages, covering Delawareans up to 600% FPL.

A track record of progress on specific goals

When Delawareans invest in change, they deliver results. Over the past several years, numerous efforts have focused on making meaningful improvement to the health of Delawareans. Specific examples include:

- Delaware Cancer Consortium's efforts to improve screening and treatment, which has led to a 19% fall in the state's cancer mortality rate between 1995-



1999 and 2005-2009 and reductions of more than 30% for African-American men and women.¹

- Delaware Healthy Mother and Infant Consortium's efforts to oversee a reduction in the infant mortality rate and eliminate the racial disparity in the rate. Women's health programs have led to a steady reduction in Delaware's infant mortality of almost 14% since 2000.²

Ongoing innovation

Delaware's health care community continues to engage in pilots and demonstration projects to improve health and health care quality and better manage costs. Several of these have already delivered rapid impact (e.g., reducing unnecessary emergency room utilization). Many of these innovative efforts are profiled in section 2.7, below.

1.2 GAPS VERSUS TRIPLE AIM

Despite these strengths, Delaware faces substantial gaps from aspirations on each element of the Triple Aim. The state's health care spending is above the national average and growing unsustainably, outcomes are generally average with overall experience of care often below average, and Delawareans remain unhealthy, with a high burden of chronic disease.

1.2.1 Unsustainable health care spending

Delaware spends approximately \$8 billion annually on health care – 25% more per capita than the national average. Some progress has been made recently (e.g., the growth in Medicaid per member costs have slowed in recent years); however, the rate of health care expenditure growth places Delaware on an unsustainable fiscal trajectory. In the period from 1991-2009, per capita health care spending in Delaware grew faster than the national average at 6.2% per year versus 5.3% per year nationally.³ This is shown in **Exhibit 2** below.

¹ Delaware Department of Health and Social Services (DHSS), Cancer Incidence and Mortality Report, 2012

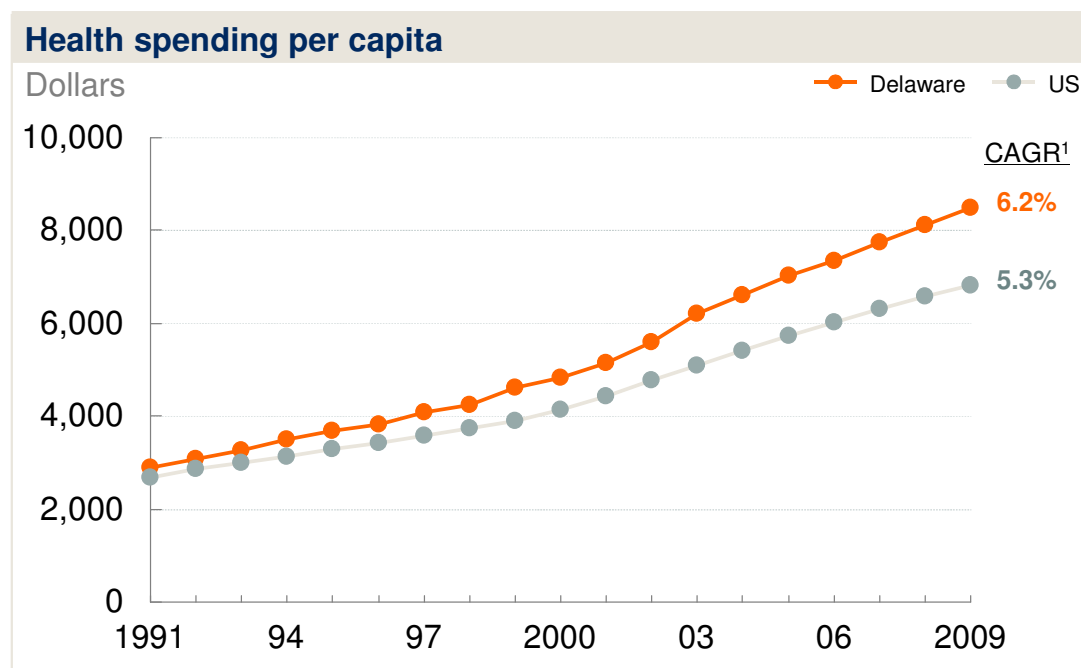
² Thomas Jefferson University, Report on Infant Mortality in Delaware, 2008

³ Kaiser Family Foundation (KFF). Average Annual Percent Growth in Health Care Expenditures by State of Residence (CMS data), 2009.



This compares to about 3.7% nominal GDP growth per year during the same period.⁴ If these rates continued, Delaware's health care expenditures would grow from 22% (in 2009) to approach 40% of personal income per capita by 2030.⁵ Health care currently consumes 17% of the State's budget on Medicaid alone, and 22.4% overall including State employee health benefits and other health care spending and investments. Were it to continue to grow uncontrolled, it would crowd out other spending, presenting an even greater fiscal imperative for better managing the growth in health expenditures.

EXHIBIT 2: TRAJECTORY OF HEALTH CARE SPENDING



SOURCE: Kaiser Family Foundation (KFF), Average Annual Percent Growth in Health Care Expenditures by State of Residence (CMS data), 2009
 1. Compound Annual Growth Rate (CAGR) provides the equivalent (hypothetical) constant year-over-year growth rate that would yield the 2009 spending per capita level when beginning with the 1991 spending level.

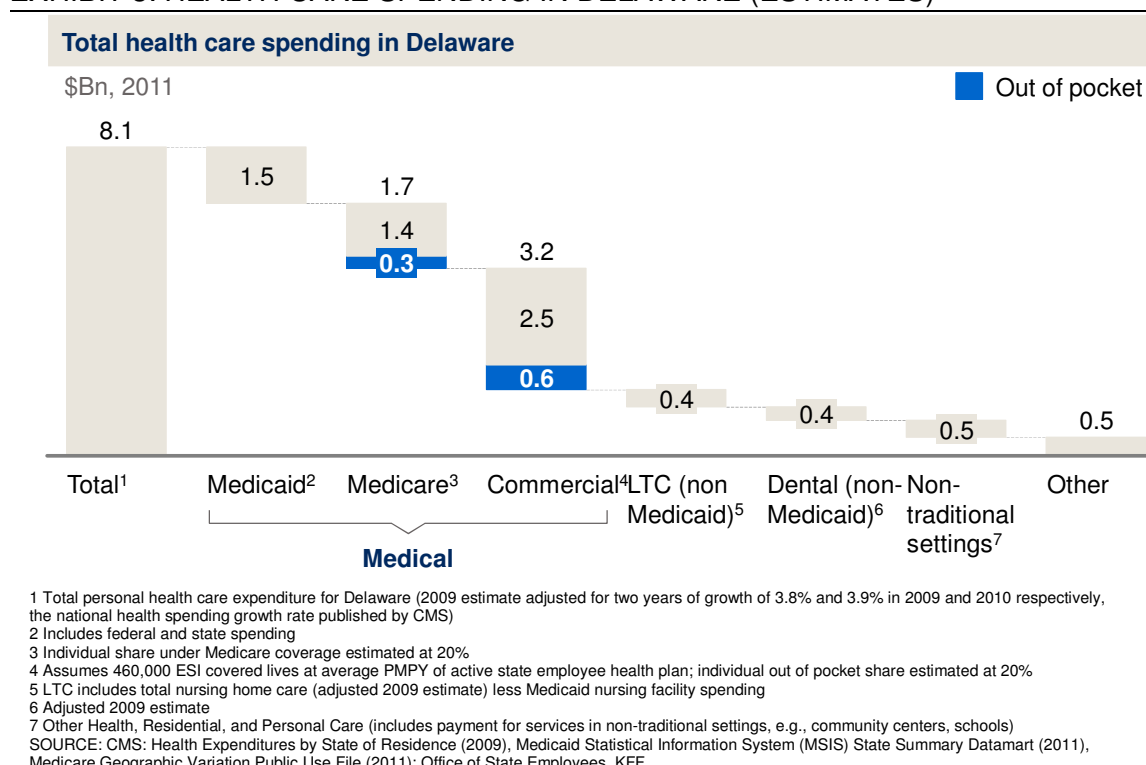
To understand what drives these costs we have broken down Delaware's health spending by payer. This is shown in **Exhibit 3** below. We have also investigated how Delaware compares in each payer category.

⁴ World Bank. World Databank, 2013.

⁵ Bureau of Business & Economic Research, UNM. Per Capita Personal Income by State, 2013; KFF. Health Care Expenditures per Capita by State of Residence (CMS data), 2009.



EXHIBIT 3: HEALTH CARE SPENDING IN DELAWARE (ESTIMATES)



Part of Delaware's higher spending is due to the state's payer distribution. Delaware expanded Medicaid to 100% of the Federal Poverty Level (FPL) in 1996 and will expand to 138% of FPL in 2014. As a result, while the percentage of Delawareans with Medicare and commercial insurance is similar to the national average, the Medicaid coverage rate is 9% higher than the national average and the uninsured rate is 6% lower.

In addition to higher overall coverage, the state's commercial and Medicaid spending per capita are 16% and 5% above the national average, respectively.⁶ Per member, commercial spending in Delaware grew 4.6% between 2009 and 2011, above the national average of 3%.⁷ Medicaid per capita spending in Delaware has declined recently, but this is due to changes in the demographics of enrollees in the wake of the recession which began in 2008 (e.g., for non-disabled adults aged 21-44, spending rose at an annual rate of 5.3% from 2008-2011).⁸

⁶ Delaware's Medicaid expenditures per capita are comparable to regional averages, e.g., Virginia's expenditures per capita are 3% above Delaware's; West Virginia's expenditure per capita are within 1% of Delaware's.

⁷ Truven Health Analytics Commercial database.

⁸ Centers for Medicaid and Medicare Services (CMS), Medicaid Statistical Information System (MSIS) State Summary Datamart, 2011.



Delaware's per capita expenditures on Medicare are at the national average and annual increases from 2008-2011 slowed from 5.5% to 1.3%.⁹

While there have been some significant pockets of recent improvement (e.g., elimination of disparities for some types of cancer screening in the last several years), this greater spending generally has not improved patient experience or health status for the population overall.

1.2.2 Outcomes do not measure up

Although there is high quality care in many places, Delaware's health outcomes are often at best comparable to national averages and substantially lag behind what has been achieved by the highest performing states, as shown in **Exhibit 4**. Delaware's health outcomes are not meeting the aspirations articulated in *Healthy People 2020*, a program launched by the U.S. Department of Health and Human Services to provide a set of national, 10-year, science-based goals and objectives for promoting health and preventing disease.¹⁰

EXHIBIT 4: EXAMPLE HEALTH CARE OUTCOMES

2010 Health outcomes				
	Delaware	US	Best state	Healthy People 2020
Low birth weight as % of births	8.9%	8.1%	5.7%	7.8%
Infant mortality per 1,000 live births	7.7	6.2	3.8	6
Heart disease deaths per 100,000	175.7	179.1	119.4	NA
Suicide deaths per 100,000	11.3	12.1	7.7	10.2
Cancer deaths per 100,000	185.7	172.8	133.7	160.6

SOURCE: CDC, National Vital Statistics Reports (age adjusted data); cancer deaths includes malignant neoplasms only

⁹ CMS Medicare Geographic Variation Public Use File.

¹⁰ U.S. Department of Health and Human Services, 2010.



1.2.3 Experience of care falls short of aspirations

Beyond this quantitative picture of outcomes, we know from providers, patients, and their caregivers that the experience of care falls short of aspirations. Clinicians feel like they operate in silos and have insufficient time or tools to provide the type of care they aspire to deliver. They also report that present reimbursement structures discourage efficient coordination of care with a team-based approach. Dozens of patient experiences (all with changed names) have been shared through the State Innovation Models effort, and while some of them describe successful encounters, many portray examples of a system that lacks coordination and the tools to be patient-focused. The experiences span across age groups and type of care (including acute care, chronic care, and care for individuals with special needs). Caregivers struggle to navigate the health system and deal with the administrative complexity required to support individuals in their care. **Exhibit 5** below provides several examples of the type of experience that has been identified by stakeholders as an opportunity to improve.

EXHIBIT 5: PATIENT STORIES SHARED BY STAKEHOLDERS (all names/pictures changed for privacy)

Ineffective care coordination – “Dave”



“Dave” is a 70 year old, Type II diabetic. He has emphysema and some dementia.

Situation

- Dave’s doctors and nurses do not talk to each other
- This leads to multiple medications and treatment plans

Result

- Dave’ mismanaged diabetes has led to multiple ED visits and the lack of a plan frustrates his family
- Medications interacting against each other means one symptom is addressed while another worsens

Access to mental health care – “James”



“James” developed psychotic illness while in college.

Situation

- James dropped out of school
- He had no insight into his illness, and no access to appropriate mental health services

Result

- He became homeless and began using substances, leading to legal difficulties
- The system of care did not meet James’s needs, resulting in more problems including social problems



Care needs for individuals with disabilities – “Jon”



“Jon” is a young adult, who is deaf.

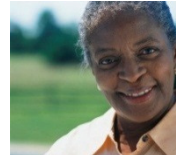
Situation

- He is in a car accident and has minor injuries
- No one at the ED could communicate with Jon adequately to understand the emotional trauma he was experiencing.

Result

- While his physical injuries were addressed an important aspect of his care was missed.

Inappropriate care setting – “Mary”



“Mary” is a cancer survivor with continued medical complications

Situation

- She needs a procedure every 6 weeks
- On private insurance, she had the procedure in an outpatient setting
- After transitioning to Medicare/Medicaid, she had to have the same procedure as an inpatient

Result

- The cost of the procedure doubled – not the procedure itself or her needs
- There was no reason to justify the higher level of care

Delaware rates average on overall health quality, based on the 2011 Agency for Healthcare Research and Quality (AHRQ) ratings, similar to other states in the region. The state is rated very strong for home health care, strong for chronic care (driven primarily by better than average home health measures) and preventive measures, and weak for respiratory disease care, and average overall for other settings, types of care and clinical conditions. Delaware’s hospitals are generally comparable on average to the national average for timely and effective care, but there are particular challenges for timely emergency care (e.g., an average of 43 minutes for a patient to be seen by a health care professional, versus 29 minutes nationally). AHRQ quality rating comparisons between payer or racial groups are not available for Delaware due to insufficient data.¹¹

1.2.4 Health status

Delaware also remains relatively unhealthy. On many measures of health status, the state is at or below national averages. In particular, Delaware has a high

¹¹ Agency for Healthcare Research and Quality, Delaware Dashboard on Health Care Quality Compared to All States, 2010



incidence of chronic disease like the rest of the United States. Specific indicators of health status include:¹²

- Delaware is above the U.S. average for key cardiovascular risk factors, including high blood pressure (35% versus 31% nationally) and high cholesterol (41% versus 38% nationally), with 258 deaths annually per 100,000 due to cardiovascular disease.
- The number of diabetics exceeds the national average (9.7% versus 9.5% nationally) and is growing faster than the national average (5% versus 4% nationally each year between 2008-2011); the pre-diabetic population is also significant (at 7.6%).
- 22% of Delawareans are smokers (including 25% of 12th graders), versus 21% nationally.
- Inactivity is on the rise, with 27% of the population living a sedentary lifestyle (versus 26% nationally), a rise of 8% between 2008-2011.
- Obesity is an increasing challenge – 29% of Delawareans are obese (versus 28% nationally), a proportion which has more than doubled since 1992. This has a major impact on spending, as obesity-attributable spending is projected to rise from ~\$390 million in 2013 to \$980 million in 2018. Another 35% of Delawareans are overweight.¹³
- Delaware faces significant mental and behavioral health challenges, for both adults and young people. For example, the proportion of adult Delawareans considering suicide rose between 2009 and 2011 (from 3% to 4.3%) while the U.S. rate stayed constant. In Delaware, 6.9% of adults and 9% of youth report depression.¹⁴
- Addiction is a serious challenge for the State. In Delaware, 5.6% of residents 12 and older report non-medical use of opioid pain relievers compared to the national average of 4.5%.¹⁵

Social determinants of health, as defined by *Healthy People 2020* are “conditions (social, economic and physical) in the environments in which people are born,

¹² Unless otherwise noted, all facts cited in in the following list come from Centers of Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011.

¹³ Governor’s Council on Health Promotion and Disease Prevention, Forging a path toward a healthier future, March 2012

¹⁴ Substance Abuse and Mental Health Services Administration (SAMHSA), State Estimates of Substance Use and Mental Disorders from the National Survey on Drug Use and Health, 2009-2011

¹⁵ SAMHSA, State Estimates of Substance Use and Mental Disorders from the National Survey on Drug Use and Health, 2011



live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” Delaware’s current position on key social and economic determinants is described below:

- **Income:** Delaware’s median household income is above the U.S. average (\$59,000 versus \$53,000 between 2007-11), but there are significant geographic differences, with Kent and Sussex Counties close to the U.S. average, and New Castle County substantially higher.¹⁶
- **Education:** Similar to median income, the proportion of Delawareans who are high school graduates (87%) and the proportion who are college graduates (28%) are at and close to the U.S. average respectively, but the proportions are higher for New Castle County than for Kent County and Sussex County.¹⁷
- **Nutrition:** The consumption of fruits and vegetables by Delawareans is broadly in line with the national average across all three counties, with approximately three quarters failing to consume the recommended five servings per day. Only 25% of the population eats enough fruits and vegetables,¹⁸ and the State has 15 food deserts.¹⁹
- **Access to health care:** 10% of Delawareans are uninsured, compared with 16% nationally.²⁰ However, despite an overall good supply of providers relative to the U.S. average (as noted above), there are geographic challenges with access, specifically with health professional shortage areas (HPSAs) designated for primary care, dental, and mental health. The shortages in mental health and dental are particularly acute in the southern part of the state.²¹

1.3 BARRIERS

As **Sections 1.1** and **2.7** describe, there is no shortage of innovative efforts across Delaware to address the challenges the state faces. However, there are a number

¹⁶ U.S. Census Bureau, American Community Survey (5-year estimates)

¹⁷ U.S. Census Bureau, American Community Survey (5-year estimates)

¹⁸ CDC, Behavioral Risk Factor Surveillance System, 2011

¹⁹ Defined as a census tract in which at least 500 people and/or at least 33 percent population reside more than one mile from a supermarket or large grocery store (for rural census tracts, the distance is more than 10 miles).

²⁰ U.S. Census Bureau, Small Area Health Insurance Estimates, 2010

²¹ HHS, Health Resources and Services Administration (HRSA), 2013



of barriers that hinder the impact of these initiatives and have prevented Delaware from moving the needle on system-wide health care improvement.

Fundamentally, three structural barriers limit progress against the Triple Aim:

- **A fee-for-service (FFS) payment structure** that incentivizes volume of services (not quality), with a general lack of experience with outcomes-based payment models. Many providers continue to receive a significant portion of payment from “Percent of Charges” reimbursement, which is essentially a “cost plus” model that provides no incentive for controlling cost, and acts as a positive disincentive to manage cost, since provider reimbursements are higher if their costs are higher.
- **A fragmented care delivery system**, with more than three-quarters of physicians in practices of five or fewer.²² This fragmentation makes it difficult to deliver coordinated care for Delawareans. Moreover, providers generally lack experience and the scale necessary to invest in managing risk and require support for transformation.
- **Our population health approach does not adequately integrate** public health, health care delivery, and community resources in support of health care goals. As a result, we spread resources thinly across many organizations and initiatives, which limits overall impact.

These barriers would be difficult enough to address independently. A number of operational challenges underlie each of them, creating additional complexity in achieving system-wide impact. These operational barriers include:

- **Gaps in the health care workforce** exist across the state, with a shortage in specific specialties and geographies (for example, a shortage of dentists in Sussex County). In addition, new skills and capabilities are required to deliver, more team-based care, person-centered care.
- **Limited information transparency** persists across the system on key metrics such as quality and cost at a provider level, hindering the ability of patients and providers to make effective value-based decisions about their own care.
- **Lack of payer alignment** has limited previous payment innovations to only affect a portion of a provider’s total payments. Compounding this, provider

²² SK&A Physician database, 2013



performance often is measured against different elements by each payer. This lack of alignment makes it difficult to invest in change.

- **Limited community resources** are spread thin across a broad range of prevention areas, preventing the sustained, focused commitment of resources necessary for population-level change.
- **Preference for pilots versus designing for scale** has limited the overall impact of the many innovative efforts ongoing across Delaware.

Delaware has a clear need to evolve its health system to achieve its goals. In order to develop a plan that best addresses the barriers limiting progress against the Triple Aim, it is important to first understand the unique aspects of Delaware's health system. These are discussed in depth in Chapter 2.

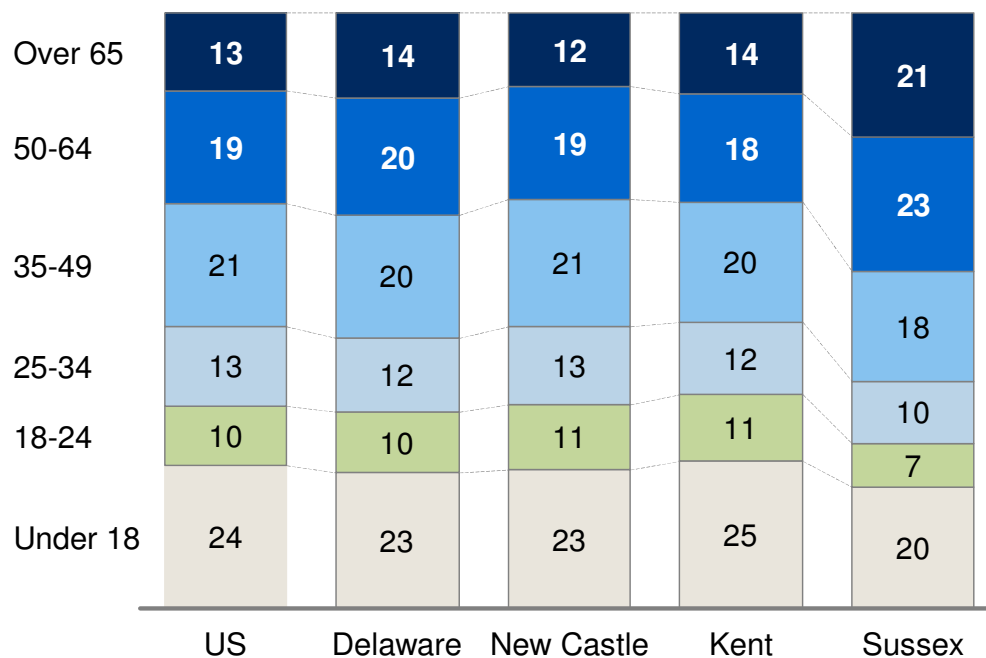


2.0 Delaware's health care system

2.1 STATE PROFILE AND DEMOGRAPHICS

Delaware is a microcosm of the United States on many dimensions. With a total population of 917,092,²³ 60% of residents are concentrated in New Castle County, the northern-most, and geographically smallest of the state's three counties. The state is the second smallest by size and sixth smallest by population. Delaware has a growing Hispanic population, particularly in Sussex County. One area where Delaware deviates from the national demographic profile is in the rate of growth of the elderly population – Delaware is aging faster than average. By 2030, the state is projected to have the ninth oldest population in the nation, with 23.7% of Delawareans projected to be over the age of 65 in 2030.²⁴ This will be particularly concentrated in Sussex County.

EXHIBIT 6: PROPORTION (%) OF POPULATIONS BY AGE, 2010



SOURCE: U.S. Census Bureau, 2010 Census

²³ U.S. Census, 2012

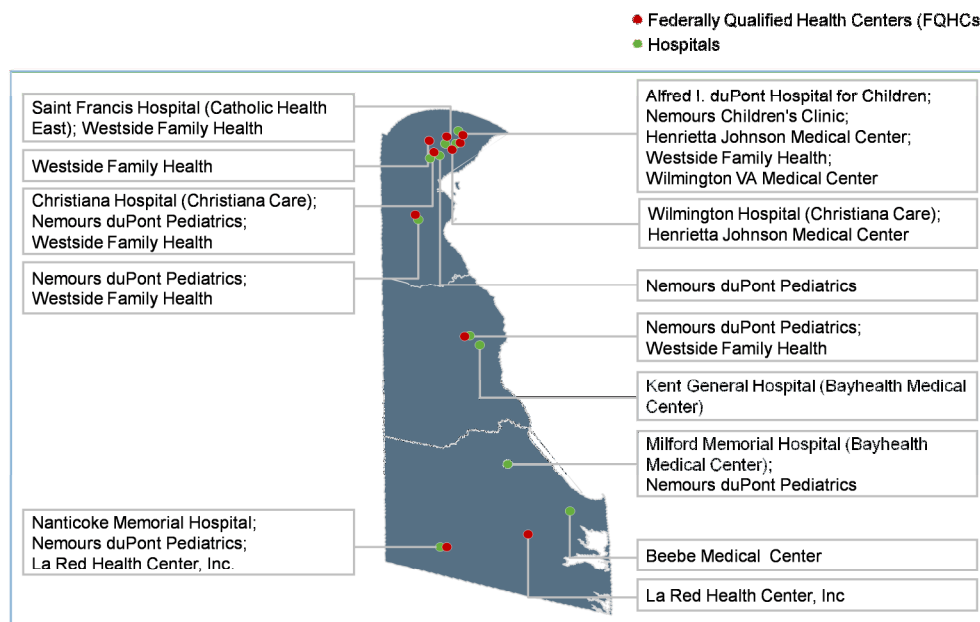
²⁴ University of Delaware Senior Center Research, Demographics and Profiles of Delaware's Elderly, 2002



2.2 PROVIDER STRUCTURE AND WORKFORCE

Delaware's health care delivery system consists of six private health systems statewide (including a children's hospital)²⁵, the Veteran's Administration (VA) hospital, three community health centers, 2,100 active patient care physicians (including 715 primary care physicians) and almost 12,000 additional members of care teams, including physicians assistants, advance practice and registered nurses, LPNs, physical therapists, chiropractors, and many others.²⁶ The vast majority of the state's provider organizations are non-profits with important community missions. Delaware does not have any critical access hospitals. The exhibits that follow describe the provider landscape in greater depth.

EXHIBIT 7: DELAWARE'S HEALTH SYSTEMS AND COMMUNITY HEALTH CENTERS



SOURCE: American Hospital Directory (December 2011), Nemours duPont Pediatrics website. Delaware Federally Qualified Health Centers (4/5/2012) <<http://www.dhss.delaware.gov/dph/hp/files/fqhcs.pdf>>

²⁵ Excluding the VA hospital

²⁶ Delaware Health Care Commission, Health Care Workforce Report (citing AAMC, 2011 State Physician Workforce Data Book); Delaware 2018 – DDOL Occupations and Industry Projections, 2010



EXHIBIT 8: MEDICAL/SURGICAL BEDS AND OBSTETRIC BEDS IN DELAWARE

Facility	Medical/Surgical Beds	Obstetric Beds
Christiana Care (Christiana and Wilmington Hospitals)	948	158
St. Francis	298	24
Bayhealth (Kent General and Milford)	291	36
Beebe	210	12
A.I. duPont	186	
Nanticoke	110	8

Delaware Health Resources Board Health Management Plan, 2010

EXHIBIT 9: NURSING HOME BEDS IN DELAWARE

County	Nursing Home Beds
New Castle	3,019
Kent	794
Sussex	1,397

Delaware Health Resources Board Health Management Plan, 2010

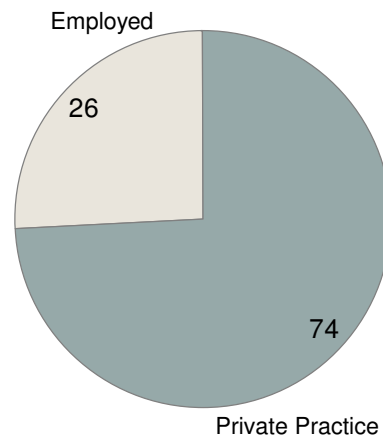
The physician landscape is fairly fragmented – with over 75% of physicians (and almost 80% of PCPs) in practices of five physicians or fewer.²⁷ Advance practice nurses practice pursuant to a collaborative agreement with a physician. On some measures, the health care workforce meets or exceeds national measures, but the workforce is concentrated in certain geographies leaving some sections of the state with significant workforce shortages (e.g., in Behavioral Health and dental care).

²⁷ SK&A Physician database, 2013



EXHIBIT 10: DELAWARE PRIMARY CARE PHYSICIANS

**Proportion of DE primary care physicians
employed by a health system or hospital**
Percent of PCPs



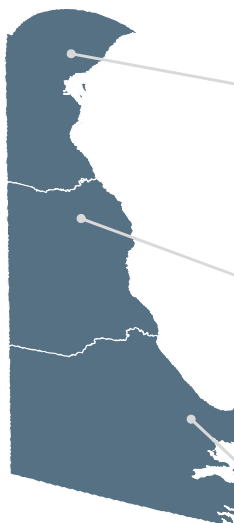
SOURCE: SK&A database, May 2013; American Hospital Directory, December 2011

Geographically, Delaware stretches from an urban and suburban environment in the north through to a rural environment south of the canal, and in particular in the southwestern corner of the state. Inherent with this are significant differences in the density of health care provision.

EXHIBIT 11: DELAWARE'S HEALTH CARE WORKFORCE BY COUNTY

DE workforce facts

- Above national average for PCPs, NPs, PAs and dentists
 - ~715 PCPs (1:1,269 physician-to-person ratio)
 - 79 NPs per 100,000
 - 33 PAs per 100,000
 - 45 Dentists per 100,000
 - 10 Psychiatrists per 100,000¹
 - 1,103 RNs per 100,000
- 92.2% PCPs say 'will be' or 'may be' practicing in 5 years
- 33% PCPs did residency in DE
- 49 schools, universities and colleges in the area (DE, NJ, PA and MD) offering 100 health care related programs
- No in-state medical or dental school



New Castle County

- 504 PCPs (95 per 100,000)
- 302 dentists (57 per 100,000)
- 73 psychiatrists (14 per 100,000)
- 7,110 RNs (1,345 per 100,000)

Kent County

- 77 PCPs (51 per 100,000¹)
- 50 dentists (33 per 100,000¹)
- 9 psychiatrists (6 per 100,000¹)
- 1,279 RNs (840 per 100,000¹)

Sussex County

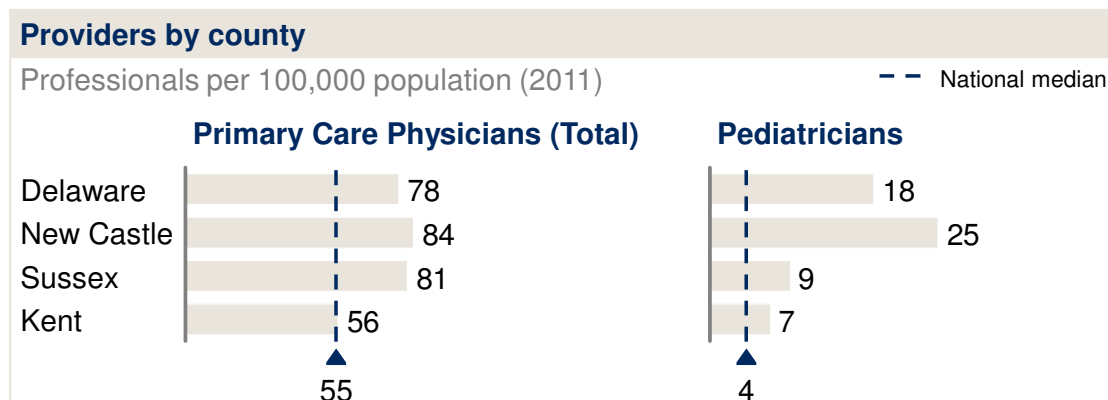
- 122 PCPs (66 per 100,000)
- 43 dentists (23 per 100,000¹)
- 7 psychiatrists (4 per 100,000¹)
- 1,481 RNs (804 per 100,000¹)

¹ Below national average

SOURCE: Delaware Health Care Commission (DHCC) Health Care Workforce Report, Health Care Workforce Recommendations, December 2012; Toth: Primary Care Physicians in Delaware (2012).

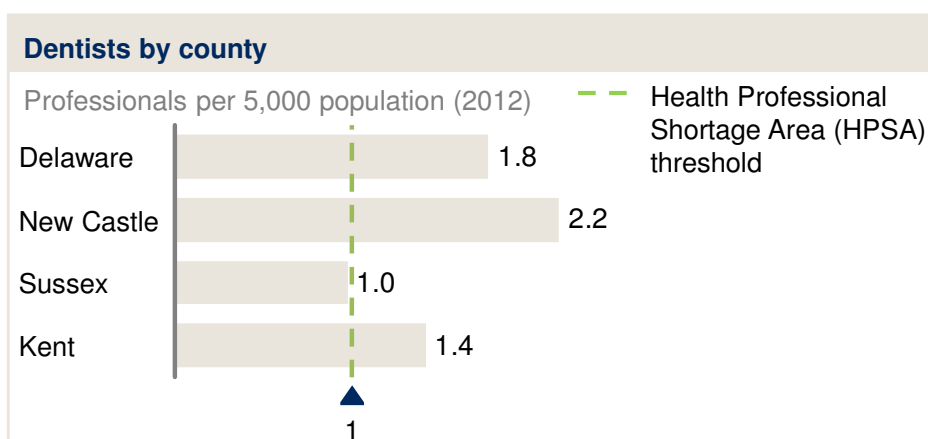


EXHIBIT 12: PRIMARY CARE PROVIDERS BY COUNTY



SOURCE: DHCC Health Care Workforce Report (citing Primary Care Physicians in Delaware, 2011, University of Delaware, Delaware Population Consortium).

EXHIBIT 13: DENTISTS BY COUNTY



SOURCE: Toth: Dentists in Delaware (2012).

2.3 PAYER STRUCTURE

Relative to the nation, Delaware has high levels of insurance coverage, with just 10% of Delawareans currently uninsured (compared with 16% nationally).²⁸ This reflects Delaware's long-standing commitment to increasing access to health care. In 1996, Delaware expanded Medicaid coverage to all adults up to 100% of the federal poverty limit.²⁹ The program experienced a rapid increase in enrollees from 2008-2012 due to the economic downturn, which increased the proportion

²⁸ U.S. Census Bureau, Small Area Health Insurance Estimates, 2010

²⁹ DHSS, Division of Medicaid and Managed Care Assistance



of Delawareans covered by Medicaid to 25%.³⁰ Delaware Medicaid covers a higher proportion of adults than the national average.³¹ Medicaid expansion to 138% FPL may add another 20,000-30,000 residents to the program.

Delaware transitioned to managed care for its Medicaid program in 1996; currently Delaware Physicians Care (Aetna) and United collectively cover approximately 80% of Medicaid enrollees.³² In 2012, Delaware introduced an integrated long-term care program which uses managed care organizations to serve individuals residing in nursing facilities, those receiving community long-term services and supports, and other full dual-eligible individuals. One goal is to expand access to home and community-based long-term care services, enabling the right care, at the right place, at the right time, and supporting broad-based demand to “age in place” where feasible.³³ The state has one PACE (Program for All Inclusive Care for the Elders) provider (St. Francis) for the dual eligible population as well.

Medicare covers 16% of Delawareans,³⁴ with just 4% of beneficiaries enrolled in a Medicare Advantage plan (compared with 25% nationally).³⁵ The state’s dual eligible population is relatively small compared to the overall Medicaid population (at 21,596 in 2011), representing just 9% of enrollees.³⁶ Compared to the U.S. average in 2009, Delaware’s dual eligible population was the 6th smallest as a proportion of total Medicaid beneficiaries, with expenditures the 5th lowest nationally relative to overall Medicaid spending.³⁷

The state’s commercial payers cover an estimated 460,000 Delawareans. The market is fairly consolidated, with two payers accounting for 75% of the market.

³⁰ CMS, Medicaid Statistical Information System (228,647 beneficiaries in 2011 – 25.1% of the State’s 2011 Census Bureau population estimate of 908,137)

³¹ KFF, Where are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults, 2013

³² KFF (citing CMS, Medicaid Managed Care Enrollment Report, 2012)

³³ DHSS, Division of Medicaid and Managed Care Assistance

³⁴ CMS, Medicare Geographic Variation Public Use File, 2011 data

³⁵ KFF (analysis of CMS State/County Penetration File, 2011)

³⁶ HealthCore, Examination of Healthcare Cost and Utilization Drivers within the Delaware Medicaid Population, 2013

³⁷ KFF. 2009 represents the most recent comparison year available.



The largest commercial payers are Highmark Blue Cross Blue Shield Delaware (60% of covered lives) and Aetna (15% of covered lives).³⁸

In addition to the Medicaid population, the state also provides coverage to approximately 115,000 State employees, retirees and dependents enrolled in state employee benefits, provided by Highmark Blue Cross Blue Shield Delaware and Aetna.³⁹ The State also manages coverage for the 25,000 individuals that move through the Corrections system each year.

2.4 SPECIAL NEEDS POPULATIONS IN DELAWARE

Delaware's special needs populations primarily receive care and other support services through Medicaid and other public programs.

As noted above, there are approximately 22,000 dual eligible individuals (who are enrolled in both Medicaid and Medicare) in Delaware.⁴⁰ Since 2012, Delaware has provided services to full-benefit dual-eligible individuals (as well as individuals receiving nursing facility long-term care and community long-term services) within the Medicaid managed care system through the Diamond State Health Plan Plus (DSHP Plus).

The State serves 7,000 Delawareans with serious and persistent mental illness (SPMI), who receive care through Medicaid and DSAMH (Delaware Division of Substance Abuse and Mental Health) programs.⁴¹ Delaware is working to reform the system of care for these individuals as part of a broader mental health focus and as part of a Settlement Agreement with the U.S. Department of Justice. The State is currently developing an amendment to the 1115 Demonstration Waiver which will enable the State to access federal funding to support the a broader array of home and community-based services for individuals with SPMI.

The Division of Developmental Disability Services serves approximately 3,700 Delawareans with intellectual disabilities, autism and Aspergers, including 900 individuals with intellectual and developmental disabilities living outside of the

³⁸ HealthLeaders-InterStudy, Delaware managed care organizations, 2012 (total market enrollment adjusted to account for changes to Medicaid, Medicare and uninsured).

³⁹ Truven Health Analytics, State of Delaware dashboards, 2012

⁴⁰ HealthCore, Examination of Healthcare Cost and Utilization Drivers within the Delaware Medicaid Population, 2013

⁴¹ DHSS, Progress Report on the First Eighteen Months of Implementation of the Settlement Agreement, May 2013



family home whose care is funded through under a 1915(c) HCBS waiver program.

2.5 HIE/EMR ADOPTION AND APPROACHES TO IMPROVE USE OF HIT IN DELAWARE

Delaware has one of the most advanced Health Information Exchanges (HIEs) in the country, the Delaware Health Information Network (DHIN). DHIN has a high rate of adoption (98% of providers and 100% of hospitals and skilled nursing facilities) and communicates lab findings and imaging reports in addition to hospital Admission Discharge Transfer (ADT) reports and medication history, giving providers an enhanced patient view to improve efficiency and effectiveness of care.

DHIN is developing new capabilities such as cross-state connections, event notification, and consumer engagement tools to leverage the existing infrastructure. There is a great opportunity to leverage DHIN's HIE to enable broad EMR-based bi-directional clinical data sharing. Providers will have the incentive to adopt EMR (Electronic Medical Records) solutions because they will be able to receive patient ambulatory data and clinical results across systems, creating a more complete patient view.

In addition, DHIN is continuing to expand the number of EMR systems it integrates with, to integrate the HIE with provider flows, and to address the challenge that 40% of Delaware providers currently still use paper records in addition to the HIE system to receive clinical results (which leads to incomplete longitudinal electronic patient records).

2.6 EXISTING DEMONSTRATIONS AND WAIVERS GRANTED BY CMS

Delaware's Medicaid program has operated under an 1115 Demonstration Waiver, the Diamond State Health Plan, since 1996. The Demonstration Waiver authorized a statewide, mandatory Medicaid managed care program, and expanded the state plan coverage to uninsured single adults earning up to 100% of the federal poverty level.

In 2012, CMS approved an amendment to the Demonstration Waiver to provide long-term care services and support to individuals residing in nursing homes, receiving community long-term services and other full dual-eligible individuals



through a mandated managed care delivery system, Diamond State Health Plan Plus (DSHP-Plus).

Delaware retains a 1915(c) waiver for residential and support services for approximately 900 Delawareans with intellectual and developmental disabilities.

The State is currently developing an amendment to the 1115 Demonstration Waiver which will enable the State to access federal funding to support the a broader array of home and community-based services for individuals with SPMI.

2.7 ONGOING INNOVATION AND FEDERAL GRANTS

Delaware's clinical community continues to innovate. This section provides brief profiles of a sampling of ongoing innovation and specific grant programs underway across the state:

Population health

- Million Hearts Delaware brings together hospitals, the American Heart Association, the State, the Medical Society of Delaware and employers to combat cardiovascular disease, and includes efforts to teach Delawareans about their blood pressure number and waist circumference to prevent health attacks and strokes.
- Delaware Healthy Weight Collaborative targets children and adults at Delaware State University and other sites, with students trained to conduct BMI screenings and develop healthy weight plans for peers.

Care coordination

- Beebe CAREs involves care coordination, access and advocacy, referrals, and empowerment for complex chronic patients. Beebe CAREs resulted in significant improvements in outcomes for participants, including a 42% reduction in re-admissions and a doubling in Quality of Life scores, generating savings more than five times program expenses.
- Christiana Care's Medical Home Without Walls program connects individuals with a multidisciplinary team that coordinates their medical care, as well as psychological and social needs such as food, housing and transportation, to keep them healthy at home, including connections to access programs which support primary care for the uninsured.



- Delaware Patient Centered Medical Home Initiative is a pilot set up by the Medical Society of Delaware and Highmark Delaware (expanding from 20 practices to 90 practices heading into its second year).
- La Red FQHC Parkinson's Telemedicine Clinic provides telehealth services for Parkinson's patients who do not live near specialists.

CMMI grant-funded projects to test innovative models for improving the quality of care across the state

- A.I. duPont Hospital for Children's PCMH model for children with asthma on Medicaid involves a family-centered approach to care, with the goal of promoting adherence to treatment and prevention simultaneously.
- Christiana Care's "Bridging the Divide" is supported by a Health Care Innovation Award grant that uses a clinically integrated data platform to support care management programming for the ischemic heart disease population.
- "Independence at Home" Demonstration Project (Christiana Care is a participant) tests home-based primary care services to Medicare beneficiaries with multiple chronic illnesses.

Mental Health System Reforms in Delaware⁴²

- Transformation of the Delaware Psychiatric Center to an acute mental health hospital for stabilization for individuals in crisis.
- Expansion and improvement of mental health care outside of facility settings, including expanding the crisis hotline to 24/7, opening a new crisis walk-in center, expanding consumer drop-in centers and peer-to-peer counseling, and reimbursing for telemedicine services, including psychiatric services to underserved areas.
- Diversion of individuals with mental health issues to the most appropriate care setting by funding mental health screeners to work with emergency doctors, psychiatrists and others to conduct evaluations and prevent unnecessary encounters with law enforcement and needless trips to emergency rooms and psychiatric hospitals.

⁴² In part to meet goals agreed in a Settlement Agreement with the U.S. Department of Justice, and more broadly to enable the system to meet the needs of Delawareans



- Expansion of access to mental health services by supporting the workforce through the HCC's State Loan Repayment Program.
- Child Mental Health Task Force initiatives, led by the Lieutenant Governor.
- CDC report and recommendations following a high number of adolescent suicides.

Workforce

- The Delaware Health Professions Consortium will be established to provide a multi-stakeholder mechanism for planning, implementing, and monitoring health professions workforce development.
- Delaware Health Care Commission's State Loan Repayment program (with support from state and federal funds) has led to a 400% increase in recruitment and placement of primary care, mental health, and dental professionals, expanding access to care for 25,000 additional Delawareans.

Other projects funded by federal grants

- State Implementation grant to Improve Services to Children and Youth with Special Health Care Needs (CYSHCN), which is supporting the development of medical homes for CYSHCN, with four currently committed to participating. (HRSA)
- Title V Maternal and Child Health Block Grant Program funding for maternal and child health initiatives throughout the state, reaching every infant in the state (approximately 12,000 annually), and reaching an estimated 21,000 women and 3,500 children through other funded services. (HRSA)
- Preventive Health and Health Services Block Grant funding for health promotion and disease prevention programs, and funding for rape crisis intervention, primarily to support a rape crisis hotline. The Governor's Council on Health Promotion and Disease Prevention, and the Delaware Healthy Eating and Active Living Coalition (DE HEAL) are partners in the funded programs. (CDC)
- Primary Care and Rural Health grants which fund strategies to expand medical student and resident physician graduate medical education in Delaware to underserved areas, identification of health professional shortage areas (HPSAs) / medically underserved areas, annual provider recruitment and retention conferences, the Delaware rural health conference, telehealth initiatives in the state, and provider recruitment tools. (HRSA)



- State Partnership Grant Program to Improve Minority Health, which funds efforts to increase knowledge and awareness of health disparities, increase cultural and linguistic competency in the health care workforce, and mobilize communities. Delaware State University, Medical Society of Delaware, AIDS Delaware, Beautiful Gate Outreach Center, and the Metropolitan Wilmington Urban League (MWUL) are partners on these initiatives. (OMH)
- Delaware Maternal, Infant, and Early Childhood Home Visiting (DE-MIECHV) program funding supporting Smart Start/HFA, Nurse-Family Partnership, and Parents as Teachers programs. This provides home visitation services to improve outcomes for children and families residing in communities at high risk of public health problems such as infant mortality, premature birth, domestic violence, child maltreatment, poverty, crime and substance abuse. (HRSA)

2.8 IMPLICATIONS

If the case for change set out in Chapter 1 outlines *why* it is essential Delaware must change, then understanding the structure of how health care is provided in Delaware today offers important nuances in *how* Delaware should approach change. This includes:

- A fundamental need to engage Delawareans so that they are aware and understand their role in moving toward greater accountability for their own health and for health care spending (e.g., through healthier behavior, better managing their conditions, value conscious use of health care system).
- An opportunity to build on and learn from the experiences of Delaware health care participants in innovative efforts across the state.
- A need to respond to the obvious gaps in the system observed by users, their families, and clinicians.
- A need for a framework that accommodates private practice physicians as well as physicians employed by hospitals and health systems.
- An opportunity to take advantage of the small number of payers aligning to support a common model – a great advantage relative to other states.
- An opportunity to build on the collaborative orientation of Delaware health care participants, to maximize joint efforts and extend them in new ways to transform health care in Delaware.



3.0 Approach taken in design process

Delaware's design of a State Health Care Innovation Plan has involved a tremendous level of stakeholder engagement: together, Delawareans have set ambitious goals and a vision of change, have helped build a unifying case for change, and have developed an innovative approach to health care transformation. Consumers, clinicians, community organizations, health systems, community health systems, and the leaders from state government have all actively shaped Delaware's plan.

3.1 GOALS

Delaware set up its design process to bring together a broad group of stakeholders in a collaborative discussion on how to best position the state to deliver on its goals for achieving the Triple Aim. A number of principles guided the design process:

- Focus on the **best interests of all Delawareans** and respect the voice of consumers (not just traditional stakeholders).
- Have no “**sacred cows.**”
- Make use of **best practice** where possible, applying pragmatic judgment.
- Focus on **getting to a practical plan**, rather than a long conceptual debate.

3.2 DEVELOPING THE PLAN

Delaware followed a structured process for developing the plan. The approach to state innovation is focused on addressing questions across six workstreams:

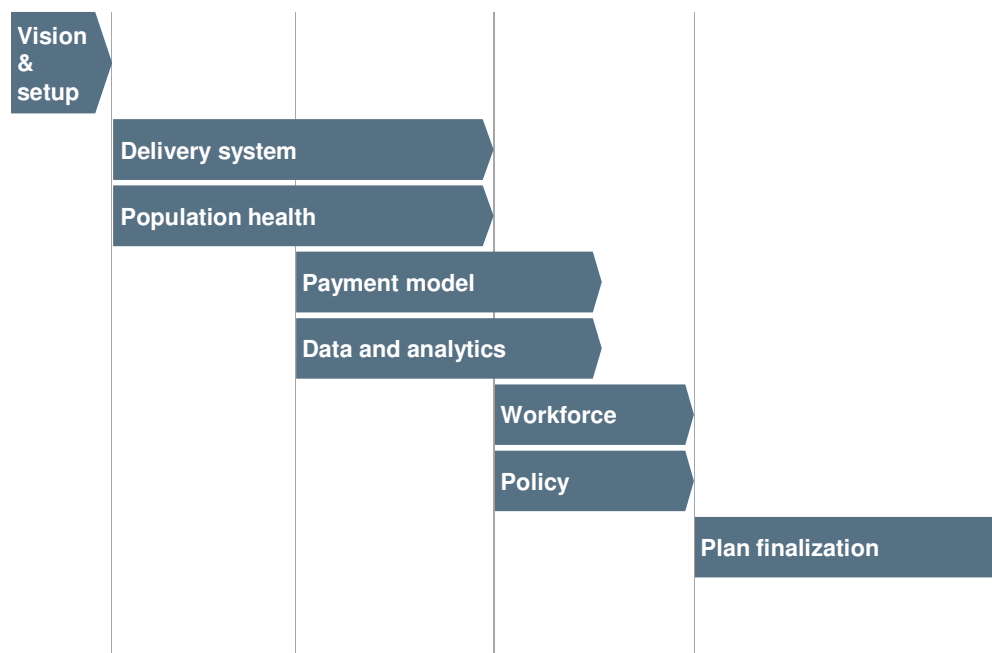
- **Delivery system:** what are the needs of the population? What changes to care delivery are required? What model for care delivery can best deliver that care? The changes to delivery, along with those for population health, shaped the requirements for the other workstreams.
- **Population health:** what population-based approaches to health promotion can improve the health of Delawareans? What is the strategy for improving health, wellness, prevention, and primary care?



- **Payment model:** what incentives are required to support the changes in delivery and population health? What framework enables outcomes-based payment models on a multi-payer basis?
- **Data and analytics:** how can we ensure the right information and tools are available at the right time and the right place to enable delivery system, population health, and payment model goals?
- **Workforce:** how do we develop the skills, capabilities, and capacity across all provider types and across the health system (e.g., for care coordination, health IT) to transition to new models of care?
- **Policy:** how can the State support and empower change in its role as regulator and purchaser?

These working groups followed a staggered sequence to account for interdependencies among them.

EXHIBIT 14: HIGH-LEVEL SEQUENCE OF WORKING GROUPS



Each working group had a chair (typically a non-State leader from the health system) and a sponsor from the State (e.g., the Secretary of Health and Social Services) that facilitated discussions that were brought back to the broader



stakeholder sessions. Two forums served as a mechanism for cross-workstream engagement. First, a portion of each monthly meeting of the Delaware Health Care Commission was devoted to an update and opportunity for input on the emerging approach to health system transformation.

Second, there were four dedicated cross workstream sessions, which have ranged from 3-7 hours in length. These sessions typically brought together 75-125 individuals from across the state for interactive discussion on the individual workstreams as well as the integrated perspective across workstreams. Finally, the chairs and sponsors of the workstreams met regularly to ensure integration of the overall effort for presentation at the stakeholder sessions and HCC meetings. **Exhibit 15**, below, describes the flow of working sessions to support model design.

EXHIBIT 15: DELAWARE SIM WORKSTREAM WORKING SESSIONS AND CROSS WORKSTREAM SESSIONS

Workstream	May		Jun				Jul				Aug		Chair/ Sponsor		
	06.	13.	20.	27.	03.	10.	17.	24.	01.	08.	15.	22.		29.	05.
Cross-workstream session	▲					▲		▲				▲			All
Health Care Commission	▲				▲						▲			▲	All
Delivery System		▲		▲	▲	▲		▲	▲	▲			▲		Bettina Riveros / Rita Landgraf
Population Health			▲	▲	▲		▲						▲		Lolita Lopez / Karyl Rattay
Payment Model			▲	▲		▲	▲			▲	▲				Matt Swanson / Bettina Riveros, Steve Groff
Data/analytics				▲		▲		▲		▲		▲			Jan Lee / Gary Heckert
Workforce							▲		▲			▲		▲	Kathy Matt / Jill Rogers
Policy						▲			▲	▲			▲		Ed Freel / Brenda Lakeman

3.3 LEADERSHIP

The development of this plan was led by senior leaders in State government, as well as leaders from the private sector, as shown below in **Exhibit 16**.



EXHIBIT 16: SIM INITIATIVE LEADERSHIP

Leadership	Affiliation	Role
Jack Markell	Governor	Overall initiative champion
Rita Landgraf	Secretary, Delaware Department of Health and Social Services (DHSS)	Sponsor, Delivery System workstream
Bettina Tweardy Riveros, Esq.	Chair, Delaware Health Care Commission Advisor to the Governor	Chair, Delivery System workstream; Sponsor, Payment Model workstream
Karyl Rattay, M.D.	Director, Division of Public Health, DHSS	Sponsor, Population Health workstream
Lolita Lopez	President and CEO, Westside Family Healthcare	Chair, Population Health workstream
Stephen Groff	Director, Division of Medicaid and Medical Assistance, DHSS	Sponsor, Payment Model workstream
Matt Swanson	Entrepreneur	Chair, Payment Model workstream
Gary Heckert	Former Director, Division of Management Services, DHSS	Sponsor, Data and Analytics workstream
Jan Lee, M.D.	Executive Director, Delaware Health Information Network	Chair, Data and Analytics workstream
Jill Rogers	Executive Director, Delaware Health Care Commission Delaware State HIT Coordinator	Sponsor, Workforce workstream
Kathy Matt, Ph.D.	Dean, University of Delaware College of Health Sciences	Chair, Workforce workstream
Brenda Lakeman	Director, Human Resources Management and Statewide Benefits Office, Delaware Office of Management and Budget	Sponsor, Policy workstream
Ed Freel	Policy Scientist, University of Delaware	Chair, Policy workstream



Delaware was committed to the process being Governor-led. Governor Markell was actively involved in the SIM design process through regular briefings, and through the cross-program leadership of Bettina Tweardy Riveros (Advisor to the Governor) and Rita Landgraf (Cabinet Secretary, Department of Health and Social Services). In addition, the Governor's cabinet was briefed on Delaware's emerging strategy for improving its health system. While the Governor and his leadership team played an important role in convening and committing the state to enable change, Delaware's process brought together stakeholders from across the health system in a public-private dialogue on how to make health care better for Delawareans. The approach to stakeholder engagement is described further below.

3.4 STAKEHOLDER ENGAGEMENT

Delaware's plan reflects several months of intensive design work involving regular and active contributions from an extremely broad range of stakeholders – including consumers, providers, payers, community groups, and the State – working together in consensus-based sessions to develop a plan that will improve health for all Delawareans.

Delaware achieved an extremely high level of stakeholder engagement. Participants in the initiative have included senior leaders (presidents, CEOs, CMOs, CFOs, medical directors, etc.) from every stakeholder group described in the technical stakeholder engagement plan, with 100 percent participation in many categories (including all of Delaware's health systems and FQHCs).

Leaders from State government were actively involved, including the Governor's office, the Legislature, Department of Health and Social Services, Office of Management and Budget, Department of Insurance, Department of Corrections and the Department of State.

Two drafts of the plan were circulated broadly within Delaware for feedback. The first draft was circulated in July, 2013 and the second draft was shared in August, 2013. A public comment period was held following distribution of the second draft, from August 16-September 25, 2013. Three public discussions were held across the state in mid-September. This feedback helped improve the plan and ensure that it aligned with broad interests of Delawareans. For example, in between the first and second drafts of the plan, stakeholders provided important



feedback that shaped the organizational structure for the Delaware Center for Health Innovation (which is Delaware's proposed governance structure).

Stakeholder support was overwhelmingly positive. During cross workstream discussions, we sought stakeholder feedback through real-time, electronic surveys. After the dissemination of the second draft, stakeholders had a further opportunity to share feedback through an online survey.

Generally, the case for change resonates strongly with Delawareans. Every survey respondent either agreed or strongly agreed that there was a compelling case for change in Delaware. Stakeholders expressed similarly positive support across individual components of this plan, with ~60-90⁺ percent of respondents supporting or strongly supporting each element of our approach.

3.5 METHODOLOGY

Each workstream took the following approach:

- **Context:** review of existing initiatives in the state and priorities for change.
- **Options considered:** consideration of options for innovation by studying case studies from SIM testing states and other innovative approaches from across the nation.
- **Plan:** development of specific initiatives as well as principles and framework for aligned stakeholder action.
- **Approach to rollout:** development of timeline and key milestones going forward, as well as integration with the overall plan.

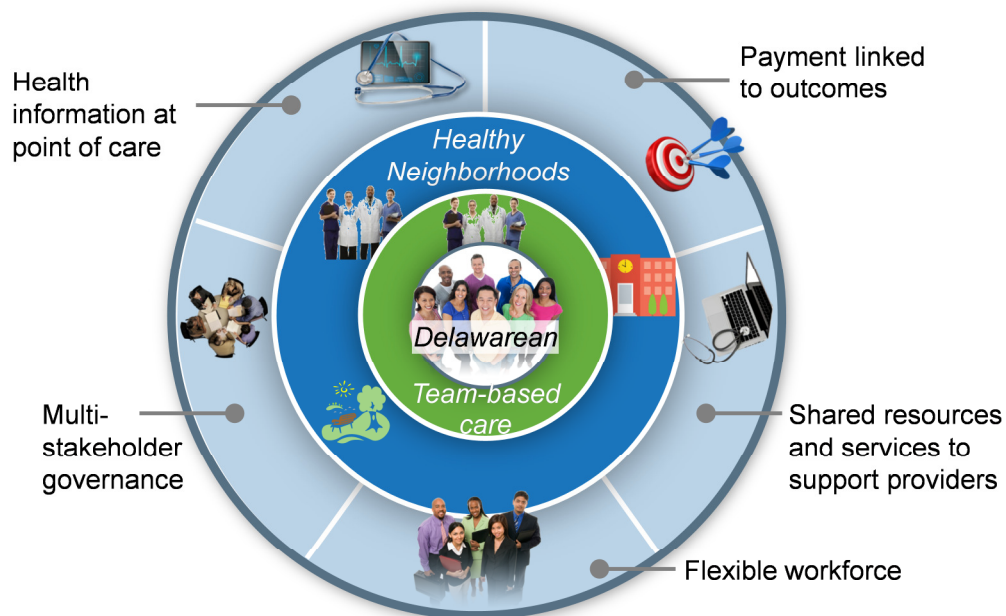


4.0 Delaware's plan

Delaware aspires to be one of the five healthiest states in the nation, to be in the top ten percent of states in health care quality and patient experience; and to reduce health care costs by six percent by 2019.

To achieve this vision, Delaware has developed a plan characterized by value, accountability, and sustainability. The plan addresses the 1) delivery system transformation; 2) patient engagement strategy; 3) new payment models; 4) data and analytics approach; 5) population health model; 6) workforce strategy; and 7) policy requirements needed to achieve Delaware's vision. **Exhibit 17** provides an overview of the plan for Delaware's health care transformation.

EXHIBIT 17: FRAMEWORK FOR DELAWARE'S HEALTH TRANSFORMATION



Delaware's plan is distinctive because it builds on the state's unique assets, including advanced health information technology infrastructure, is flexible and inclusive of all providers, and connects across existing reform efforts. In addition, it represents an extremely broad, deep level of stakeholder engagement and is backed by the full commitment of the State. In all, it represents a scalable, replicable model for national health transformation.



4.1 DELIVERY SYSTEM

Delaware aspires to build on the strengths of the current health care system while transitioning to a model that delivers higher quality care at lower cost. This vision builds from a set of common principles that describes the patient-centered, team-based care all Delawareans should consistently expect.

4.1.1 Context

Delaware has great strengths in its provider community. Delivery system innovation across the state continues to generate positive outcomes (e.g., eliminating disparities in certain types of cancer screenings, reducing unnecessary utilization). It also has significant and unique assets that support its delivery system (e.g., DHIN). Delaware's delivery system, however, does not consistently provide the coordinated, team-based, value-oriented care required to meet the state's goals.

Barriers have limited the ability of Delaware to translate its strengths into progress towards the Triple Aim. The state's care delivery system is fragmented with most primary care providers in private practice (~74%)⁴³, and clinicians feeling like they work in silos; this makes care coordination particularly challenging.

4.1.2 Options considered

Delaware's first step in evaluating options for delivery system transformation was to understand the needs of its different populations.

⁴³ SK&A database, May 2013; American Hospital Directory , December 2011



EXHIBIT 18: POPULATION SEGMENTS AND NEEDS

	Sub-segment	Examples of sub-segment needs
Elderly	<ul style="list-style-type: none"> Top 1% of need Top 5% of need All the rest 	<ul style="list-style-type: none"> Continuous, comprehensive care, support and monitoring (home and site of care) Rapid support and response system with triaging Access to care when needed
Adults	<ul style="list-style-type: none"> Complex chronic Chronic/ at risk Healthy adults 	<ul style="list-style-type: none"> Comprehensive, coordinated disease management Multiple access channels for self-management Preventive measures, and active management of major risk factors
Maternity and Peds	<ul style="list-style-type: none"> Pregnancy Neonatal Pediatrics 	<ul style="list-style-type: none"> Access to OB/GYNs, and prenatal care/regimens Access to high quality NICU facilities/capacity Age-appropriate immunization coverage
Special Needs	<ul style="list-style-type: none"> Behavioral health Developmental disabilities Addiction and substance abuse Dual eligibles 	<ul style="list-style-type: none"> Screening, diagnosis and comprehensive treatment Community support systems Access to specialty care and services tailored for addiction and substance abuse Continuous, comprehensive care, support and monitoring (home and site of care)

Each population has a unique profile in terms of breakdown by spend and payer as well.

EXHIBIT 19: POPULATION SEGMENTS BY PAYER/MEDICAL SPEND (ESTIMATES)

	Total population, 2011 Number individuals (000s)					Total medical spending (millions) (pmpp ¹), 2011, Dollars			
	Medicare	Medicaid	Commercial	Un- insured	Total	Medicare ²	Medicaid ³	Commercial ⁴	Total
Elderly (65+)	110	10	6 ⁴	-	120	1,400 (12,200)	200 (19,700)	70 ⁴ (11,700)	1,600 (13,400)
Adults (19-64)	13	115	348	76	550	300 (23,000)	900 (7,500)	2,700 (7,700)	3,800 (8,100)
Adolescents/ peds (1-18)	-	100	110	12	220	-	400 (3,800)	300 (3,000)	700 (3,400)
Infants	-	6	5	-	11	-	40 (6,300)	100 (19,600)	140 (12,400)
Pregnancy	-	6	5	-	11	-	30 (4,800)	60 (12,000)	90 (8,100)
Total⁵	123	227	463	88	900	1,700 (13,300)	1,500 (6,600)	3,200 (6,900)	6,300 (7,750)

1 Estimated pmpp excludes 76,000 Adults and 12,000 Adolescents/ Peds who are not insured

2 Adds Medicare spend on dual eligibles, but does not include duals in denominator of PMPY calculation; 3 Includes all special needs populations

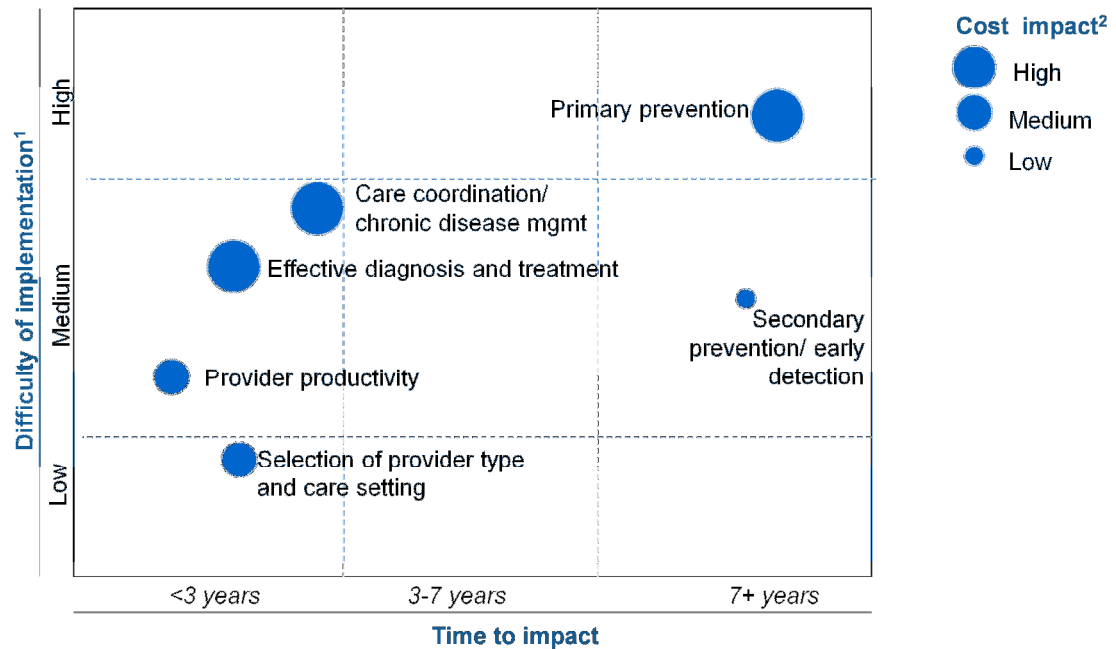
4 Estimate based on Medicare Advantage penetration (~5%), and pmpp spend extrapolated from Medicare avg pmpp; 5 Subtracts pregnancies to avoid double counting

SOURCE: Kaiser Foundation, CMS, extrapolations from DE State Employees and Retirees data, U.S. Census



Delaware also reviewed potential interventions, or sources of value, that could be applied across population segments. These vary from each other in level of complexity, level of impact seen in case examples, and length of time to impact. **Exhibit 20** describes the sources of value considered for delivery system transformation.

EXHIBIT 20: SOURCES OF VALUE (ESTIMATES)



¹ Includes assessment of historical success rates and execution risk

² Estimate of total cost of care savings based on numerous literature reviews, case examples, and State and national statistics

One tension encountered among stakeholders was the balance between interventions which address current health problems (e.g., targeting individuals with significant chronic disease) versus working to prevent health problems in the future (e.g., primary prevention efforts). For each type of initiative Delaware considered the difficulty of implementation and time to impact and potential magnitude. Ultimately, stakeholders reached consensus on care coordination and effective diagnosis and treatment as the priority target areas for Delaware’s delivery system transformation.⁴⁴

⁴⁴ Community-based approaches which include primary and secondary prevention are included in the “Healthy Neighborhoods” initiative described in the Population Health section below.



EXHIBIT 21: OPTIONS FOR PRIORITY AREAS OF FOCUS

	Healthy		Chronic		Special Needs		Example areas of focus
	Healthy	Acute	Single	Multiple	Beha- vioral ¹	Dis- ability ²	
Elderly				D	F		A Prevention – adults B Prevention – youth C Effective diagnosis and treatment D Care coordination – adults/elderly E Care coordination - youth F Care coordination / health homes – adults/elderly G Care coordination / health homes – youth H Care coordination / health homes – special needs
Adult	A						
Adolescents							
Children	B	C		E	G	H	
Pregnant							
Infants							

¹ Includes mental health, addiction, substance abuse

² Includes physical, mental and developmental disabilities

Finally, Delaware considered different approaches to clinical integration that would support delivery system transformation. These varied in degree of formality and setting of care. **Exhibit 22** below describes the models considered. There is widespread agreement that some form of clinical integration is required to make meaningful progress toward coordinated, team-based care.



EXHIBIT 22: MODELS OF PROVIDER INTEGRATION AND CARE COORDINATION



4.1.3 Plan for delivery system

4.1.3.1 Areas of focus

Based on an examination of Delaware's spending by population segment, two segments stand out. The first segment is patients with chronic conditions, who represent 15-20% of patients but about 50% of costs. This segment of patients generally has multiple interactions with the health care system and experience significant gaps in care. Perhaps no surprise to clinicians, this segment is important because the state must focus on how to deliver better and more coordinated, team-based care for both adults/elderly and also children with complex chronic conditions. A significant theme in discussions was that the need for the coordination is not simply in areas relating to physical health, but also includes behavioral health. Coordination also requires better management of transitions of care (e.g., from pediatrics to adults) and integrating long-term services and support.

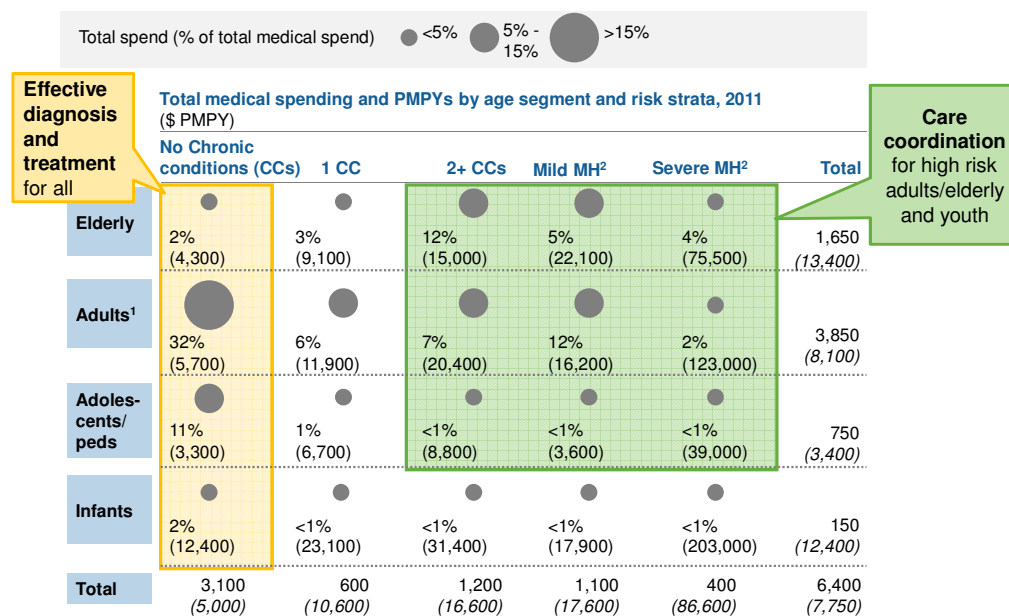
The second major segment which stood out is that nearly half of costs are not driven by chronic conditions and represent more episodic interactions with the health care system of otherwise healthier adults and children. Here the challenge



is not necessarily the coordination of care, but rather the massive variations in diagnosis and treatment that result in quite shocking differences in costs.

Delaware's plan focuses on both of these segments, promoting **care coordination for high risk patients** (including better integration with behavioral health) and ensuring **effective diagnosis and treatment** across all population segments.

EXHIBIT 23: HEALTH CARE SPENDING BY POPULATION



¹ Includes pregnant women

² Mild mental health and severe mental health patients include patients that have chronic conditions (single or multiple)

SOURCE: 1 US Census Data; Health Expenditures by State of Residence (2009), Medicaid Statistical Information System (MSIS) State Summary Datamart (2011), Medicare Geographic Variation Public Use File (2011); based on risk strata spend multipliers from other delivery systems, extrapolated to DE population and cost total

4.1.3.2 Addressing areas of focus

In order to effectively address these areas of focus, Delaware aligned on core principles that will underlie its approach to care delivery. Care delivery should be:

- Patient-centered
- Outcomes-oriented
- Technology-enabled
- Team-based
- Coordinated across providers



- Patient choice of provider and convenient access to care

Care coordination

The main opportunity for increasing value through care coordination is in reducing avoidable admissions and ED visits, increasing proactive ambulatory care, and promoting greater patient accountability for maintaining their own health. Together we have developed a picture of what better coordinated care will look like.

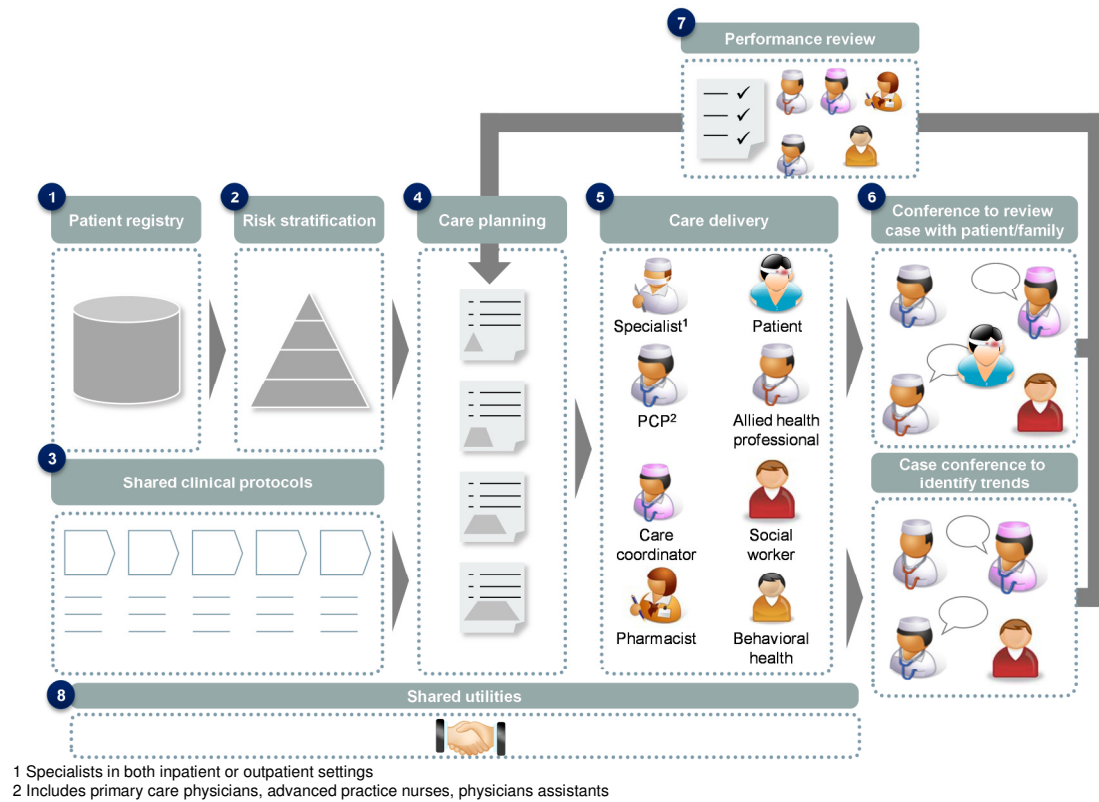
EXHIBIT 24: FROM/TO PATIENT EXPERIENCE

Today...		Future...
<ul style="list-style-type: none">▪ Every new person I see asks me the same questions all over again▪ I never get to see the same people even though I'm having the same things done again and again▪ I'm confused about what options are open to me and how I'll deal with my conditions over the next few years▪ No-one takes overall responsibility for helping me▪ Different staff don't seem to talk to each other		<ul style="list-style-type: none">▪ I only have to give my name and address once. And everyone I interact with knows what I've covered with other staff▪ I have a plan to look after myself, which I really feel in control of▪ The nurse at my practice just called to remind me that my yearly check is due next month. And I know to call my care co-ordinator if I find things are getting worse▪ My pharmacist checks that I'm taking my pills because she notices if I haven't picked up my regular prescription▪ If I need something, my care co-ordinator can organize it straight away - I don't have to wait for another assessment

In order to deliver this, stakeholders (including health care professionals and consumers) outlined critical changes needed to the process of how care is delivered.



EXHIBIT 25: PROPOSED DELIVERY SYSTEM



- **Patient registries** are a foundational starting point to be able to assemble key data on individuals so that providers of all types can access the record of their patients.
- **Risk stratification** is an essential step to identify those patients that need additional support and care to maintain their independence and avoid unnecessary hospital admission (*see below for additional detail.*)
- **Clinical guidelines** are needed to provide guidance and support to clinicians and other care professionals to help them best care for the most acute needs of their patients (*see below for additional detail.*)
- **Care planning and care coordination** by providers (either embedded with or dedicated to provider sites) is required to help patients and their families navigate the care system, especially for those patients with the greatest need (i.e., top 5-15% of risk for future health care utilization). The current levels of care coordination fall far short of this aspiration; moving to the future model will require a significant number of additional care coordinators (either through new hiring or retraining of existing workforce) and more streamlined care coordination in some instances (where it overlaps today). Achieving the envisioned level of care coordination requires more care coordinators, tools to stratify patient risk (i.e., their need for care



coordination), a team-based approach to care, and transformation of practices.

- ***Multi-disciplinary teams*** that deliver more coordinated care and better enable effective diagnosis and treatment. The complexity of care required for many patients requires a broad set of providers working together to support health and health care. This may involve behavioral health specialists, nurses, physicians, pharmacists, physical therapists, social workers, community health workers, and other traditional and non-traditional care providers.
- ***Joint discussions with patients and their families*** in order to reinforce more person-centered care that underlies this approach to delivery system transformation. These discussions involve both immediate treatment decisions and ongoing care plans. They are critical to empower patients to better manage their own health.
- ***Performance reviews and discussions*** that focus on effective management of the health of populations. These interactions foster a culture of continuous improvement that will sustain progress towards achieving the Triple Aim over time.

The model envisions a future delivery system characterized by increasing clinical integration balanced with flexibility in the approach to integration. The integration will be supported by the payment model (see below) that encourages these more integrated organizations to move towards outcomes-based payment.

Effective diagnosis and treatment

Delaware will focus on reducing unwarranted variation in care. It will identify a select few areas (that likely will evolve over time) that are high cost (based on total costs) and high variation, where guidelines are likely to have a significant impact, and where clear measures exist.

A statewide clinical guidelines/protocols resource will be established (see shared services and resources below) to select priority areas, identify and disseminate guidelines, and measure performance.

Addressing “super utilizers”

Delaware’s focus on care coordination and effective diagnosis and treatment will complement and build from efforts already underway to improve care for “super utilizers.” These include the programs such as the ones profiled earlier (e.g., Beebe CAREs). They also complement DHSS programs to engage public and private service providers, community-based organizations and Medicaid to



address potentially-avoidable and frequent Emergency Department (ED) utilization in specific neighborhoods. Based on claims data analysis and geographic mapping, pilot programs have been developed to connect behavioral health clients with co-located primary care services. Beginning in January 2014, communities, service providers and DHSS agencies will come together to develop approaches to reduce potentially-avoidable ED visits among pregnant women.

The new focus on care coordination for high risk individuals and on effective diagnosis and treatment builds from the lessons learned in the ongoing programs and positions Delaware to more effectively and efficiently care for the super utilizer population in the state.

4.1.3.3 Shared services and resources to support providers

To support the widest possible range of clinicians and professionals in delivering effective care, there is a need for a shared set of tools and programs. These tools and programs have been identified by working groups as areas where there are significant benefits to scale and there is a need for common approaches to facilitate high-performing multi-disciplinary teams across systems and settings of care. They will be available to all providers as a common resource to promote better delivery of care and support providers as they assume additional accountability for each aspect of the Triple Aim. Specifically, the plan contemplates a number of shared services and resources, including:

1. ***Risk stratification***: building on the DHIN infrastructure, this tool will provide a common mechanism to identify patients in the top 5-15% of need for care coordination and foster a common way of communicating about the intensity of care coordination needed among health care providers, patients, and their families to best serve the patient.
2. ***Identification of care gaps***: also building on the DHIN infrastructure, this tool will notify providers and patients about gaps in care by comparing need for care coordination and treatment with care patterns and the treatment a given patient is supposed to receive based on the population he or she falls within.
3. ***Clinical guidelines and protocols***: providers have identified a need for a mechanism to share best practices to reduce unwarranted variation in care. This service will facilitate the rapid dissemination of best practices among the state's providers, focusing on a limited set of high cost, high variation areas, with strong clinician participation.
4. ***Care coordination support***: this resource will function as a shared service to either pre-qualify or certify vendors and by doing so, help providers source



the care coordinators, tools, and resources they need to deliver care consistently with the aspirations outlined earlier. Identifying and integrating care coordinators into practices can be particularly challenging for many providers who may not have the time to do so or the resources to support full-time care coordinators on their own. This will make it easier for providers, on an optional basis, to find the care coordination support they need from vendors which have been pre-vetted.

5. ***Transformation support:*** providers often require significant support to transition their practices to more team-based care that focuses on the health of populations. This resource will support providers with coaching – either directly or by pre-qualifying vendors – in that transition. Services will likely include coaching on population health management, practice transformation, and team-based care.
6. ***Learning collaboratives:*** this resource will foster a common dialogue among providers transitioning to the new vision for care delivery through which they can share best practices and lessons learned in forums bringing together communities of providers across Delaware.

4.2.3.4 Quality measures on a common scorecard

High quality care is at the core of delivery system transformation, and achieving more effective care delivery means doing so in a way that can be measured and tracked. Today, performance measures proliferate; the future model will develop a common scorecard of a simple set of quality measures reflecting national guidelines and protocols that continue to ensure high quality care for Delawareans and ease administrative burden for providers. This scorecard may be embedded in the DHIN for convenient access and to optimize automatic population. It will complement a set of broader performance goals for Delaware's overall transformation on each dimension of the Triple Aim.

Delaware's common provider scorecard will focus on just a few metrics in number (e.g., 5-10), which

- Align with the payment system
- Are capable of being measured digitally
- Are relevant across multiple professionals
- Are in a priority area for improvement

Exhibit 26 below provides a preliminary illustration for the common scorecard.



EXHIBIT 26: ILLUSTRATIVE EXAMPLE OF PROVIDER SCORECARD

Category	Examples
Transformation	<ul style="list-style-type: none">▪ Document coordination and consultation between clinicians at various transition points in care▪ Meaningful use of data
Access	<ul style="list-style-type: none">▪ Average wait time in office▪ Average wait time to get appointment (e.g., days/weeks)▪ Access to providers on nights and weekends▪ % of practices accepting new patients
Process	<ul style="list-style-type: none">▪ Timely referral to hospice for end of life patients▪ Triage and rapid response to urgent problems▪ % of patients in top 10% of risk with developed care plans▪ % adherence with care plan▪ % adherence with AAFP Choosing Wisely list
Outcomes	<ul style="list-style-type: none">▪ Vaccine rates▪ Prenatal care in the first trimester▪ Basket of HEDIS metrics
Patient satisfaction	<ul style="list-style-type: none">▪ Net Promoter Score
Cost	<ul style="list-style-type: none">▪ Total medical expenditures (TME)▪ TME growth rate vs. GDP

4.1.3.5 Rationale

This approach positions Delaware to achieve its aspirations for more coordinated, team-based, and value-conscious care. Delaware's plan addresses the needs of elderly, adults, *and* pediatric populations. It also balances a focus on high-cost, high risk segments with broad-based interventions across settings and populations. While the focus is on coordination for high-risk individuals, the approach is intentionally inclusive of multiple specialties (e.g., behavioral health) and settings of care (e.g., long-term services and support), and populations (e.g., adults and children). It also identifies a set of supporting resources to ensure that providers of all types and experience can evolve their practices.

Since the ultimate goal is better health, Delaware's delivery system approach must be combined with the population health program described later in this plan. The aligned incentives and supporting workforce, infrastructure, and policy environment collectively enable more person-centered care and establish a strong foundation for Delaware to achieve the Triple Aim.



4.1.4 Approach to rollout

Pursuing the developments described will require a focused effort early on to develop the infrastructure, followed by ongoing support as transformation scales. In order to support a move to care coordination, an early concentration of effort will be needed to establish the shared services and resources to support provider transition to a model of coordinated care. This work will scale as a greater percentage of providers transform the way they deliver care.

To support more effective diagnosis and treatment, a similar rollout timeline will be needed. A clinical committee will be set up to finalize the areas of focus, identify and develop protocols and guidelines in these priority areas to ensure a standard approach and reduce variations in cost, and develop metrics to track progress on the common provider scorecard. Once launched, this committee will continue to oversee this process—updating areas of focus as needed, refining protocols and guidelines on an ongoing basis, and tracking and disseminating information about progress in each area.

Over the course of the next year, Delaware envisions the following high-level sequence to its delivery system approach:

Quarter 1

- Begin initial setup of shared services starting with care coordination
- Begin development of provider scorecards

Quarter 2

- Continue detailed design of initial set of shared services (e.g. care coordination)
- Begin detailed design of next set of shared services (e.g. clinical guidelines)

Quarter 3

- Begin to prequalify (or pre-certify) vendors (e.g., care coordination and transformation support)
- Continue clinical working sessions to identify/develop guidelines

Quarter 4

- Publish initial scorecards and guidelines
- Finalize learning collaboratives to support initial wave of providers beginning new payment models in 2015



4.2 PATIENT ENGAGEMENT

4.2.1 Context

Supporting individual engagement in health and wellness is a critical component to achieve Delaware's broader goals to transform the health care system and ensure access to quality affordable health care for all Delawareans. Each component of the plan, from delivery system, to population health, to workforce depends upon successful engagement by individuals in their health and health care.

Delaware already has several important patient engagement programs in place. For example, Delaware's "5-2-1-Almost None-0" program informs consumers about the importance of balance in diet and activity. Another example is Delaware's "Know Your Numbers" initiative, which creates visibility for Delawareans about the importance of knowing key health status measures (e.g., blood pressure). The DHIN is currently developing technology to provide access for consumers to all of their health records that are accessible through the DHIN.

4.2.2 Options considered

Delaware considered several options for its patient engagement strategy. The first consideration was where to focus. Options included:

- Informing: identifying opportunities to educate and inform consumers about health and healthy behaviors.
- Enabling: supporting patients in changing how they engage in their health and health care (e.g., with tools).
- Influencing: engaging with patients to encourage self-management and healthy living.
- Incentivizing: developing incentives and rewards for behaviors.
- Enforcing: requiring or limiting certain behaviors (e.g., through benefit design or policy changes).

Delawareans generally expressed a preference for patient engagement strategy that focused on informing and enabling consumers to engage positively in their



own health. Stakeholders also evaluated the types of programs that Delaware could pursue, ranging from tools to help consumers compare costs to building from the DHIN's emerging mobile technology for patient access to information, to connecting with aggregators (e.g., schools, employers) to develop peer-based and education-based influencing strategies.

4.2.3 Plan for patient engagement

Delaware's patient engagement strategy focuses on the use of technology, state of the art access to health information, social marketing, community and peer support, outreach, and education to empower all health care consumers with actionable health information and tools.

This strategy will include provision and adoption of a series of innovative publicly downloadable apps designed to extend the technology base for patient health empowerment, access to care, and care coordination. In particular these tools will address: (a) personal health empowerment (e.g., through the promotion of chronic disease self-management and risk reductions behaviors); and (b) improved transparency about Delaware's health care system. Through the series of proposed apps, Delawareans will gain easy electronic access to their personal medical records, as well as information about evidence-based risk reduction behaviors, information to enable value-conscious health care choices, and access to health care services in Delaware. Collectively, this information will encourage Delawareans to make data-informed decisions about their health care, potentially incentivize healthy activity, and include the public as a vital component of Delaware's new statewide delivery and payment model.

The strategy will also include implementation of a statewide social marketing and education campaign to communicate unified health and health care decision making and utilization messages. Delaware will deploy targeted messaging to consumers and communities to position Delawareans as informed, empowered fully-participating members of the expanded health care team. Messages will tie together improved access to health care through expanded health care coverage with the importance of prevention, early detection, and primary care, and the role of Delawareans as decision-makers and consumers in the health care system.

Ultimately, Delaware's patient engagement plan will generate cost savings by enabling fully-informed and aware patients to engage in healthy behaviors and to identify the most appropriate care settings, supporting value-based purchasing,



reducing unnecessary utilization, eliminating duplication of services, and improving care coordination.

4.2.4 Approach to rollout

Delaware will phase the patient engagement strategy in over the course of the next three years. The first year will focus on building out new technology. During the course of the first year, Delaware also will introduce the social marketing campaign, which will continue into the next two years. The second year will also focus on the introduction of new apps to support patients in engaging in their own health. This phased approach will work in support of and in conjunction with the Healthy Neighborhoods program described below to engage and incentivize individuals to improve their health.

4.3 PAYMENT MODEL

Delaware intends to transition to a payment model that rewards value. The goal is for all or most care in the state to transition to outcomes-based payment that incentivizes both quality and management of total medical expenditures over the next five years. All providers will be accountable for meeting a common, simple set of quality measures organized around a common scorecard shared across the state.

4.3.1 Context

Delaware's health care system remains predominantly fee-for-service (FFS), with providers incentivized to provide a higher volume of care rather than higher value care. As a result, Delaware's providers generally have little experience managing risk. This persistence of FFS payment models stifles innovations in care delivery. There is widespread agreement in the value and need for a shift to outcomes-based reimbursement.

Barriers to new payment model adoption include a lack of payer alignment, with the result that past attempts at payment model innovation have affected an insufficient portion of a provider's payments to encourage the changes needed for care delivery and resulted in an increased administrative burden for providers. Another barrier to scaling existing pilots is the diversity in the provider environment, which means that transformation needs and perspectives differ within the system.



4.3.2 Options considered

Delaware considered payment models that varied primarily based on the reward structure and the level of performance aggregation. In evaluating the potential options, Delaware considered lessons from programs around the country and globally, including the State Innovation Model testing states and existing CMS and CMMI models. The evaluation of each option considered potential for impact, ability to incentivize changes required to achieve Delaware's vision for health care delivery (i.e., more person-centered, coordinated, team-based care and more effective diagnosis and treatment), and fit with the structure and experience of Delaware's provider community.

Delaware considered two general types of reward structures for outcomes-based payment: pay for value (or pay for performance) and total cost of care. Each of these models focuses on incentivizing quality *and* value. They are described further below.

- **Pay for value (P4V):** providers earn bonuses for meeting **both** a set of quality measures *and* managing resource utilization.
- **Total cost of care:** providers share in savings generated by the system if they meet **both** a set of quality measures (just like in pay for value) *and* reduce health care costs per member for their patients compared against a benchmark. There are several types of total cost of care models, which vary in the level of potential savings shared with providers and the level of risk taken by providers:
 - Upside-only gain sharing models: providers that meet quality measures are eligible to share a portion of savings achieved and bear no risk if costs exceed expectations.
 - Upside and downside risk sharing models: providers that meet quality measures share in savings and also take accountability for some risk if costs exceed expectations.
 - Prospective payment models: providers share all savings and take full accountability if costs exceed expectations (expectations are adjusted to ensure that savings also accrue to the system overall in order to make progress against the cost component of the Triple Aim). One form of prospective payment is capitation, where providers are paid a fixed amount in advance of a given time period.



Measuring performance on quality and cost in total cost of care models requires a certain number of attributed patients in order to meaningfully reward performance (versus random year-to-year variation). For performance aggregation, stakeholders considered models ranging from market-level aggregation to informal models in which providers form virtual panels of patients for the purposes of measuring performance.

The exhibits that follow illustrate the reward structure and organizing model options considered.

EXHIBIT 27: INNOVATION IN OTHER STATES: REWARD STRUCTURE AND PERFORMANCE AGGREGATION

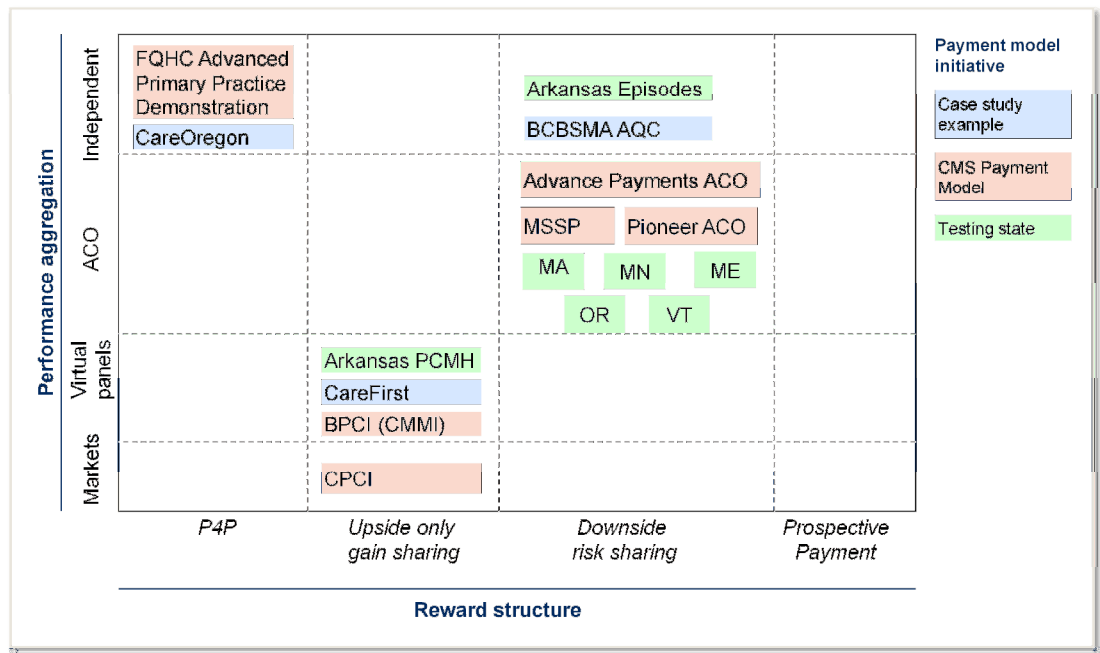








EXHIBIT 28: ORGANIZING MODELS

	Name	Overview	Description	Organizer
Single corporate entity	1 Large physician practices		<ul style="list-style-type: none"> ▪ Larger practices / provider organizations with shared reimbursement 	<ul style="list-style-type: none"> ▪ Provider leadership/ champion
	2 Hospital-based health system		<ul style="list-style-type: none"> ▪ Hospital system including employed physicians and outpatient services 	<ul style="list-style-type: none"> ▪ Health system
Formal / Joint-venture	3 ACO with hospital		<ul style="list-style-type: none"> ▪ Provider organizations united for reimbursement coordinated around hospital 	<ul style="list-style-type: none"> ▪ Hospital / Health system
	4 ACO without hospital		<ul style="list-style-type: none"> ▪ Provider organizations united for reimbursement without hospital 	<ul style="list-style-type: none"> ▪ Provider organizations ▪ Community groups
Virtual	5 Virtual panels of provider organizations		<ul style="list-style-type: none"> ▪ Small provider organizations join to create scale for transformation, risk 	<ul style="list-style-type: none"> ▪ Payer, provider organization, or vendor
N/A	6 Not participating		<ul style="list-style-type: none"> ▪ Providers not participating in total cost of care model 	<ul style="list-style-type: none"> ▪ None

In aligning on the model for Delaware, stakeholders also reviewed specific technical design considerations, including:

- Pace of roll-out of the new payment model across the state.
- Level of performance rewarded (whether providers are rewarded based on relative improvement or meeting absolute benchmarks for quality and cost).
- Pace of transition to end-state within the payment model (e.g., increase level of risk).
- Metrics used for eligibility for participation, eligibility for payment, and level of payment.
- Member attribution methodology (i.e., attribution based on member selection, primary care utilization, or another metric).

4.3.3 Plan for payment model

Delaware's payment model is built around a common set of quality measures and accountability for managing per member costs, with the goal of incentivizing value.

4.3.3.1 Principles for payment



In reviewing the options for Delaware’s payment model, stakeholders identified the following principles:

1. *Population-based* as core foundation, with providers assuming accountability for the overall care of their patients (as opposed to just for discrete encounters or individual episodes), with potential for episode and/or other models to be layered on in the future.
2. *Multi-payer alignment* to support the business case for delivery system transformation, with room for differences in patient populations.
3. *Common vision* that includes accountability for access, quality, and experience as well as total cost of care.
4. *Multiple transition paths* to account for differences, structures, and capabilities among providers.
5. *Continuous improvement*, with established checkpoints during transition.
6. *Balanced rules* for payment model participation that account for the advantages of scale, clinical integration, and competition.
7. *Design for scalability* from the outset, even if providers and payers choose to stage rollout for operational or financial reasons.
8. *Strive for administrative simplicity* while confronting the needs of some payers for administrative consistency with national standards.
9. *Plan for the transition costs* to some providers (e.g., new capabilities for PCPs, reduced inpatient volume for hospitals).
10. *Role for fee-for-service*, recognizing that fee-for-service will continue to make sense for some payments.
11. *Flexibility*, recognizing that providers will make different decisions on organization and risk.
12. *Incentives aligned with care for the highest risk patients* in a way that prioritizes quality and continuity of care.

4.3.3.2 Payment model design

Delaware’s proposed payment model reflects the principles identified above. It is a flexible, inclusive model for transitioning to outcomes-based payment. The overall goal is for the vast majority of Delawareans to receive their care from providers incentivized by quality and total cost of care.

Quality and performance measures will link to the common scorecard described earlier. Providers in Delaware have expressed a preference for a tiered approach to quality measurement so that better performance on quality is linked to



increased participation in the P4V or total cost of care incentives. Specific levels and approach to quality measurement will be determined by each payer.

In order to account for differences in baseline experience with these types of payment models, Delaware's plan introduces the option of either beginning with P4V or entering directly into total cost of care models. Providers may choose to vary their starting point with each payer. By necessity, the specific bonus levels, thresholds, and form of total cost of care remain discussions between individual payers and providers. Delaware's vision, however, is for two prototypical models for the total cost of care approach for Medicaid and Medicare, which may also be models for the commercial market. These are described in greater depth below.

Prototypical models

Delaware envisions Medicaid will offer providers two types of total cost of care arrangements, and Delaware will invite Medicare to offer similarly structured models. Delaware plans to require its Managed Care Organizations to offer payment models consistent with these prototypes when the new contract period begins in 2015. These models are both population-based, and differ only in the nature of savings shared and level of risk. Providers may still choose to negotiate prospective reimbursement structures with any payer – these merely serve as the starting point models. Commercial payers may choose to adopt these models for their providers.

- **Upside only option⁴⁵:** Providers continue to be paid fee-for-service for the duration of a performance period (potentially one year). At the end of each performance period, providers who meet quality measures and whose risk-adjusted per member costs fall below a benchmark, share a portion of savings. Providers share in savings that exceed a minimum savings rate of 2-4% depending on population size, with a maximum (“stop gain”) of 10% of benchmark spending. A minimum attributed population of 5,000 beneficiaries is required per payer; patients are attributed retrospectively (with preliminary assignment) based on plurality of primary care services.
- **Upside and downside risk sharing⁴⁶:** Similar to the upside only option, providers continue to be paid fee-for-service for the duration of a performance period (potentially one year). At the end of each performance

⁴⁵ Aligns with existing CMS/CMMI population-based Medicare ACO payment model

⁴⁶ Aligns with existing CMS/CMMI population-based Medicare ACO payment model



period, providers who meet quality measures and whose risk-adjusted per member costs fall below a benchmark, share a portion of savings. Providers also bear risk if costs exceed expectations. Providers share in savings that exceed a minimum savings rate of 1%, with a maximum level of savings (“stop gain”) or losses (“stop loss”) of 10% of benchmark spending in year 1, rising to 15% in year 2. A minimum attributed population of 15,000 beneficiaries is required per payer (5,000 in rural areas); patients are attributed retrospectively or prospectively (option for provider) based on plurality of primary care services.

Exhibit 29 below describes preliminary views on the level of savings shared for Medicaid and Medicare. The levels vary to account for differences in typical provider margins across payers. The level of savings shared for Medicare would be in line with existing CMS/CMMI population-based ACO models.

EXHIBIT 29: POTENTIAL LEVEL OF SAVINGS/LOSSES SHARED WITH PROVIDERS BY MEDICAID AND MEDICARE IN TOTAL COST OF CARE MODELS

Payer	Upside only	Upside and downside
Medicaid	30%	50%
Medicare	50%	70%

Across all payment models, Delaware’s payers will fund provider investments in care coordination (level and approach likely to vary by payer).

4.3.3.3 Provider organizing models

Delaware’s goal is to maximize inclusiveness and provider participation in outcomes-based payment models. This theme is reflected in the option to begin with P4V. It is also reflected in the approach to the types of organizing models for providers to participate in these payment models. The proposed approach initially offers providers the option to participate through either formal (e.g., through Accountable Care Organizations) or virtual structures as long as minimum panel requirements are met.

This approach purposefully offers many options in order to balance for the need for scale and clinical integration to deliver more coordinated, team-based care with flexibility to organize so that many types of providers are included. For example, one important goal for care delivery is to ensure integration of primary care and behavioral health; the proposed approach offers flexibility for these



types of providers to organize together to participate in the new payment model through an Accountable Care Organization.

4.3.3.4 Rationale for model

The design of the proposed payment model meets Delaware's specific needs as outlined by stakeholders. In particular, the plan aligns payers on an overall payment model framework, which enables providers to transition a significant portion of overall payments to a common outcomes-based model. At the same time, the variation between models reflects the need for multiple options to enable broad provider participation from year 1.

Similarly, Delaware's approach to organizing models balances flexibility and structure. Though the majority of providers are expected to participate as part of an Accountable Care Organization or similar structure (either with or without hospitals), the model allows for virtual options in order to ensure that Delaware's private practice clinicians have broad options for participation without consolidation.

4.3.3.5 Achieving 80% coverage in new payment models

Delaware's plan positions the State to achieve at least 80% of the population receiving care under new payment models. Delaware Medicaid will introduce the models described earlier in this section and Delaware will invite Medicare to introduce similar models. Delaware's commercial insurers all participated in the development of the State Health Care Innovation Plan, both in the development of the common scorecard approach described in section 4.1 and in the approach to payment described in this section. The plan builds from initiatives already underway (e.g., Highmark Blue Cross Blue Shield Delaware and the Medical Society of Delaware's ACO model and PCMH initiative) and complements the transition within the commercial market towards value-based payment.

Delaware's commercial insurers are expected to transition a significant portion of their payment structures to pay for value or total cost of care models over the next several years.

Collectively, these actions will result in at least 80% of the population receiving care through outcomes-based payment models, supported by a common scorecard of quality measures.



4.3.4 Approach to rollout

Transitioning to the new payment model will require additional refinement of model options by individual payers, including specific financial details. Delaware will also work with CMS to seek Medicare participation in the new payment model.

Payers will need to incorporate the details for the model option selected into new payer-provider contracts. Providers will need to decide which model option to participate in (with the option of not participating) and which organizing model to adopt, which may involve contracting with other providers for payment if they opt to join Accountable Care Organization structures.

Over the course of the next year, Delaware envisions the following high-level sequence to its payment model approach:

Quarter 1

- Conduct detailed technical design, including historical claims analysis, participation requirements, and approach to rollout

Quarter 2

- Continue detailed technical design
- Conduct financial impact modeling

Quarter 3

- Continue financial impact modeling
- Develop training strategy and materials for providers and consumers about new payment models

Quarter 4

- Complete payment training materials and conduct trainings

4.4 DATA AND ANALYTICS

Delaware's plan for health system transformation depends on access to the right information at the right time and the right place. In order to empower patients, deliver coordinated, team-based care, take accountability for quality and costs of populations of patients, and simplify the health system, each participant requires high-quality data. The Delaware Health Information Network (DHIN) provides a tremendous foundation for enabling data-driven care. Delaware's vision is for its



technology infrastructure to continue to lead the nation and be a core source of distinctiveness of the overall transformation.

4.4.1 Context

Delaware has some of the highest rates of Health Information Technology (HIT) adoption in the country, with 98% of providers adopting the Health Information Exchange (HIE), 83% of providers with Electronic Medical Records (EMRs) and a 98% e-prescribing rate. Given this advanced starting point, Delaware will focus on opportunities to improve the value of HIT through the state's HIE system, the Delaware Health Information Network (DHIN) rather than further expanding adoption. The DHIN is one of the most advanced HIE networks in the country. It connects a broad group of health care stakeholders to share a wide range of clinical information. It also has a robust set of capabilities and features, and is continually developing new capabilities to serve Delaware.

DHIN's high adoption (98% of providers, 100% of hospitals and skilled nursing facilities, and many others) makes it a central platform for rapid communication within the clinical community. DHIN communicates lab findings (99% of results) and imaging reports (97% of studies) in addition to hospital Admission Discharge Transfer (ADT) reports and medication history, providing enhanced patient views and a community health record to providers to improve efficiency and effectiveness of care. DHIN also offers providers patient medication history and continuity of care documents which can be directly downloaded to any HL7-compatible EMR. In addition to providing information to enable better patient care, DHIN performs public health reporting on notifiable conditions, vaccinations, and syndrome surveillance (e.g., to provide early detection of flu outbreaks) to allow more rapid and targeted responses to public health problems.

Furthermore, DHIN is developing new capabilities to serve Delawareans. DHIN has launched an event notification system that notifies Medicaid Managed Care Organizations and providers when one of their patients is discharged from the hospital (more than 7,000 notifications and alerts were sent in November alone). DHIN is currently piloting the extension of this program to ambulatory providers. To empower patients, DHIN is developing a consumer engagement tool that leverages its HIE capabilities to provide patients access to their clinical data and connect them with providers (a core component of the patient engagement strategy described earlier). To increase the value of all its capabilities, DHIN is continually expanding the types of data being exchanged, with plans to add



ambulatory, public health, claims, and medical device data (e.g., EKG). This will be facilitated by the development of broad EMR-based bidirectional clinical data sharing. Finally, to provide continuity of care across state lines, DHIN is developing an inter-state connection with CRISP, Maryland's HIE. In the longer term, Delaware also aims to expand the connection of DHIN with additional statewide and regional public health databases (e.g., prescription monitoring program, vaccination registry) to increase the health information available.

Delaware payers and large providers have also invested in advanced technology capabilities (e.g., risk stratification, attribution, total cost of care analysis), which have been deployed to support current payment innovation pilots.

4.4.2 Options considered

In developing a plan for building data and analytic infrastructure, Delaware stakeholders inventoried and assessed the state's existing capabilities, including data sources, infrastructure, information flow and system linkages, in order to identify the infrastructure required for delivery system, population health, and payment innovation.

Stakeholders considered three options for developing the technology and information flow needed to deliver more person-centered, coordinated, and team-based care that varied based on how much standardization is required across providers and payers:

- **Mostly consolidated infrastructure and technology**, with all stakeholders using/sharing the same infrastructure and technology. This offers potential cost synergies from economies of scale as well as reduced operational complexity for users, and could involve custom solutions being transitioned to a central utility.
- **Standardized but not consolidated technology**, involving standardized output agreed-upon by all stakeholders, with independent execution and delivery. This offers the consistent informational output to support statewide rollout of a new payment model, without potential complexities from shared infrastructure.
- **Not standardized or consolidated infrastructure and technology**, with no standardization of output and no technology/infrastructure sharing or consolidation. This is most relevant for situations where cross-stakeholder variation does not impact solution consistency, or where standardization is not achievable.



Exhibits 30 and 31 illustrate the proposed capabilities required by the level of standardization.

EXHIBIT 30: SYNTHESIS OF CAPABILITY STANDARDIZATION (1/2)

		Xx = Added standardization choice	
Categories	Not standardized	Standardized but not consolidated	Mostly consolidated
1 Payer infra- structure	<i>Near term – Population stratification</i> Pooling analytics ¹ Claims patient registry <i>Near term – Care gap analysis² (whole person view)</i>	Population attribution & adjustment Longer term – Population stratification Pooling analytics ¹ Performance reporting Specialist/facility analytics Longer term – Care gap analysis ² (whole person view) Event management based on claims (e.g., alerts) Payment	
2 Provider- payer – patient connect- ivity	Patient engagement ³		ACO enrollment ^{4,5} Provider pooling tools ⁵ Provider input into attribution/segment ⁶ Metrics capture (non-clinical and clinical) Reporting/data visualization ⁵ Patient engagement ³ Patient transparency

¹ Common/standardized interface for multi-payer pooling; pooling logic potentially different by payer; ² Tools not standardized, definitions/display standardized; ³ Can be implemented with private payer tools or by central iTriage tool to connect patients and providers; ⁴ Common/standardized portal; legal agreements specific to payers; ⁵ Common/standardized portal; methods/calculations potentially different by payers; ⁶ Consolidated workflow tools and resources/people for subscale practices



EXHIBIT 31: SYNTHESIS OF CAPABILITY STANDARDIZATION (2/2)

		Xx = Added standardization choice	
Categories	Not standardized	Standardized but not consolidated	Mostly consolidated
3 Provider – patient care mgmt tools	Care coordinator workflow tools and resources/people ⁶ Near term – Clinical-data based analytics (e.g., care gap analysis) Communication support tools Steerage to 24/7 clinical access Telemonitoring, mobility, home monitoring tools		Care coordinator workflow tools and resources/people ⁶ Event management based on clinical data (e.g., alerts) Longer term – Clinical-data based analytics (e.g., care gap analysis)
4 Provider-provider infrastructure			Admission/discharge data EMR-based clinical data Clinical patient registry Whole population registry
Additional DE – specific capabilities			Consolidation of government claims APCD and clinical data (e.g., all payer care database) Non-reimbursed service reports Inventory of community assets

1 Common/standardized interface for multi-payer pooling; pooling logic potentially different by payer; 2 Tools not standardized, definitions/display standardized; 3 Can be implemented with private payer tools or by central iTriage tool to connect patients and providers; 4 Common/standardized portal; legal agreements specific to payers; 5 Common/standardized portal; methods/calculations potentially different by payers; 6 Consolidated workflow tools and resources/people for subscale practices

4.4.3 Plan for data and analytics

Delaware’s vision is to develop a robust payment innovation infrastructure that builds upon existing state assets to enable the overall goals of the delivery system and payment innovation efforts. This will require an array of technology capabilities, which will be sequenced in a way that both enables short-term impact and builds the foundation for continued long-term improvements.

4.4.3.1 Components

Payer claims-based tools: Tools deployed by payers to implement the payment model (e.g., attribution, risk stratification, gain-sharing analytics), evaluate and report on provider performance (e.g., total cost of care calculation, care gap analysis, performance reporting), and generate payment. Patient risk stratification is a critical enabler of care delivery innovation, and is a foundational component of the Delaware HIT solution set. Providers will receive an integrated summary of their patient panel across all payers via the provider portal, which will include patient risk scores for care coordination support, total cost of care, care gaps, conditions and a variety of other related data. Payers will run risk stratification algorithms independently and provide this data to the portal.



Provider portal: Web-based, multi-payer portal to enable the exchange of information between payers and providers. Payers distribute reports via the portal and will provide data visualization tools (e.g., claim-level drill down) to providers via the portal. Providers will also be able to use the portal to submit quality metrics, to the extent that they do not have the technical sophistication to do so via their EMR and the HIE. This is a critical component for enabling small and rural providers to realize benefit from the program even if they have limited technology capabilities.

Patient portal: Web-based portal to enable patients to access their health information, as well as evaluate and select the providers that will best meet their individual needs.

Provider care management tools: Set of population health management tools that will enable providers to better manage the overall health of their patients. This will include robust care coordinator workflow capabilities, member engagement (e.g., email, mobile) functionality and sophisticated clinical data-based analytics.

Health Information Exchange: HIE is at the core of the Delaware model. ADT alerts will be transmitted to all practices in real-time to enable rapid engagement of their attributed patients. Integration of ambulatory data will be accelerated to equip providers with a full longitudinal patient record for their patients. Care management tools will have access to all inpatient data immediately.

4.4.3.2 Stakeholder collaboration

The Delaware payers will collaborate on infrastructure deployment to ensure a unified, cohesive experience for providers and patients. This will involve a high-level of standardization for key components (e.g., quality metrics, total cost of care calculation methodology, performance report formatting). In many cases, the underlying infrastructure behind each component will be stakeholder-specific (e.g., payer analytic tools), but the outputs will be consistent. To the extent that consolidated infrastructure is required to ensure a consistent provider / patient experience (e.g., provider portal), the payers will support the establishment of a single system to which they will provide the necessary data and build the required interfaces.

4.4.3.3 Development strategy

Payer claims-based tools: Payers will maintain and build on independent analytics, data sources, and IT infrastructure to support new payment and care



delivery models. Payers will also develop an essential set of core metrics (through the multi-stakeholder approach described earlier in the plan for the delivery system), principles for specific analytics (e.g., risk stratification), and reporting formats to providers for assessment of quality and cost.

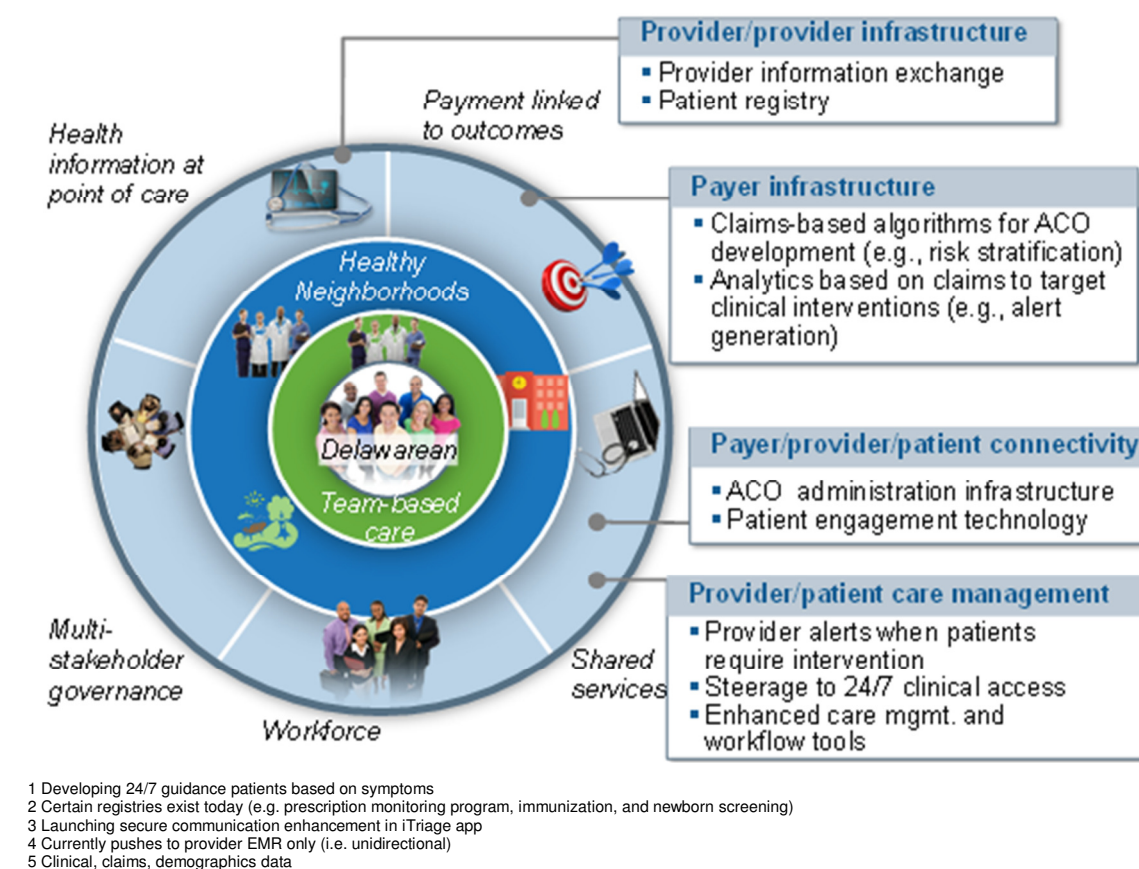
Provider portal: Delaware will prioritize building a multi-payer provider portal leveraging DHIN's web interface to enable access to performance reports created/provided by all payers, input of information required to administer population health (e.g., ACO enrollment and information to perform performance analytics/metrics), as well as patient access to health data (e.g., clinical data, quality and cost metrics).

Provider care management tools: In the near term, Delaware will develop guidelines and create resource centers that help providers adopt the process changes required by care coordination and select/implement supporting tools. In the medium-term, Delaware plans to pre-qualify or certify care coordination vendors, develop central clinical data-based analytics to support a variety of provider tools and build a central channel (e.g., call line) connected to HIE for 24/7 clinical steerage available to all DE residents.

HIE: Delaware will continue to build on existing HIE capabilities (e.g., develop alerts to providers for patient clinical events), expand interoperability to additional EMR and additional HIE systems (e.g., out-of-state, national) and, in the long-term, integrate HIE with public health data, claims, demographic, and other data sources (e.g., prescription monitoring program, Medicaid claims, driver's license registrations).



EXHIBIT 32: PRELIMINARY ROADMAP FOR DEVELOPING EXISTING AND NEW CAPABILITIES



4.4.3.4 Coordination with other state-wide HIT initiatives

Delaware's strategy to coordinate with state-wide HIT initiatives follows a three-part approach:

1. Build off DHIN's HIE to connect providers, hospitals, and community agencies across the state:
 - Increase clinical data exchange between providers (e.g., admission/discharge reports, ambulatory data from EMR-based bi-directional communication).
 - Deliver longitudinal patient records to a broad range of providers in the state to increase continuity of care.
 - Pull data from state-wide public health databases and integrate into provider workflows (e.g., vaccination records and reminders, prescription monitoring program alert if patient already has prescription for controlled substances).



- Lookup for patient insurance coverage (e.g., single point of contact for eligibility and formulary).
- Build a central claims database to perform system level analyses.
- 2. Leverage DHIN’s web interface to create a multi-payer provider portal for performance reporting and metrics input:
 - Perform clinical quality measure reporting to providers.
 - Allow providers to input information for standardized metrics and give feedback to patient attribution.
- 3. Connect the DHIN to the patient engagement strategy, which aims to connect patients and providers, and to guide care:
 - Roll out patient engagement and care guidance tool state-wide.
 - Upgrade the tool with a secure messaging and clinical results delivery system for patients to engage directly with providers.
 - Provide basic clinical guidance and patient health data.
 - Support Meaningful Use Stage 2 consumer engagement objectives.

4.4.3.5 Approach to reach rural providers, small practices and behavioral health providers

Delaware believes in broad provider access to patient data relevant for care. To support this goal, the DHIN has driven HIE adoption efforts to reach the widest base of providers possible, including rural, small practice, and behavioral health providers. The current HIE adoption rate is 98% among providers. DHIN accomplished this by employing a solution that requires minimal hardware investments from providers to connect to the state HIE (e.g., basic computer and a broadband connection).

Delaware recognizes that the exchange of mental and behavioral health data requires higher than usual privacy and security controls. To facilitate the exchange of health data between behavioral health providers while respecting patient privacy, DHIN is planning an upgrade to allow more granular consent than the current “all or nothing” permissions that exist today.

Delaware also has a strong regional extension center, Quality Insights of Delaware, which has promoted EMR adoption in Delaware to one of the highest in the nation (83%). This statewide effort has enabled providers of all types to leverage health information technology in their practices.

4.4.3.6 Expected MMIS impact



MMIS is the system of record for all Medicaid claims and payments and will continue this function into the future. Delaware will leverage the Medicaid Decision Support System (DSS) to complement state analytics with measures to track state outcomes.

MMIS can serve as the starting point for different data integration approaches:

- Aggregate MMIS Medicaid claims with state employee claims into a single database as a start to a multi-payer claims database for analyzing outcomes, utilization, quality, and cost.
- Integrate MMIS Medicaid claims data with HIE clinical data to create a comprehensive patient view of Medicaid patients.

Delaware will leverage Medicaid DSS to support SIM initiative analytics to calculate measures required to track performance of the new delivery and payment model.

Delaware does not anticipate substantial changes in MMIS functions, other than possibly adding metrics analyzed by DSS, which remain to be determined.

4.4.4 Approach to rollout

Delaware is focused on accelerating impact from its payment innovation program. To enable the launch of new payment models by early 2015, Delaware has developed a detailed and pragmatic launch plan that will ensure that critical components are enabled, including core analytics (e.g., risk stratification and adjustment, attribution, total cost of care calculations), report generation and distribution. Procurement and development efforts are already underway to ensure that these components will be available as required.

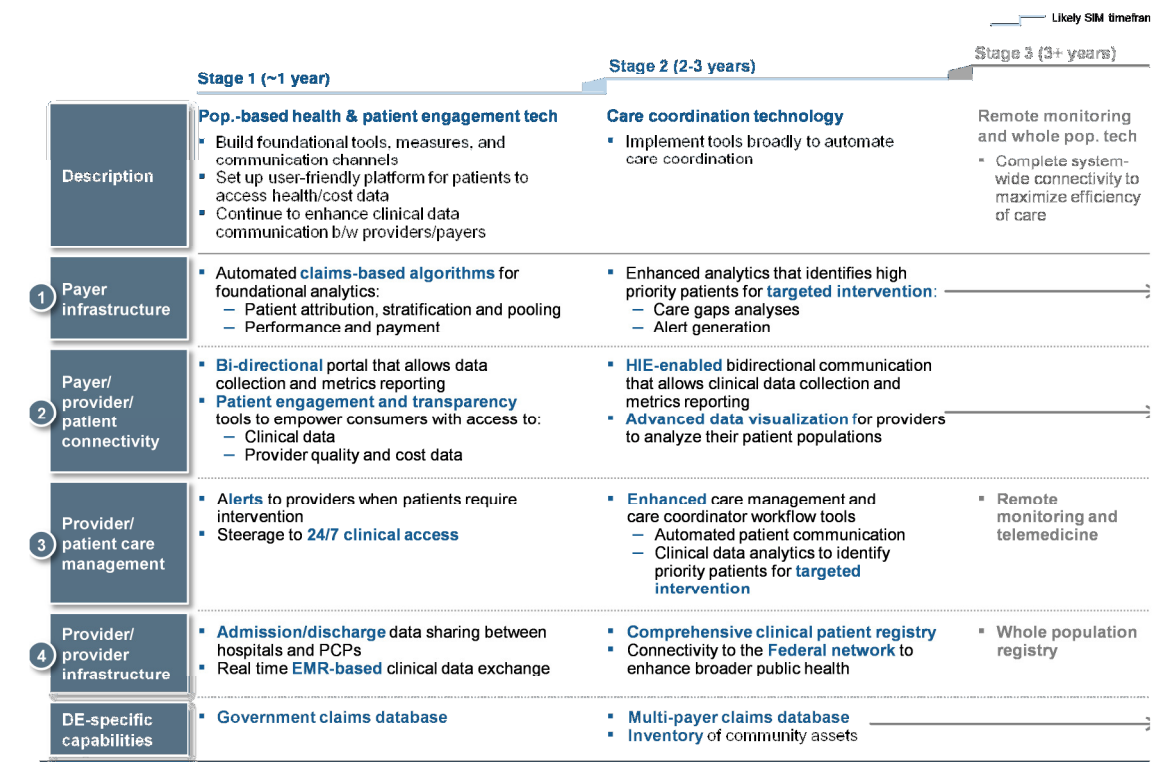
The data and analytics infrastructure will be deployed with a focus on leveraging existing assets, enabling near-term impact and providing a foundation for sustained performance improvement. Delaware will focus the initial deployment (year 1) on building foundational tools (e.g., HIE-based event management), measures, and communication channels; establishing a user-friendly platform for patients to access health/cost data; continuing to enhance clinical data communication between providers/payers; and developing a sustainable long-term funding model for DHIN initiatives.

Years 2 and 3 will primarily be focused on provider build out of the care management infrastructure, including vendor pre-qualification and potentially



state/vendor agreements to improve technology access among smaller providers. Significant enhancements will also be made to the existing infrastructure, including the addition of data visualization capabilities to the provider portal, and potentially the establishment of a multi-payer claims database, potentially integrated with the state HIE. Delaware will also look for opportunities to drive impact through the integration of other state population data, and develop an automated system for checking symptoms and provide guidance to a **24/7 steerage channel**, (e.g., web, phone line), with the ability to look up patient medical records for more advanced triage.

EXHIBIT 33: STAGED APPROACH TO ROLLOUT FOR DATA AND ANALYTICS INFRASTRUCTURE



4.5 POPULATION HEALTH

Delaware aspires to be one of the five healthiest states in the nation by 2019. Delaware's approach to population health focuses on integrating and coordinating community health services with public health and the care delivery system, complementing additional health promotion and disease prevention efforts. Communities will mobilize to address their most important health determinants, employers will be proactive proponents of healthy behavior, education will be



provided for caretakers and family members of patients on relevant health care issues and available local resources, and every Delawarean will seamlessly connect to resources that promote health, wellness, and prevention.

4.5.1 Context

Current situation

Delaware has an active and innovative community devoted to improving population health. Organizations across Delaware continue to invest in new programs focused on prevention and wellness. Communities across the state also have organized to promote health and wellness. These efforts have yielded significant progress in particular areas (e.g., reducing infant mortality). Examples of these programs and collaborative efforts include:

- *The Healthy Weight Collaborative*, a national initiative funded by the Affordable Care Act, creates local partnerships among primary care practices, public health, and community-based organizations to reverse the obesity epidemic. Delaware is focused on improving health for children and adults at four different sites: an elementary school, a high school-based wellness center, a medical clinic, and a college campus.⁴⁷
- *United Way of Delaware's Live United 2015* provides an outcomes-based plan for increasing the proportion of underserved populations receiving community-based services, the number of uninsured Delawareans linked to services, and access to a helpline for health and human service resources. One example is the *Healthy Delawareans Today and Tomorrow* initiative, supported by AstraZeneca, which has “provided healthcare resources to more than 200,000 Delawareans since the program began in 2007.”⁴⁸
- *The Healthy Sussex Worksite Wellness* program assists local businesses in promoting employee health and wellness by offering free or discounted healthy activities to more than 50 members from four partner agencies.⁴⁹
- *Promoting Healthy Activities Together (PHAT)* teaches adolescents the importance of healthy eating and physical activity over an eight week program.
- *South Wilmington Planning Network (SWPN)* brings approximately 40 agencies together to promote health in Southbridge.

⁴⁷ Christiana Care News, <news.christianacare.org/2012/03/1138>.

⁴⁸ United Way of Delaware's website, <www.uwde.org/health.php>.

⁴⁹ Sussex County Health Promotion Coalition website <www.healthysussex.org>.



The State also has committed to health, most recently through the efforts of the Governor's Council on Health Promotion and Disease Prevention (CHPDP). The CHPDP was created in May 2010 "to advise the Governor and Executive Branch state agencies on the development and coordination of strategies, policies, programs and other actions statewide to promote healthy lifestyles and prevent chronic and lifestyle-related disease."⁵⁰ The Council identified and assessed a number of needs in Delaware (e.g., high tobacco use and excessive alcohol, lack of exercise, poor diet, high obesity, high prevalence of diabetes and cardiovascular disease), generating in December 2011 a set of 120 unique ideas for improving health and preventing illness. The resulting recommendations were framed into a structure comprising five areas⁵¹:

- ***Implementation of recommendations***, including establishing committees, monitoring progress, funding implementation, and assigning specific roles and accountabilities.
- ***Create a more responsive health care system***, including measurably improving the accessibility and promotion of integrated primary and preventive care, standardizing and supporting evidence-based practice, establishing universal use of electronic health records, and establishing and supporting health care workforce recruitment and retention strategy.
- ***Implement policies and programs that support and improve health***, including developing policy and funding that supports healthy communities, incentivizing businesses to provide a workplace that encourages healthy living, and evaluating effective program outcomes.
- ***Create a healthy and supportive environment***, including accessible exercise/physical activity and healthy eating programs, improving the physical environment (e.g., public transportation), and ensuring children in schools have access to affordable and healthy foods and beverages.
- ***Build capacity for individual health***, including campaigns to promote healthy lifestyles, engaging community-based organizations (e.g., schools, workplaces, health care, faith-based organizations), and improving health literacy.

⁵⁰ Delaware Council on Health Promotion and Disease Prevention (CHPDP) website.
<<http://dhss.delaware.gov/dhss/dph/dpc/chpdp.html>>

⁵¹ "Building a healthier future: recommendations of the Delaware Council on Health Promotion and Disease Prevention, January 2012. <
http://dhss.delaware.gov/dhss/dph/dpc/files/chpdp_recommendations_2011_final.pdf>



The CHPDP recognized seven Delaware municipalities in June 2013 for implementing policy and program initiatives that bring together community-wide resources to encourage health in their community.

Barriers

Despite these ongoing efforts, however, Delawareans remain unhealthy and the state remains far from its goal of being among the five healthiest states in the nation. Several barriers limit the effect of the population health initiatives underway across Delaware, including:

- Existing resources are **spread too thinly**.
- There is a **lack of connection and leadership** across health care initiatives, with mostly volunteer leadership in the organizations and coalitions.
- There is **limited awareness** of available resources and potential return on investment benefits, including time horizon – while health and wellness typically take years, case examples in Delaware suggest it can be done faster.
- Many Delawareans remain **uninsured** or underinsured (e.g., dental care for adults).
- The health care payment model does not incentivize integration of the delivery system with community organizations focused on health promotion.

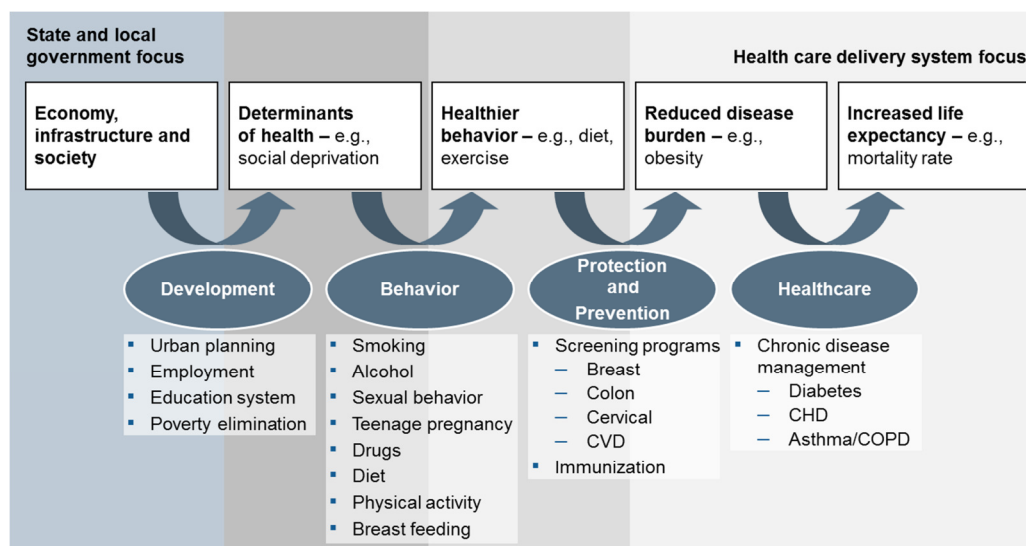
These barriers not only affect Delaware's population health statistics, but also represent lost opportunities for prevention.

4.5.2 Options considered

Seeking to address these barriers and build on existing population health efforts, Delaware first evaluated where in the spectrum of population health interventions to focus. **Exhibit 34** below describes the potential areas of focus considered.



EXHIBIT 34: POTENTIAL POPULATION HEALTH INTERVENTIONS



Delaware considered how to balance breadth versus depth in reviewing potential approaches to drive population health improvements (e.g., broad educational campaign versus specific focus on access to care). The options varied in potential for impact and time to impact (e.g., determinants of health take longer to address than prevention and screening), and the gaps in current programs against each of these potential options. For example, Delaware already has many programs focused on specific population needs and conditions.

Delaware reviewed potential frameworks for integrating population-based approaches to health promotion with the delivery system. Delaware considered options for how to organize communities (e.g., by county or smaller neighborhoods, by hospital catchment) and for how communities can integrate with the care delivery system (e.g., common scorecards, shared resources). Delaware also considered whether to implement the initiative statewide or begin with a pilot programs focused on specific areas with the greatest need.

Throughout these discussions, Delaware referred to a number of case examples as potential models for how to improve health through integrating efforts of community organizations with each other and with the care delivery system. Within Delaware, example initiatives include:

- Organizing transportation for patients who were previously unable to attend medical appointments (e.g., CHAP).
- Helping people who were homeless or suffered mental illness or addictions (e.g., West Center City).



- Community efforts to convert a plant into a place for community members to walk and bicycle (e.g., in Seaford).
- Federally Qualified Health Centers (e.g., Henrietta Johnson Medical Center, La Red Health Center, Westside Family Healthcare).

Outside the state, additional models for addressing these design options include:

- Initially focusing on a specific area (e.g., diabetes or obesity) through a broad-based community wide coalition encompassing medical care systems, grassroots community stakeholders, and community organizations (e.g., Akron's Accountable Care Communities).
- A governing partnership among providers, community members and those taking financial risk, partnering with a network of local Patient-Centered Primary Care Homes (PCPCH) that receive payment incentives for keeping patients healthy (e.g., Oregon's Community Care Organizations).
- Designated areas based on a community's specific needs that have a community team and partner with the care delivery system and existing services (e.g., Vermont's Health Service Areas).

All of these examples share the common principal of bringing otherwise unconnected individuals and organizations together.

4.5.3 Plan for population health

4.5.3.1 Focus

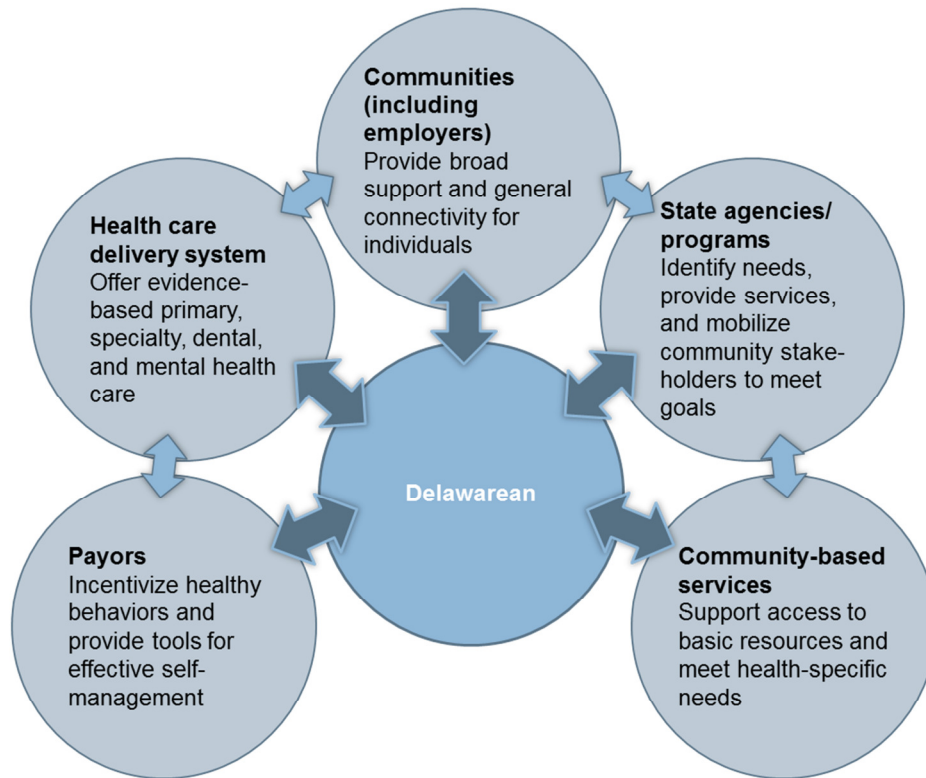
Delaware plans to further its commitment to population health by extending the work of the Governor's Council and focusing on two pressing needs:

1. Ensuring seamless integration and coordination of the Delivery System model with the broader community, and with non-health care providers and organizations. **Exhibit 35** describes the interdependencies from the perspective of an individual Delawarean.
2. Ensuring that all Delawareans understand the importance of primary and preventive care, and how to access and navigate the care, community and public health systems.

These needs are highly interrelated, and Delaware will address them both through a strategy aimed at integrating population health efforts. Combined with the patient engagement strategy, this focus on integration will position Delaware to make meaningful progress toward being one of the five healthiest states in the nation.



EXHIBIT 35: INTEGRATION AS A PRIORITY FOR POPULATION HEALTH



Delaware ultimately prioritized integration because while it has so much ongoing work in specific areas (e.g., healthy eating, reducing obesity), it generally lacks a framework to connect community efforts with each other and the delivery system. In order to create a sustainable model to improve population health, Delaware's plan must prioritize an approach that meaningfully improves coordination and integration across community organizations, the medical care delivery system, and the services and work led by the Division of Public Health.

4.5.3.2 How integration will be achieved

Delaware's payment model will facilitate significant innovation in aligning the delivery system with community efforts to promote health, wellness, and prevention. Furthermore, Delaware will foster the development of "healthy neighborhoods" throughout the state to promote primary and preventive care. These Healthy Neighborhoods will foster integration through

- **Fostering transparency:** Developing a **database of community resources** for both providers and patients to access and reference. Each healthy

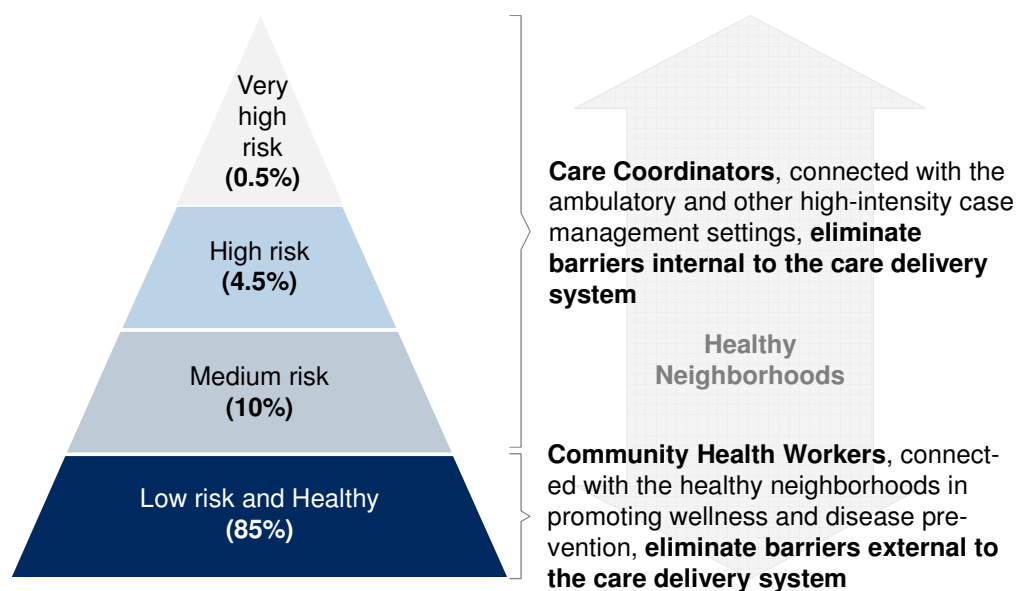


neighborhood will be responsible for maintaining a tailored database of resources based on the health needs and social makeup of its members.

- ***Creating a mechanism that brings leaders together:*** Creating a governance structure that serves as a **forum for bringing together leaders** from both local community organizations (e.g., schools, non-profits, employers, public health, social workers, community health workers (CHWs)) and medical providers (e.g., PCPs) to discuss health themes unique to the neighborhood, including community awareness, assistance and prevention.
- ***Setting common goals:*** Developing **common goals and a shared, tailored action plan** for addressing each community's most pressing health needs. This ensures that community efforts are coordinated with care delivery and public health efforts, presenting a unified community message and enabling collaboration with organizations such as charitable 501(c)(3) hospitals, which must regularly update implementation strategies based on their IRS-required community health needs assessments (CHNA).
- ***Building a cross-trained and aligned workforce:*** Identifying a dedicated team to address the action plan, ensuring the neighborhood's workforce (e.g., community health workers) is appropriately **cross-trained, coordinated** across the population risk pyramid (**Exhibit 36**), **and aligned with the unifying neighborhood goals**. CHWs will not only help to populate the resource database, but also serve as a liaison among providers and community organizations, for example, addressing how to use the care delivery system, identifying resources available for patients, educating community members, and connecting neighbors with appropriate care services.



EXHIBIT 36: HEALTHY NEIGHBORHOODS INTEGRATE ACROSS CARE COORDINATION



4.5.3.3 Healthy neighborhood characteristics

A healthy neighborhood will have the following characteristics:

- Communities organize into “neighborhoods” of 50,000-100,000 and align with at least one multi-professional health care facility (e.g., health system, FQHC).⁵²
- Organizations within the community form a **Healthy Neighborhood Council**, which will meet quarterly and take responsibility for reviewing data on outcomes and needs, and developing an annual **health action plan**.
- The **composition of the Healthy Neighborhood Council reflects the community’s specific needs**, including CHWs, care coordinators, and medical providers as members, as well as possibly including members such as the local school district health person, public health member, social workers, behavioral health specialists, pharmacists, and nurses.
- The healthy neighborhood program will fund a **Community Champion** – a dedicated full time staff member who will be responsible for organizing and regularly convening the Healthy Neighborhood Council (e.g., a local workgroup).

⁵² A multi-professional health care facility can serve multiple healthy neighborhoods.



- Participating organizations should be prepared to commit a portion of time from their own resources (e.g., existing Community Health Workers) to form a healthy neighborhood team, tasked with implementing the health action plan. Community Health Workers will serve on the ground as “integrators”.
- Neighborhoods will have **accountability for performance** in delivering on their health action plan and progress against overall state goals for health. If in initial periods neighborhoods do not meet these goals, technical assistance will be provided. Performance will be published in the community and statewide.

Delaware’s Division of Public Health (DPH) will provide the following support to each healthy neighborhood:

- **Data:** inventorying of health services in each neighborhood, and defining the State’s needs
- **Scorecards:** populating scorecards for each neighborhood with progress against health goals
- **Technical assistance:** offering technical assistance and help to build the neighborhood design
- **Resources:** dedicated part time to each healthy neighborhood team

DPH will work with Community Champions in these neighborhoods to develop a resource network that integrates health care services with public health and community services. The population health committee of the Delaware Center for Health Innovation will have responsibility for leading the healthy neighborhood program across Delaware. In addition to its central role in providing technical expertise and data (at the state level and for each neighborhood), the Division of Public Health will serve on the population health committee.

4.5.4 Approach to rollout

As the care delivery system evolves throughout the state, Delaware will phase in these healthy neighborhoods through an application process that ensures community readiness. Prospective healthy neighborhoods will be asked to submit an application to the Delaware Center for Health Innovation. This application process will be available to all geographic areas in Delaware and will specify criteria that must be met for a community to be designated a healthy neighborhood. As a result, Delaware’s healthy neighborhoods will likely roll out across the state in three phases:



- **Phase 1:** As communities form their Healthy Neighborhood Councils and prepare to mobilize their Community Health Workers, a growing number of communities over time will apply for and become designated healthy neighborhoods. Social marketing efforts will focus on select communities based on social/health indicators and/or community readiness.
- **Phase 2:** Community coalition efforts will intensify focus on prioritized determinants of health, including the potential formation of accountable care communities where the delivery system and healthy neighborhoods are more formally linked.
- **Phase 3:** All Delaware geographic communities will be part of either a healthy neighborhood or an accountable care organization/community.

Over the next 12 months, the DPH will begin establishing data and infrastructure capabilities and building a baseline dataset. During the next six to nine months, the DPH will also begin the inventory process to determine Delaware's health services and define the state's needs. Over the remaining three to six months, the DPH will work with the Delaware Center for Health Innovation, clinical and community leaders, and consumers to identify a set of statewide goals for health and wellness that will become common aspirations across all neighborhoods, creating the common scorecard. This scorecard will remain flexible enough that the approach for addressing these aspirations can still be tailored to the needs and resources of each neighborhood.

Many of the necessary resources already exist in Delaware to promote health and wellness. The Division of Public Health will dedicate staff support to each healthy neighborhood to provide input, technical assistance such as team programs (e.g., cancer, neonatal), and data for measurements on a quarterly basis. The prospective neighborhood's multi-professional health care facility(ies) and other organizations will make in-kind contributions through commitment of full or part time resources.

In the initial phases of detailed design and preparing to implement the approach to population health, Delaware will continue to build on the existing understanding of patient and consumer behavior and will work with employers, community organizations, and other groups to promote better health.



4.6 WORKFORCE

Delaware's aspiration is to become a "Learning State," creating and actively supporting a culture of interdisciplinary training and retraining. Education experiences will be accessible, coordinated, relevant and more exciting than ever before and Delaware will be a national leader in developing a health care workforce that is on the cutting edge of innovation. Delaware envisions a future in which the highest quality health care, the best health outcomes and lower health care costs are achieved by patient-centered, multi-disciplinary teams delivering integrated and comprehensive care. Achieving this vision will depend on all of the health professions working in coordination and therefore involves retraining the current workforce and new training programs for the future workforce. Communication, critical thinking, and analytical skills, along with facility in the use of health information technology will be necessary to deliver and continuously evaluate care delivery systems including the effectiveness and efficiency of care teams.

The future health care workforce in Delaware will be broader, more diverse, and more geographically distributed to meet the needs of Delaware's diverse populations, to respond to the expansion of access to health care coverage and to support a heightened focus on prevention and wellness. Delaware's future healthcare workforce will be more empowered, better integrated, and more nimble than today. New and more clearly defined career trajectories will complement the learning environment to attract and retain the most committed and highest quality employees into Delaware's health care community.

Delaware will build on the existing work of the academic institutions, the individual health systems, the Medical Society of Delaware, the Delaware Academy of Medicine, the Delaware Health Care Commission (DHCC), the Delaware Health Science Alliance (DHSA), and others to broaden the culture of learning and become a true "learning state." Emerging innovative approaches to undergraduate and graduate health professional training in primary care and behavioral health will serve as a reminder that change and innovation are already integral elements of Delaware's health care workforce landscape.

Consistent with Delaware's approach to health care delivery system, payment transformation and population-based approaches to health promotion, workforce transformation is designed to foster and reward innovation and results rather than to prescribe, mandate or elevate one approach over another. Because the composition of health care delivery teams will vary to meet the specific needs of



patients, Delaware's transformed workforce will include a broad range of professional, para-professional and lay health care workers. These members of the health care team will function as collaborative, interdependent members of health care teams that move beyond treating patients to truly including patients, families and communities in all aspects of health and health care. This vision will contribute to a sustainable workforce that will empower multi-disciplinary, coordinated care for all Delawareans and, ultimately, better health and will position Delaware as a national leader in health care workforce development and innovation.

4.6.1 Context

Current situation

In many respects, Delaware has a strong health care workforce and supporting infrastructure. Innovation in health care workforce training and education continues across the state:

- The DHSA is pioneering cross-disciplinary training programs, including bridging programs offered by the University of Delaware, Thomas Jefferson University, Christiana Care Health Systems, and Nemours.
- Novel training programs, such as the University of Delaware's simulation training (e.g., postpartum hemorrhage training scenario for student nurses at the Maternal Health Simulation Lab) and the Healthcare Theatre, have been successfully implemented. For the Healthcare Theatre, theatre students are trained to portray patients and family members in unscripted but directed scenarios that give health care students across specialties the opportunity to practice working together and interacting with patients. Feedback is then provided to these students by experts in communication and in health care.
- Delaware's Medical Reserve Corps, initially created to respond to emergencies and disasters, includes hundreds of licensed medical professionals and is a potential resource in support of Healthy Neighborhoods and other SIM initiatives.
- Delaware Health Care Commission's State Loan Repayment program (with support from state and federal funds) has led to a 400% increase in recruitment and placement of primary care, mental health, and dental professionals, expanding access to care for 25,000 additional Delawareans.



- The Medical Society of Delaware (MSD) has an affiliate agreement with HealthTeamWorks for the training, mentorship and tools to deliver local practice transformation.
- The Delaware Academy of Medicine offers a broad range of information and educational services for Delawareans, including health libraries across the state.
- Project ECHO is a weekly telemedicine/telehealth conference that joins primary care providers (PCPs) with multidisciplinary teams of specialists to improve the management of patients with certain complex conditions. The multidisciplinary team can include: Psychiatry, Infectious Diseases, Addiction Specialist, Pharmacist, Patient Educator, etc. This program does not include direct patient care. Project ECHO training topics include, but are not limited to: Pain Management, Hepatitis C, Medication Assisted Treatment (Buprenorphine), etc. The current focus of Delaware's Project ECHO Program is on testing the effectiveness of the Pain Management program in a Federally Qualified Health Center, Westside Family Healthcare and the University of Delaware's Nurse Managed Community Health Center. On average, 40% of a FQHC's physician's patient panel consists of persons with chronic pain conditions. According to surveys, most PCPs have expressed low confidence in their ability to effectively manage pain. Delaware selected this initial focus because treating pain among the underserved is particularly challenging.
- As a learning organization, Christiana Care created the Learning Institute with eight Centers.
 - 1. Transforming Leadership
 - 2. Innovation, Instructional Design and Technology
 - 3. Diversity & Inclusion, Cultural Competency & Equity
 - 4. Simulation Training
 - 5. Patient & Family Education
 - 6. Interprofessional Collaboration
 - 7. Employee and Career Development
 - 8. Educator Development, Evaluation and Research

Christiana's is a "virtual institute" created to foster collaboration and innovative learning, nurturing new ways of thinking and encouraging growth and development outside of traditional departmental lines. Each center has a



different leader and overall leadership of the Institute falls under Rosa Colon-Kolacko, PhD, Sr VP System Learning.

- Delaware's successful peer counseling programs in areas such as substance abuse/behavioral health and breastfeeding/maternal and child health are innovative and effective tools to engage hard-to-reach populations, improve health and health care and develop employment opportunities for at-risk populations.

Despite the overall strengths of the workforce and the training systems across the state, existing needs remain. Delaware's workforce appears strong at the state level, as shown in **Exhibit 37**, but the state's workforce has pressing needs in several specialties, including primary care, mental health, and dental, and in particular geographies, such as parts of central and southern Delaware.

EXHIBIT 37: OVERVIEW OF DELAWARE'S WORKFORCE

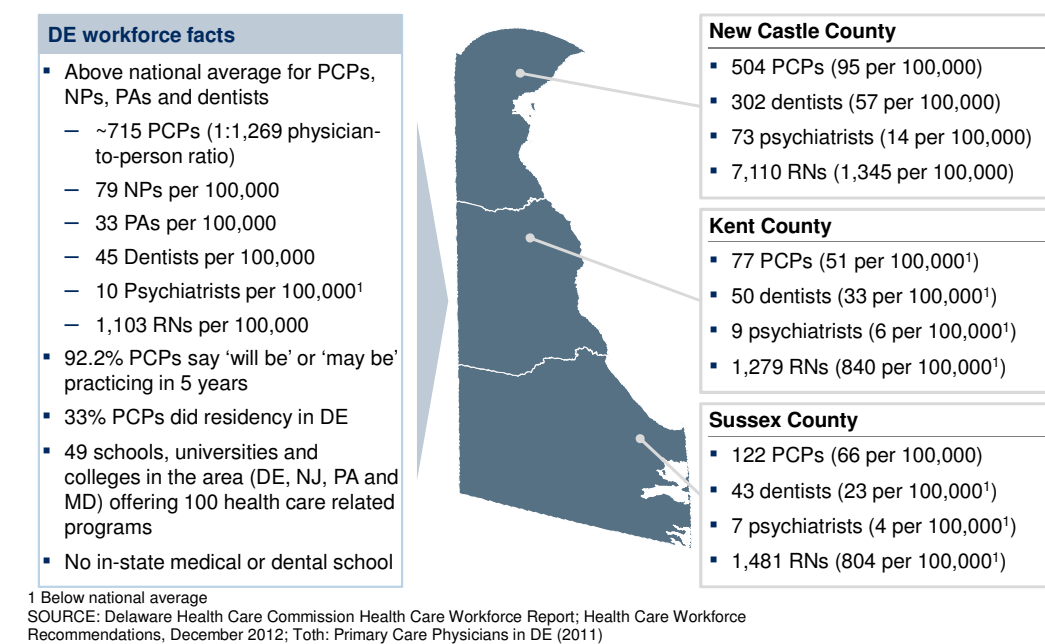
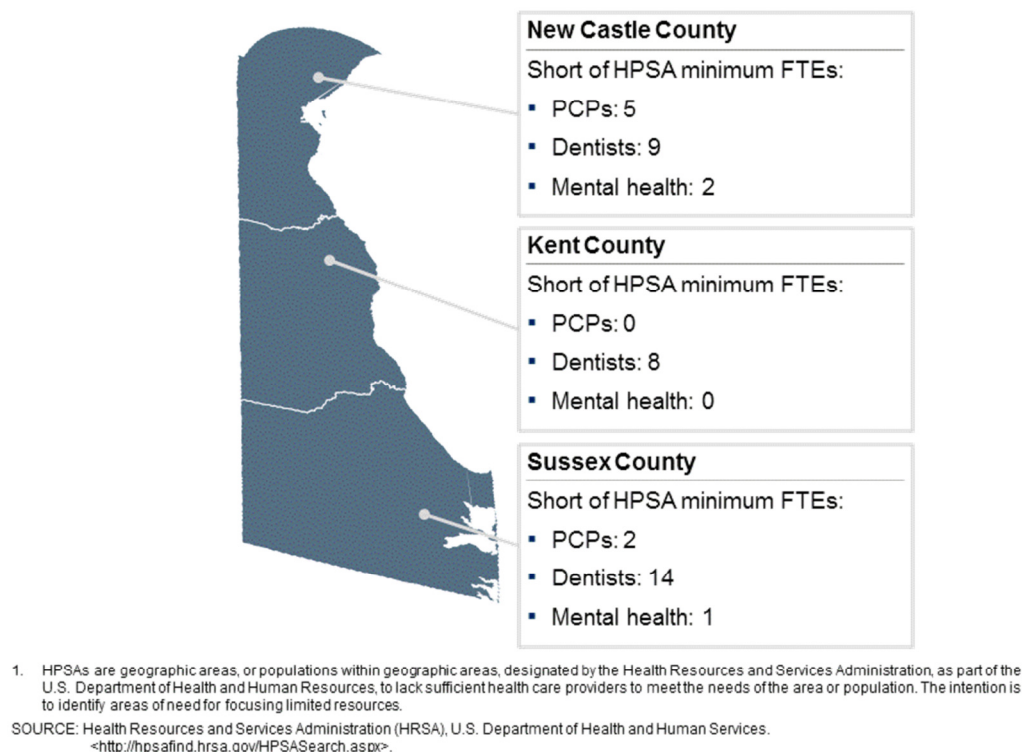


Exhibit 38 shows that Delaware falls below HPSA (Health Professional Shortage Areas) designation criteria for primary care providers, dentists, and mental health specialists in some of its counties.



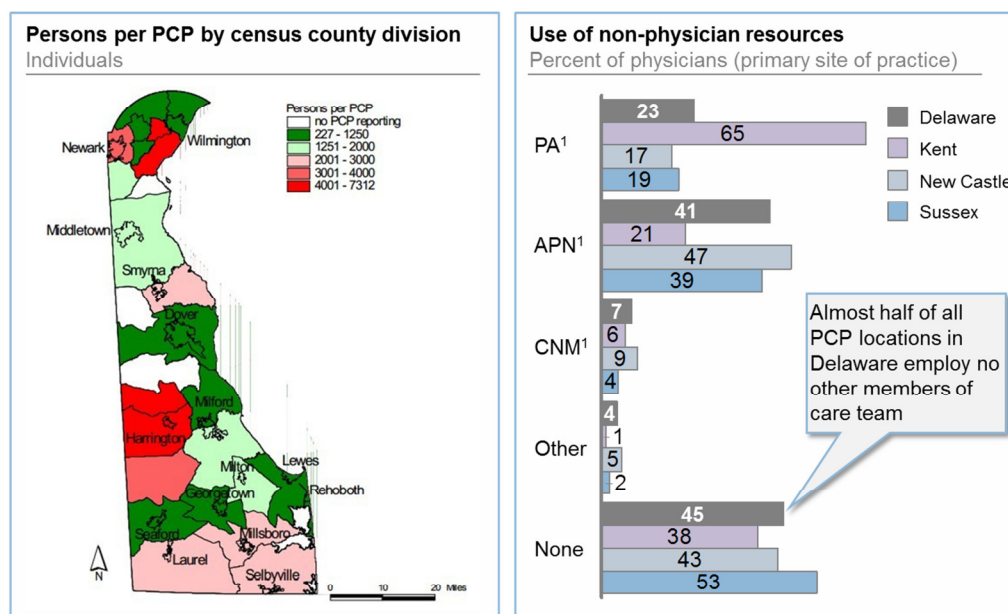
EXHIBIT 38: HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA)



There is also significant variation in involvement of non-physicians within care teams across physician offices: nearly half of all primary care practice locations in Delaware employ no other members of the care team (**Exhibit 39**), suggesting small, fragmented practice sites.



EXHIBIT 39: DELAWARE'S PRIMARY CARE PROVIDERS



1. Abbreviations represent the physician's assistant (PA), advanced practice nurse (APN), and certified nurse midwife (CNM).
SOURCE: Toth, Primary Care Physicians in Delaware, University of Delaware, 2011

Delaware Health Care Commission (DHCC) workforce recommendations

In its 2012 workforce initiative, the DHCC identified specific existing needs for the state. Those needs broadly fall into the following overall objectives:

- Fully implement the Institute of Medicine's recommendation to build an infrastructure for the collection and analysis of professional health care workforce data
- Support and continue to expand Delaware's health information technology infrastructure
- Support state-of-the-art health care workforce education and training programs
- Ensure a supportive regulatory and policy environment for health care professionals
- Ensure integrated and supportive practice environments for health care professionals
- Create and implement a comprehensive health care workforce recruitment strategy

Delaware's plan for health transformation identifies important needs for additional care coordinators, skills and capabilities to practice in multi-



disciplinary care teams, and a broader health care informatics and health IT workforce. The health system transformation plans also highlight a pressing need to more effectively channel the community workforce towards better population health.

Barriers

To implement such workforce changes, Delaware must successfully remove remaining barriers to closing existing gaps and moving towards the workforce required as part of the health system transformation. These barriers include the following:

- **Limited coordination** across training programs and institutions. Although some progress has been made through the efforts of the Graduate Medical Education Consortium and the Delaware Health Science Alliance, there is an opportunity to further strengthen this coordination.
- Workforce efforts remain **generally focused on traditional approaches through traditional channels**. For example, there remains limited use of retired providers or recruitment of health care workforce outside of health care.
- **Unclear roles and definitions** make it difficult to communicate about the health care workforce, result in duplication of efforts in some cases, limit the ability to understand current capacity, and obscure the ability to identify opportunities to redistribute the workforce to align effectively with the emerging requirements for care delivery, population health, and analytics. This is particularly true for, but not limited to, care coordination, where there is little uniformity around the definition and roles for care coordinators, health navigators, health ambassadors, health coaches, community health workers, and other individuals who support more coordinated care.
- **Lack of a compelling and clear career trajectory** makes it more difficult to recruit and retain health care workers and limits workforce innovation.
- Prevalence of individual funding for their own training **limits access to training and retraining programs**.
- Many individuals **do not practice at the top of their license**. This results in a more expensive and less empowered workforce.
- **Licensing and credentialing** processes remain cumbersome and hamper recruitment efforts.



4.6.2 Options considered

Given its evolving health care system, Delaware's requirements for workforce include the following:

- *Care coordinators* must be able to work in various settings (e.g., PCP office, shared across PCPs, hospital, behavioral health specialist) and should be defined by their roles and skills, not by license or job titles. High level care coordinators are required for the top 5-15% highest risk of Delaware's population, but care coordination is also important for the healthy and lower risk population, with a focus on prevention and lowering risk of disease.
- *Multi-disciplinary teams* are critical for effective team-based care. The current clinical community is not trained to create or work efficiently and effectively in teams. There must be an awareness of the full team makeup and enhanced capacity in behavioral and dental health. Team composition and leadership will vary depending on care need and clinical setting, but will involve a broad set of professionals in most cases.
- *Community health workers* will play an important role as Healthy Neighborhoods connect with the health care delivery system. A unified approach to establishing training requirements, qualifications, job duties and accountability will be a critical element for success.
- *Skills and capabilities are required to support more effective diagnosis and treatment*, which must be supported by relevant training and retraining to reduce unwarranted variation in care for priority areas and support practice at the top of license and training.

Delaware considered the following options for addressing workforce requirements:

- **Education:** Changes in existing and development of new curricula to embed required skills and capabilities and to ensure that future absolute numbers of trained workers meet strategic needs across all necessary roles
- **Attraction / recruiting:** Increasing supply of targeted clinicians
- **Retraining:** Changes to continuing professional development to embed new skills / behaviors
- **Regulation:** Changes in licensing and certifications to enable workforce shifts
- **Incentives:** Addressing both attraction and changes in professional behavior



- **Productivity:** Improving clinician productivity to address workforce gaps
- **Service reconfiguration:** Using service reconfiguration opportunities to introduce workforce models that will deliver higher-quality, more efficient services

4.6.3 Plan for workforce

Delaware's plan provides initial clarity on care coordination roles and distribution across care needs, identifies likely care coordination needs, and defines a set of specific strategies to address the barriers to workforce training and development.

In order to achieve better patient outcomes, Delaware expects that care coordination will operate across all levels of the system – in the community, in the PCP's office, hospitals and treatment centers, and care facilities – as depicted in **Exhibit 40**. Care coordinators will require different levels of training depending on the risk stratification of the patient and the setting in which they are providing care – in the community versus in a health care setting. Care coordination could involve community ambassadors, care coordinators, health coaches, nurse navigators, and many other roles.

EXHIBIT 40: DELAWARE'S SUSTAINABLE MODEL FOR A FLEXIBLE WORKFORCE

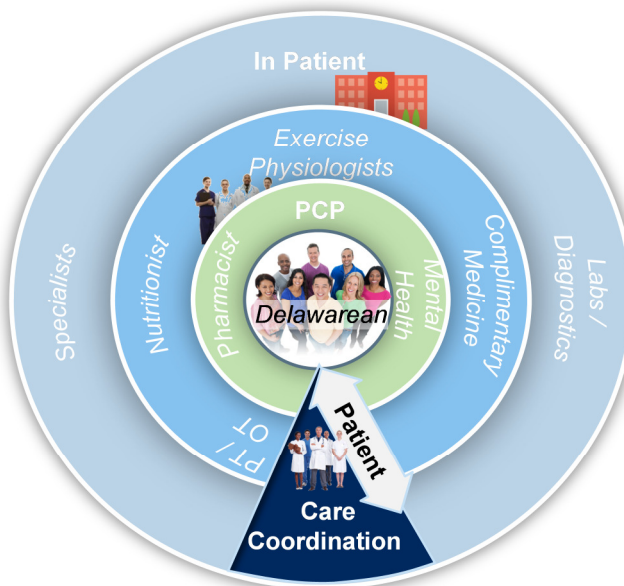
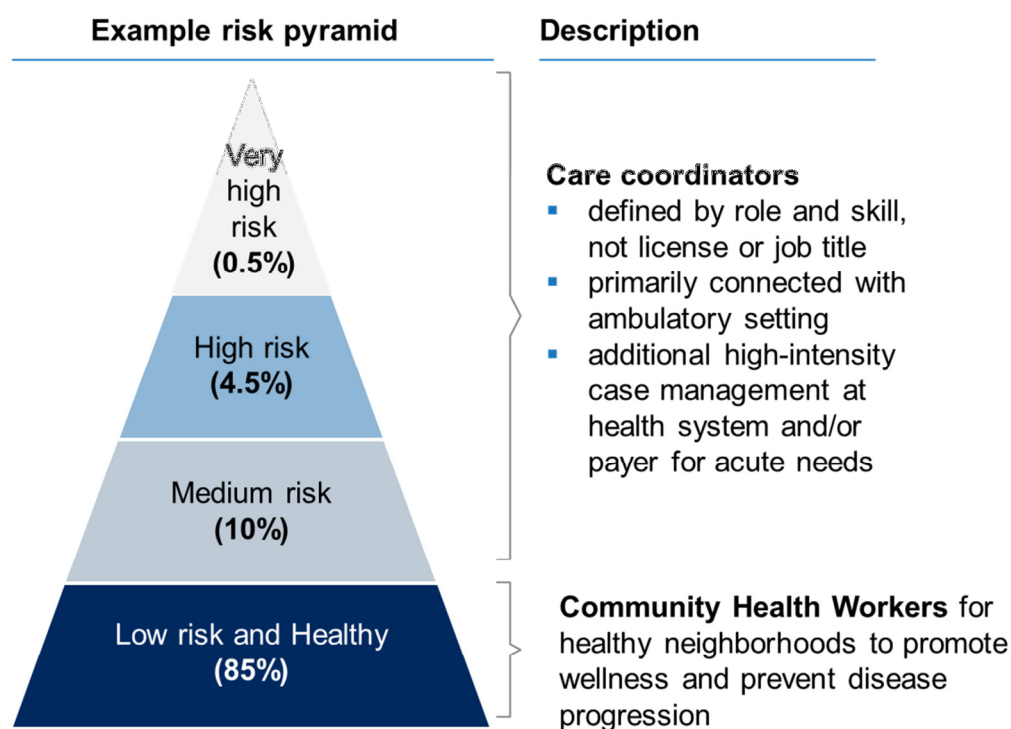


EXHIBIT 41: ILLUSTRATIVE ROLES FOR CARE COORDINATORS AND COMMUNITY HEALTH WORKERS



Care coordinators are individuals who enable team-based care by coordinating among providers, community leaders, and families to support patients in engaging in their own health. Critically, care coordinators should be defined by role and skill (not license or job title) and at a minimum need to be able to help navigate care for high risk patients, work effectively in care teams, and motivate behavior change. Some requirements may vary for adults versus children and for specialized populations. Health coaches, nurse navigators, and others will work as care coordinators with these patients in the top 15% of the risk stratification to ensure coordination of care and compliance with treatment plans. It is estimated that Delaware may require as many as 500 care coordinators, over time, to ensure effective coordination of care for these high risk adults and elderly, as well as high risk children. Some of these resources are already present in our health care community.

Community health workers, by contrast, are individuals whose role is to support the healthy neighborhoods by connecting individuals to health resources and the delivery system, promoting wellness and preventing disease progression. Health coaches, health ambassadors, and others will work as community health workers



to help keep the at-risk adults and elderly population from moving up in the risk stratification.

To achieve its workforce vision, Delaware has developed the following specific strategies:

1. ***Align on common definitions and roles***, particularly for care coordination, as well as a common career ladder. As the care delivery system changes, it will become increasingly important to have alignment on common roles, enabling better collaboration as well as the collection of data to show the role's effectiveness in patient care.
2. ***Create a semi-annual forum***: Create a semi-annual forum for all health care related workforce training and retraining institutions and programs to coordinate and align on high priority themes (e.g., through DHSA and other state organizations) and ensure a common set of innovative learning goals shared by each academic institution and provider. These themes may include advanced and mid-level (e.g., physician assistants, dental hygienists) practice providers, retooling mid-and senior-level managers, and health IT and informatics training.
3. ***Survey / inventory workforce infrastructure***: Survey and inventory existing workforce infrastructure. Delaware likely needs to attract and develop more dentists, pediatricians, and mental health workers, as well as primary care practitioners in high need areas. The State intends to also recruit and develop more professionals in information technology (IT) and analytics to be empowered in effectively utilizing the analytics on patient outcomes and with electronic medical records (EMRs). For effectively addressing workforce needs, the State needs to better understand its existing workforce. For example, Delaware has approximately 180 community health workers, which compares favorably to the national average (per 100,000 population), but additional detail is required to determine the precise nature and extent of need for additional community health workers. While Delaware's Department of Health has completed a preliminary survey of the workforce, a more detailed survey and inventory is needed.
4. ***Assess retraining of people from other sectors***: Assess opportunities to retrain people from other sectors. Delaware's workforce will be unique, not only utilizing individuals across the whole health care system, but also offering to retrain workers who have gained key skills from industries outside of health care (e.g., customer service people in the financial service sector).



5. ***Extend GME work beyond physician education:*** Establish a “***Delaware Health Professions Consortium***” to provide a multi-stakeholder mechanism for planning, implementing, and monitoring health professions workforce development. The Consortium will be organizationally connected to other system transformation through the governance structure for Delaware’s SIM initiatives. It will provide a centralized framework for leadership, innovation, program development, and the continuous incubation of new and/or enhanced program development whether those programs are centrally administered or led by an individual organization from within the Consortium. ***Specifically, for programs that the Consortium itself designs and implements*** (in contrast to programs created by one of the Consortium’s members), the Consortium will complete the following core functions:

- Centralized Administration
- Accreditation by the indicated accrediting body; e.g. the ACGME/AOA
- Faculty Development
- Fund Solicitation/Management

The Consortium will incubate the development of a variety of health professions training programs, all needed to supply the diverse levels and types of health providers required in the emerging new healthcare system. The Consortium’s first critical building block will be medical education programs, specifically primary care (family medicine). New and/or enhanced residency programs are required to increase the primary care workforce in Delaware. Through innovative design they will provide interdisciplinary and community-based training opportunities in diverse settings and regions throughout Delaware. Current GME programs may additionally be enhanced to include special tracks in new geographic areas of the state and/or new community health/special population experiences. The availability of new experiences within current programs is expected to stimulate broad interest among existing resident physicians who will generate communication within their peer networks that will cultivate interest and fill slots in any **new** residency program.

The Consortium will foster the development of innovative primary care teaching programs that provide interdisciplinary training opportunities, support the principles of “team-based” care, and foster new service delivery models such as:

- Patient-Centered Care
- Mental/Behavioral Health Service Integration



- Integrated Use of Health Information Technology (for clinical care and distance learning)

Finally, the Consortium will provide leadership to the creation of process and policy to develop a formal pipeline of aligned requirements and incentives for individuals who are pursuing a primary care medical career, completing training in Delaware, and ultimately practicing in Delaware.

6. ***Map out an education plan (high school to graduate level):*** Bring hospitals and academic institutions across the state together to map out an education plan that includes high school students through graduate students. Delaware not only expects increased educational innovations, such as additional health care theatres and simulation labs, but also seeks to enable workers to truly practice at the top of their license, beginning at the foundation, education. To accomplish this, training / re-training modules at Delaware's institutions must ensure a sustainable pipeline of workforce members.
7. ***Develop top-of-license guidelines:*** Develop guidelines that empower individuals to practice at the top of their license and relinquish some lower end responsibilities to others on the team. Additionally, work with the policy group to streamline and simplify licensure and credentialing requirements.
8. ***Connect efforts with patient engagement:*** Connect workforce efforts with a patient engagement strategy for individual and family education. Delawareans – the patients and their families – will be engaged by the coordinated workforce to help them better understand how to make healthy choices; to teach them the essentials of nutrition, exercise, and mental health; and to familiarize them with helpful resources available in their neighborhoods.
9. ***Connect with Learning Collaboratives:*** Connect with learning collaboratives that will support practices in delivering more coordinated, team-based care to integrate the workforce strategy with the delivery system transformation. These collaboratives may leverage existing learning communities, such as the Magnet Learning Communities under the American Nurses Credentialing Center (ANCC) Magnet Recognition Program.
10. ***Create awareness of existing opportunities:*** Generate awareness of existing opportunities and promote the efficient redistribution of Delaware's existing workforce to fulfill needed roles in various regions. While the number of existing roles related to care coordination (including case managers, navigators, health coaches, health ambassadors, and community health workers) in Delaware is not fully known, the state has a potential surplus of



some health care roles, such as Licensed Practical Nurses (LPNs). Targeted marketing could be done regarding an opportunity for LPNs to retrain and serve as care coordinators, assuming there are ample LPNs and a shortage of care coordinators.

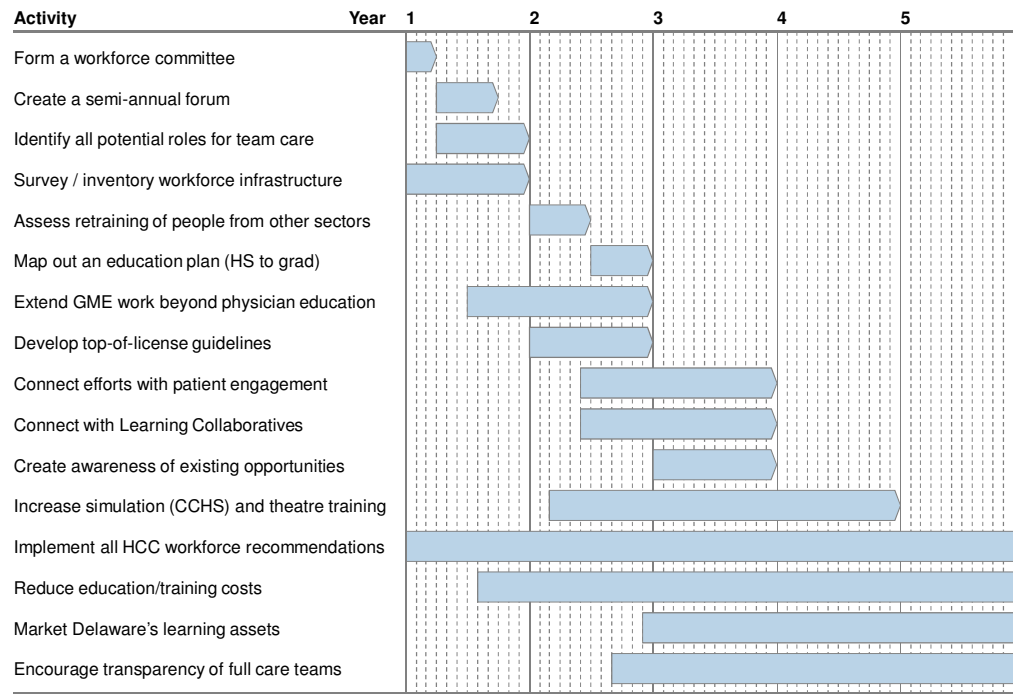
11. ***Increase simulation education, theatre and hybrid training modules:*** In addition to increasing the utilization of Delaware's simulation expertise (CCHS) and Healthcare Theatre as tools to advance education across priority areas, Delaware can leverage in-state expertise to offer additional hybrid training courses. For example, Delaware can build off of hybrid models currently offered at the University of Massachusetts and Farleigh Dickinson to train existing mental health providers in Delaware to work in primary care.
12. ***Fully implement all HCC workforce recommendations:*** Delaware strives to implement the Delaware Health Care Commission workforce recommendations that were identified by the 2012 workforce initiative.
13. ***Reduce education/training costs:*** Invest in reducing costs of education through targeted funding and request to health care training programs to reduce costs. The State will examine options to make online and hybrid courses more available to current employees in the workforce to make it easier for them to advance in the workforce. It will also look to extend and build upon the Delaware Health Care Commissions' State Loan Repayment program.
14. ***Market Delaware's learning assets:*** Market Delaware's learning assets through multiple channels, including universities, career fairs, high schools and colleges. These marketing efforts will be targeted and tailored to fulfill workforce needs.
15. ***Encourage transparency:*** Continue to push for transparency, potentially leveraging the DHIN, for both patients and providers regarding their full care teams. For example, hospital discharge planners should always know whether a patient has a PCMH care coordinator.

4.6.4 Approach to rollout

Delaware has a unique opportunity, being a state without a medical school, to invest its health care dollars across the entire health care workforce to achieve its vision. The state expects the implementation of its strategies to generally follow the five-year approach depicted in **Exhibit 42**.



EXHIBIT 42: DELAWARE'S WORKFORCE STRATEGIC APPROACH



4.7 POLICY LEVERS

The State has a variety of tools at its disposal to enable and empower health care transformation—from information aggregation and purchasing to regulation and legislation. The design process has brought together a diverse group of policymakers, regulators, association leaders, payers, providers, and consumers to examine the role of the State in health care, identify policy requirements needed to support transformation, and take steps to build the foundation for successful implementation. Specifically, the design process included representatives from the Governor's office, legislative leaders, the Health Care Commission, the Department of Health and Social Services, the Department of State, the Department of Corrections, Division of Services for Aging and Adults with Physical Disabilities, Department of Insurance, and others. This approach to policy design increases the likelihood that Delaware can institutionalize the vision for transformation.



The primary intention of Delaware’s policy approach is to catalyze change by convening stakeholders for the benefit of all Delawareans. The Health Care Commission and the Department of Health and Social Services convened stakeholders throughout the design phase to develop this plan with broad, active input from individuals and organizations across the state. In addition, as a purchaser of Medicaid, State Employee health benefits, and through the Department of Corrections, the State will implement a set of payment models aligned with the outcomes-based approaches described earlier.

4.7.1 Context

There are over a dozen Delaware-specific offices or Boards that are involved in health care, representing a significant opportunity to enable change.

Several offices oversee policy or regulation related to health care, including the Health Care Commission (charged with setting policy to lead to basic, affordable health care for all Delawareans) and the Department of State (that oversees professional regulation). Other offices are involved in the direct provision of health care or related services (e.g., the Department of Health and Social Services) or the purchasing of services for a population within the state (e.g., the Department of Corrections). This purchasing role is particularly noteworthy, as the State purchases insurance for a significant part of its population through Medicaid, its State employees program, and the Department of Corrections.

These offices serve a variety of functions, including that of regulator, licensor, funder, and provider of services, and collectively represent the array of ways transformation can be supported by state government. **Exhibit 43** provides an overview of these bodies and the roles they play. It also highlights the primary levers the State expects to use to enable Delaware’s plan for health transformation.



EXHIBIT 43: PUBLIC AGENCIES AND ROLES IN HEALTH CARE

	Participation in SIM	Purchaser	Regulator	Licenser	Service provider	Public health role	Funder	Infrastructure support	Convener	Coordinator/info provider	Marketer
Governor's office	✓										
Governor's Council on Health Promotion and Disease Prevention	✓										
Attorney General's office											
DE General Assembly	✓										
DE Dept of Correction	✓										
DE Dept of Education											
DE Dept of Health and Social Services	✓										
DE Dept of Insurance	✓										
DE Dept of Natural Resources & Env. Control											
DE Dept of Technology & Information											
DE Office of Mgmt & Budget (Empl. Benefits) ¹	✓										
DE Children's Department											
DE Department of State (Prof'l Regulation, Gov't Info Center, Boards/Commissions)	✓										
DE Department of Transportation											
DE Health Care Commission	✓										
DE Health Information Network	✓										
DE Rural Health Initiative											
Health Fund Advisory Committee											
Health Resources Board	✓										
Interagency Resource Management Committee											
Workers Compensation Task Force											
Centers for Medicare and Medicaid Services	✓										
National Institutes of Health											

¹ Also includes a clearinghouse of federal grant information

Delaware has already utilized some of these levers to lay the groundwork for successful innovation:

- **Alignment with Delaware Health Resources Board's Health Resources Management Plan.** The State has delayed the development of the new Health Resources Management Plan by the Health Resources Board (responsible for Delaware's Certificate of Public Review program) to ensure it reflects the needs outlined in this plan.
- **Alignment with new Health Insurance Marketplace.** Information about this plan was included in the plan certification requirements for the health insurance marketplace.
- **Passage of legislation supportive of transformation.** Several pieces of legislation recently passed that complement various aspects of Delaware's vision, including, for example, enhancing access of dentists to practice in Federally Qualified Health Centers (FQHCs).
- **Medicaid coverage for services delivered via telehealth.** In 2012, Medicaid extended coverage for certain services delivered by telehealth,



demonstrating the State's commitment to transformation in payment, workforce, and delivery system.

4.7.2 Options considered

To bring about the transformation outlined in this proposal, a variety of needs have emerged for which policy or regulatory action could be helpful:

Shift to outcomes-based payment models. Delaware's ability to transition to more value-oriented care relies on aligning incentives across the health system. The State has an important role as a payer and has to identify the best approach to enable this change. In particular, Delaware evaluated the best approach to support this component of the transformation approach through its upcoming procurement for Medicaid Managed Care providers.

Expanding access, in particular in primary care, dental, and behavioral health. The SIM process has revealed significant needs in the health care provider base, specifically in primary care, dentistry, and behavioral health in certain areas of the state. Various levers are available to address these shortages, some policy-related and others not: changes to licensing requirements, changes to credentialing requirements, better communication among those involved with the process (e.g., to avoid duplication of credentialing steps among the State, payers, and providers), and better training for practitioners on how to effectively navigate the credentialing process.

Payment model innovation. The new models outlined in this State Health Care Innovation Plan are built upon payment model innovation. Although much of the innovation will be driven directly by payers (including the State-as-payer), additional policy action may further facilitate this innovation. Delaware will consider what, if any, further steps will be necessary or helpful to create a policy environment supportive of payer alignment, and of the kind of provider models outlined above.

Data and analytics enhancements to drive transformation. The DHIN is a core element of the health care landscape in Delaware, and one that will play a significant role in supporting the innovations outlined in this plan. In particular, the DHIN will be expanded to host technology-related services (e.g., risk stratification and care gaps shared services, the provider portal, the All Payer Claims Database) that will involve managing additional patient data. Making many such enhancements (e.g., involving patient data) and financing them will



likely need to be facilitated by policy and/or regulatory action. Options to address these needs include working within the DHIN's current governance structure to make enabling changes, or to take legislative steps to expand its authority to meet the needs that transformation requires.

Governance structure to facilitate transformation. A governance structure to support and enable improvements to the health system is similarly crucial. Such a structure is needed to carry out functions such as establishing protocols and guidelines to support effective diagnosis and treatment; developing shared services to support the transition to coordinated care; creating a common scorecard to track the progress of providers; developing an education and training strategy to build new skills and capabilities in the healthcare workforce; implementing the patient engagement strategy; and setting up the Healthy Neighborhoods program. There are many options for governance, varying based on the powers granted to such a structure, the length of time (e.g., temporary or permanent) it will exist, and the extent to which it is a public versus private organization.

Mapping resources. Helping citizens understand the health care resources available to them is another foundational need that emerged. Such work could be accomplished by citizens who organize in the private sector, an existing office within government (e.g., the Division of Public Health), or a new body created by transformation (e.g., the Healthy Neighborhoods program).

4.7.3 Plan for policy

Delaware intends to address each of the above areas in support of transformation:

Shift to outcomes-based payment. Delaware will use its purchasing authority to require the State's Medicaid Managed Care Organizations to implement payment models consistent with those described in this plan. Delaware Medicaid will establish a procurement process for managed care beginning in January 2014, with new contracts expected to be in place for the start of 2015.

Expand access, particularly in primary, dental, and behavioral health. To expand access, Delaware will explore a variety of steps to streamline the current process, including reducing duplicative background checks among payers, providers, and the Department of State, and leveraging the common CAQH credentialing application to simplify the process. The Health Care Commission has convened a workgroup – representing individuals from the Department of



State, the Department of Health and Social Services, payers, and providers – to address this issue.

Payment model innovation. While much of the innovation needed for payment model innovation will be driven by direct actions of payers (including the State-as-payer), additional policy steps likely will be useful to facilitate that innovation. The Health Care Commission will be working with the Deputy Attorney General’s health team, including counsel for the principal health agencies (e.g., the Department of Health and Social Services) to determine what, if any, further steps beyond private action will be necessary or helpful to create a policy environment that is supportive of payer alignment, and of the kind of provider risk models outlined above.

Data and analytics-based enhancements to drive transformation. To facilitate the expansion of the DHIN needed to support transformation (e.g., managing additional patient data, requiring payers to provide financing), a team has begun engaging its staff and Board, along with legislative staff, to lay out what policy changes (if any) are necessary and to make such changes.

Mapping resources. Mapping health resources so that Delawareans know where they can go to find relevant health care information and services, including finding the social supports and resources needed to live healthy lifestyles, will become a key role played by the Healthy Neighborhood program.

Governance structure to manage transformation. In order to ensure continued momentum for health transformation, Delaware will establish a governance structure tasked with implementing the health care innovation plan. The next section provides additional detail on the proposed governance approach

The State expects to be able to implement new payment models without State Plan Amendments or Waiver requests.

4.7.4 Approach to rollout

Delaware will take steps to implement the proposed policy changes at the start of 2014. Over the course of the next year, Delaware envisions the following high-level sequence to its policy approach:

Quarter 1

- Stand up the Delaware Center for Health Innovation
- Embed new payment model in Medicaid’s procurement for managed care



Quarter 2

- Begin regular operations for Innovation Center (if not already in progress earlier in the year)
- Develop recommendations on credentialing and licensure
- Complete or continue expanded access and DHIN changes

Quarter 3-4

- Continue policy support as needed (e.g., for any other legislative/regulatory changes required)



5.0 Implementation

Translating this strategy into concrete change on the ground will require a concerted effort over several years. We need to be clear on how we will measure success and drive change. At a more detailed level, we need to know what we will accomplish within a set timeframe, the resulting capabilities, and budget needed to support them. Finally we need to spell out how such an effort across multiple payers and providers will be governed and what needs to be done to cause this effort to “go live.”

5.1 GOVERNANCE

5.1.1 Why governance is needed

Delaware’s vision for health and health care requires a continuing forum to bring stakeholders together and sustain momentum. A new set of resources and services must be established and delivered to providers statewide—services that require the expertise of clinicians, public health professionals, and patients. Communities must be brought together to establish programs (e.g., Healthy Neighborhoods). Progress must be tracked. Effort must be put forth to ensure momentum continues.

For these and other reasons, stakeholders have concluded that governance is critical to the long-term success of this work and to ensuring the ongoing inclusive participatory nature of transformation. Delaware proposes to establish such a structure and call it the Delaware Center for Health Innovation (“Innovation Center”).

5.1.2 Principles of design

Based on stakeholder feedback, several principles will guide governance design. The Governance model should create an entity that will:

- Establish protocols and monitor implementation
- Connect with the Health Care Commission and the DHIN
- Continue the multi-stakeholder approach



- Have a Board large enough to be representative and small enough to move quickly
- Be a public-private structure

5.1.3 Proposed governance model: Delaware Center for Health Innovation

The Innovation Center will be a corporate entity with representatives from both the public and private sector whose purpose is to continue to drive transformation of Delaware's health system, support implementation of the State Health Care Innovation Plan, serve as a continuing forum to bring stakeholders together, and ensure an ongoing inclusive and participatory approach to transformation. Its specific responsibilities include

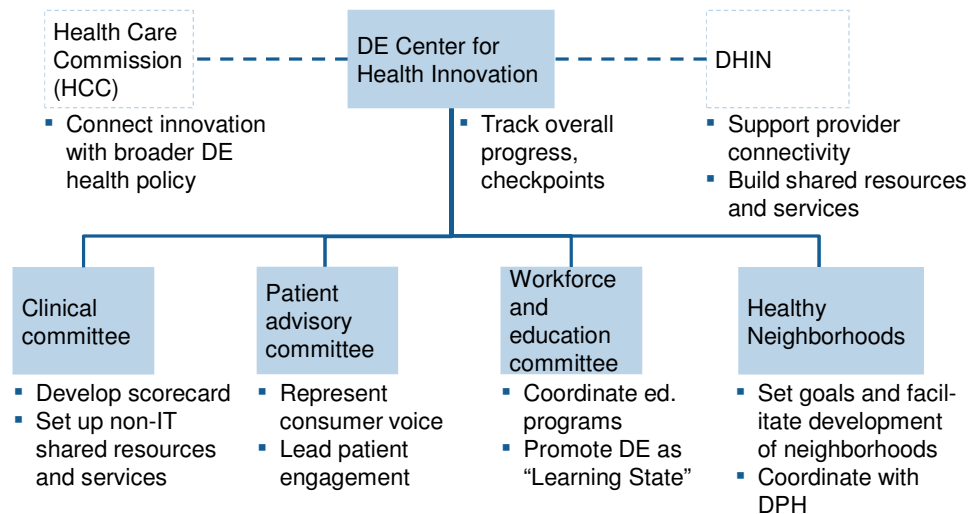
- Tracking and monitoring overall progress against a state health scorecard
- Setting up shared services and resources (technology-based shared services will be developed by the DHIN), including guidelines and protocols
- Developing and creating transparency around a common provider scorecard
- Managing the patient engagement strategy
- Operationalizing Delaware's vision as a "Learning State"
- Implementing the Healthy Neighborhoods strategy

It will be composed of a multi-stakeholder Board, four committees focused on delivering specific services, and will have full-time staff and contract support.

The Innovation Center Board will track and monitor overall progress, and be supported by four committees with diverse constituencies: (1) a Clinical Committee to provide shared services and resources, issue protocols and guidelines, and promote a common scorecard; (2) a Patient Advisory Committee focused on managing the patient engagement strategy and providing the consumer perspective for all work of the Innovation Center; (3) a Workforce Training and Education Committee to coordinate education programs, implement the workforce strategies and operationalize Delaware's vision as a "Learning State"; and (4) a Healthy Neighborhoods Committee to focus on the population health component of Delaware's plan. See **Exhibit 44** below for an overview of the organizational structure and roles of the Innovation Center.



EXHIBIT 44: ORGANIZATIONAL STRUCTURE AND ROLES OF INNOVATION CENTER



Board

The Innovation Center will have a Board with 9-15 members that includes patient representatives, providers, payers, representatives of the state, and employers. This structure will ensure that the voices of all key stakeholders are heard, while still having some nexus to the State.

The Board will have specific responsibilities in addition to reviewing and approving the work of each committee. The Innovation Center Board and immediate staff will be charged with evaluating the success of transformation and tracking progress. It will have responsibility for collecting, updating, and sharing outcomes against the overall goals of the transformation program. The Innovation Center will have a full-time staff of an Executive Director and 2 full-time administrators.

Committee leadership, structure, responsibilities



To carry out its work, each committee will be led by a Chairperson and supported by the Innovation Center's central team. They will have the following composition and responsibilities:

1. **Clinical Committee.** The clinical committee will operationalize several of the shared resources and services that support providers, and have responsibility for Delaware's common performance scorecard. It will be composed of a diverse set of practitioners across geographies and providers. The committee will identify, distribute, and regularly update a select number of protocols and guidelines to focus on more effective diagnosis and treatment. This involves selecting the initial clinical areas of focus and relevant guidelines, the format of the protocols and guidelines it will circulate, and measures to monitor performance. The committee will also develop a common scorecard of metrics for providers to track the impact of the transformation, and to publicize the results across the state. In order to accomplish this, the committee must finalize the initial set of metrics, design the scorecard and report/format, and expand and/or revisit the metrics on a regular basis. The committee also will establish the care coordination and transformation support shared services and resources, and learning collaboratives—including pre-qualifying care coordination vendors to support Delaware's providers.
2. **Patient Advisory Committee.** The Patient Advisory Committee will represent the patient perspective on all services and/or activities provided by the Innovation Center. It will also have responsibility for the patient engagement program.
3. **Workforce Education and Training Committee.** The Workforce Education and Training Committee will coordinate workforce and educational training statewide to fill gaps and build capacity to support the new delivery system, population health, and technology requirements. It will have primary responsibility for leading efforts to position Delaware as a "Learning State" – a national leader in workforce innovation and development.
4. **Healthy Neighborhoods Committee.** This Committee will have responsibility for coordinating efforts to improve population health and will lead the Healthy Neighborhoods program. This will involve facilitating identification and establishment of the neighborhoods, setting statewide goals for population health, ensuring continued integration of population health efforts with the delivery system, and creating transparency on progress against the health goals of the Triple Aim.



5.1.3 Authority and Accountability

The Innovation Center's authority will stem from the quasi-official nature of it and its imprimatur as the leading body for health care innovation in the state.

The Innovation Center will report twice a year to the Governor, the General Assembly, the Health Care Commission, and the DHIN. In that report, it will be responsible for outlining progress in each area of its work described above.

5.1.4 Timeline for implementation

The Innovation Center will play a foundational role in transformation, and therefore it is important to establish this structure early on. In order to maintain momentum and move forward on the State Health Care Innovation Plan, it ideally will be established in the beginning of 2014.

5.2 HIGH LEVEL TIMELINE

5.2.1 Overall timeline

Delaware's plan is for a multi-year transformation. This will only be achieved by a deliberate approach to implementation that takes into account the perspectives, needs, and capabilities of all stakeholders. The new payment and delivery models and population health infrastructure and the data and analytics, workforce, and policy requirements to support these models will be phased in over time, responsive to the needs of stakeholders to move toward transformation in a measured way.

Over the next five years, the vision is to move nearly all providers to outcomes-based payment models linked to total cost of care. Delaware's plan builds the supporting infrastructure required to enable this transformation, including patient engagement, developing shared services and resources for providers, enhancing health information flow and connectivity, evolving Delaware's workforce, and implementing the governance and policy changes required to enable change.

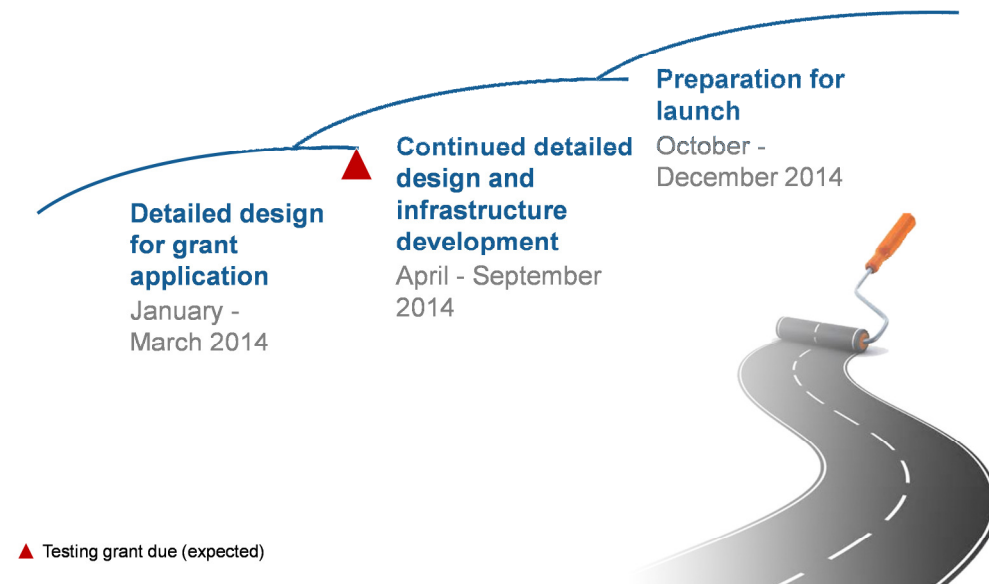
This approach is purposefully comprehensive to ensure Delaware is on a sustainable path to meeting its goals for achieving the Triple Aim. Change of this nature requires regular review to ensure progress and make course corrections along the way. These 'checkpoints' are described in greater depth in the evaluation section.



5.2.2 Near-term approach

As noted, setting into motion this reform will require a focused effort over the next 1-2 years. See **Exhibit 45** below for an overview of that initial time period of reform:

EXHIBIT 45: TRANSFORMATION THROUGH YEAR 1



- **From now until March 2014**, Delaware will transition into detailed design. A core focus of this period will be ensuring development and submission of a distinctive application to CMMI for a testing grant to catalyze Delaware's health transformation. Delaware will also engage CMS in aligning Medicare payment models with those outlined in this plan. During this period, Delaware will set up the Delaware Center for Health Innovation and will also begin the detailed design on the payment model and important supporting infrastructure (e.g., on scorecards, shared services, and data for provider reports).
- **From April 2014 until September 2014**, the focus will turn to detailed design across the initiatives.

- **From October 2014 until December 2014**, Delaware will continue detailed design and prepare to begin the transition to new payment models in the first half of 2015.

5.2.3 Milestones

The table below describes important milestones and estimated timing for the initial period of detailed design, implementation, and testing of Delaware's State Health Care Innovation Plan. The Delaware Center for Health Innovation will have primary responsibility for refining these milestones over time, incorporating broad stakeholder feedback.

EXHIBIT 46: INITIAL PROGRAM MILESTONES

Milestone	Estimated Timing
Delaware Center for Health Innovation launched	1 st quarter 2014
Medicaid MCO RFP launched	1 st quarter 2014
New payment model for Medicaid detailed design complete	1 st -2 nd quarter 2014
CMMI Model Testing Grant application submitted	1 st quarter 2014
Health Resources Board strategy developed	2 nd quarter 2014
Workforce strategy detailed design complete	2 nd quarter 2014
Initial Healthy Neighborhoods stood up	3 rd -4 th quarter 2014
Shared services and resources available	4 th quarter 2014-1 st quarter 2015
New MCO contracts in place	1 st quarter 2015
New payment models live	1 st -2 nd quarter 2015



5.3 DRIVERS OF ACTION FOR EACH STAKEHOLDER

Health transformation is a challenging process that requires the commitment of various stakeholders working together. **Exhibit 47** below describes the theory of change underlying the approach set out in this plan.

EXHIBIT 47: DELAWARE'S DRIVER DIAGRAM

Aims	Primary Drivers	Secondary Drivers
<p>Delaware will...</p> <ul style="list-style-type: none"> Be one of the 5 healthiest states in the nation by 2019 (chronic disease prevalence, healthy and preventive behavior indicators) Be in the top 10 percent in health care quality and patient experience by 2019 (outcome measures TBD) Reduce health care costs by 6 percent by 2019 	<ul style="list-style-type: none"> Engage patients in their health Ensure every Delawarean has a Healthy Neighborhood to improve integration among community organizations and create local plans to enhance wellness, prevention, and primary care Provide care coordination for all high-risk adults/elderly and children that is person centered and team-based Promote more effective diagnosis and treatment Align incentives so that more than 80% of population receives care in total cost of care models that reward outcomes, with flexibility to maximize participation Design for scale and create transparency to ensure momentum 	<ul style="list-style-type: none"> Rollout iTriage app for consumers to access their own health information and complement it with an awareness strategy to promote adoption Engage providers to encourage patient engagement to achieve meaningful use 2 Develop a patient portal for added transparency Develop and publish a common scorecard, aligned with provider scorecards and quality goals linked to payment Create transparency about resources Support Neighborhood goals with DPH technical expertise Link continued receipt of funding to progress against goals Develop shared resources for care coordination, practice transformation, and learning collaboratives Move to outcomes-based payment with aligned incentives for coordinated across payers Develop and disseminate guidelines for best practice care coordination Train and retrain workforce to focus on team-based training, expand access to providers (e.g., by simplifying credentialing), and better understand current care coordination workforce Identify set of high cost, high variability measures, identify and develop guidelines, and create transparency about performance Develop a Common provider scorecard with aligned quality metrics, linked to Healthy Neighborhood scorecard Develop data and analytics infrastructure (e.g., provider portal) to create transparency about cost performance for providers Cultivate an IT workforce to support expanded data infrastructure Embed new payment models in Medicaid MCO RFP Set up Delaware Health Innovation Center to create continued forum to focus on change at scale and to promote transparency Build from DHIN to create broad transparency (e.g., through all payer claims database)

Specific incentives for each stakeholder group include:

- **Individuals** (in their role as patients, clients, consumers, and caregivers): patients will find a health care system more centered around their care and sensitive not only to the outcomes achieved on their behalf, but the costs they pay and the experience they have; there will be no new significant restrictions (e.g., they continue to choose their provider(s), subject to their insurance). This simpler, higher quality system will likely expand access, preserve choice, and improve affordability for individuals, who will also have the tools to engage more purposefully and take greater accountability in managing their own health.
- **Clinicians:** primary care doctors and specialists—in particular who are sole practitioners or are part of small practices—will be aided in providing the type of coordinated care not possible in small practitioner settings, and given the opportunity to share in the financial benefits of managing costs as they



improve the health of Delawareans. Clinicians preserve independence and benefit from administrative simplicity through multi-payer participation in this new vision for health care in the State, with flexibility in how they come together to take accountability for improving quality and better managing costs through different models.

- **Health systems:** providers will have the opportunity to embrace change by playing a role in designing that change, enabling them to invest with greater certainty in the tools and capabilities needed to improve on every dimension of the Triple Aim. Hospitals and health systems will be able to help take costs out of the system in a way that provides safeguards against their downside risk and opportunities to share in the benefits. The approach to rollout ensures that Delaware's health systems – all of which are non-profits – can continue to deliver on their community missions and build from their existing portfolio of innovation towards better health for Delawareans.
- **Community health centers:** Delaware's three Federally Qualified Health Centers (FQHCs) will have to opportunity to continue to deliver on their mission, better engage with their patients, and build from their multi-disciplinary care structure towards increasing interconnectivity with caregivers across the State. In addition, the FQHCs will have an opportunity to share in the benefits of taking costs out of the system.
- **Payers:** payers can make meaningful progress on affordability. For commercial payers, this relieves the pressure to consistently raise rates and raise premiums for consumers and provides an opportunity to offer more affordable coverage options. For employers in their role as payers, this vision will support a healthier workforce and support affordability of health care coverage as well. For public payers, this supports long-term fiscal viability.
- **Taxpayers:** the vision for Delaware is grounded in sustainability and responsibility. Taxpayers will benefit from this approach because it enables high quality care for Delawareans and puts the State on a path towards long-term sustainability.

Taken together, these incentives suggest that while transformation will be a multi-year effort, each player has incentives to join together in the journey.



5.4 EVALUATION

To deliver on the Plan, Delaware is committed to rigorous monitoring and evaluation of the implementation of the Plan and the overall impact on each element of the Triple Aim.

5.4.1 Measures

Delaware will develop a set of metrics to measure progress across the transformation effort. The measures will reflect overall progress against the Triple Aim, and specific progress on each component of Delaware's plan. They will complement the common provider scorecards. **Exhibit 48** below provides an early perspective on potential measures.

EXHIBIT 48: PRELIMINARY MEASURES FOR EVALUATION

	Goal	Metric
High-level goals: The Triple Aim	▪ Improved outcomes	▪ Basket of HEDIS measures
	▪ Enhanced experience	▪ Net promoter score
	▪ Health	▪ Chronic disease burden, prevalence of Behavioral Health conditions
	▪ Reduced cost	▪ TME trend vs historical and baseline trend
Initiative-based indicators	▪ Payment	▪ Covered lives and % of population of total cost model ▪ Covered lives and % of population of P4V model
	▪ Metrics	▪ % of patients with care plans (target 10%)
	▪ Shared resources and services	▪ % of practices using 1+ shared service or resource
	▪ DHIN	▪ % of practices using bidirectional payer-provider portal
	▪ Healthy Neighborhoods	▪ % of population covered by a Healthy Neighborhood ▪ Wellness and screening rates
	▪ Policy response	▪ Governance structure stood up and active participation in governance
	▪ Workforce	▪ Number of care coordinators vs. number required

5.4.2 Potential data sources

The DHIN and individual payers (including Medicare and Medicaid) and providers will contribute data where necessary, with a focus on ensuring minimal administrative effort for data collection and evaluation. Sources include Medicaid



administrative claims (which will feed the overall scorecard, common provider scorecards, and provider performance reports), as well as surveys administered by individual payers, providers, and the Division of Public Health.

5.4.3 Method for continuous improvement and evaluation

The Innovation Center Board will review these measures quarterly and have responsibility for making adjustments to the overall effort if necessary. Transparency will be a critical component of the evaluation process and the Innovation Center will publish progress against these metrics on a regular basis. The Board and staff of the Innovation Center will be available as needed to CMS to support the evaluation process. The Innovation Center will maintain regular progress reports about the extent and impact of implementation and will make data, Board members, and other stakeholders available to CMS as requested.

The Innovation Center will build capacity to conduct this research over time. In the near-term, it will consider options to request support from a third-party research organization (e.g., from DHSA).

5.5 BUDGET AND POTENTIAL IMPACT

As noted above in the Case for Change, Delaware spends approximately \$8 billion annually on health care, including more than \$5 billion for those on Medicaid, Medicare and commercial health insurance. **Exhibit 49** below shows the expenditures by payer type:

EXHIBIT 49: COSTS BY PAYER (2011)⁵³

Payer type	Total expenditures	Percent of total	Population	Average PMPY
Medicare	\$1.4 Bn	26%	143,000	9,600
Medicaid	\$1.5 Bn	28%	227,000	6,600
Commercial	\$2.5 Bn	46%	463,000	5,520

⁵³ Baseline spending based on Medicaid and Medicare PMPY based on CMS data (MSIS and Medicare Geographic Variation Public Use File; includes dual eligibles in both Medicaid and Medicare; Commercial PMPY based on extrapolation from DE State Employees and Retirees data.



These costs of healthcare are projected to grow substantially in a base case scenario due to the combination of demographic growth, medical inflation and new technology. As a result total spending of \$5.5 billion (medical expenditures excluding out of pocket costs) is projected to grow to ~\$10.5 billion over the next decade if nothing is done to change the growth trend.

A primary goal of our SHIP is to "bend the trend" and we have projected at a high level the impact we expect based on 1) potential gross impact over time and, 2) the participation of payers and providers in new payment model. This gross impact projection needs to take account of 3) recurrent spending on care coordination and shared savings and 4) one time investments in transformation. Combining all four of these factors produces a net saving relative to baseline.

The headline figures are:

- Spending to rise from \$5.5 billion to \$10.5 billion in the base case
- Greater than 8% gross savings or \$850 million is possible to achieve through the changes identified (with 6% achieved by 2019)
- Recurrent spending of up to \$190 million falling to \$120 million will be required for care coordination fees and shared savings payments to providers
- Non-recurrent spending of about \$160 million spread over a decade will be needed for IT, practice transformation and support to implement these changes
- Total recurrent net savings of over \$700 million per year relative to baseline once full impact is reached
- This will reduce the rate of per capita medical cost growth from 5% to 4% (after recurrent and fixed costs) over the next 10 years.

The two exhibits below shows the summary of the build-up. The first exhibit shows the baseline and works through to gross savings. The second exhibit shows how recurrent and nonrecurring costs reduce the gross savings to net savings.



EXHIBIT 50: PROJECTION OF GROSS SAVINGS⁵⁴

Baseline	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Spend per capita (\$)	6468	6600	6825	7117	7451	7872	8344	8827	9358	9921	10518
Total spend (\$M)	5504	5766	6169	6538	6955	7481	8030	8575	9183	9824	10511
Insured population (000s)	851	874	904	919	933	950	962	971	981	990	999
Provider participation*	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
TCC	–	40%	55%	70%	80%	85%	90%	90%	90%	90%	90%
P4V	–	30%	20%	10%	5%	5%	5%	5%	5%	5%	5%
Neither	–	30%	25%	20%	15%	10%	5%	5%	5%	5%	5%
Total	–	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Impact by Year of Participation	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
TCC	–	0.5%	2.5%	4.5%	7.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
P4V	–	0.0%	0.5%	1.0%	2.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Neither	–	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Gross impact	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Savings (\$M)	–	19	76	157	284	442	593	686	744	796	852
Impact as % of Spend for participants	–	0%	1%	3%	4%	6%	8%	8%	8%	8%	8%

* Participation levels are meant to reflect a representative provider in Delaware and can serve as a proxy for percent of the population receiving care from providers in new payment models; estimates are provided for purposes of projecting Delaware's potential savings and expenditures over time, rather than to reflect specific requirements for levels of participation

⁵⁴ Baseline spending based on Medicaid and Medicare PMPY based on CMS data (MSIS and Medicare Geographic Variation Public Use File; includes dual eligibles in both Medicaid and Medicare; Commercial PMPY based on extrapolation from DE State Employees and Retirees data. Medicaid excludes dual eligibles (note that medical expenditures for dual eligibles are included in Medicare baseline spend), SPMI, and Developmental Disabilities. Baseline growth rates based on CMS 2011-2021 National Health Expenditure Projections.



EXHIBIT 51: PROJECTION OF NET SAVINGS AFTER INVESTMENT

Gross impact	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Savings (\$M)	—	19	76	157	284	442	593	686	744	796	852
Impact as % of Spend for participants	—	0%	1%	3%	4%	6%	8%	8%	8%	8%	8%
Recurrent costs (\$M)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Care coordination fees	—	30	39	49	58	65	74	84	91	98	106
Shared savings	—	1	19	45	75	109	115	85	48	23	13
Fixed investments (\$M)	2014	2015	2016	2017	2018	2019 ¹	2020 ¹	2021 ¹	2022 ¹	2023 ¹	2024 ¹
Transformation support	2.9	2.3	1.5	0.8	0.6	3.0	3.0	3.0	3.0	3.0	3.0
Delivery system	3.0	10.8	10.0	10.0	4.0	—	—	—	—	—	—
Population health	2.0	4.8	4.2	2.4	1.8	—	—	—	—	—	—
Payment	3.0	1.5	1.5	0.8	0.6	—	—	—	—	—	—
Data & analytics	4.0	14.0	13.6	11.8	11.2	4.0	4.0	4.0	4.0	4.0	4.0
Workforce	1.2	2.9	2.9	2.3	2.3	—	—	—	—	—	—
Policy	0.8	0.8	0.8	0.4	0.4	—	—	—	—	—	—
Net Savings	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Total (\$M)	(17)	(50)	(17)	35	130	258	393	515	615	678	729
Percent of baseline	-0.3%	-0.9%	-0.3%	0.5%	1.9%	3.5%	4.9%	6.0%	6.7%	6.9%	6.9%

¹ Estimate for 2019-2024 is for in-kind support that may spread across multiple areas of focus depending on need; included in transformation support for simplicity

NOTE: Corrected for typographical error on 4/28/14

Below we outline the key elements of these headline figures.

By 2024, we expect the annual savings by payer segment to be as follows (savings net of recurrent costs, but prior to fixed investments, which are expected to be relatively small by 2024):

- Medicaid: \$145 million annually
- Medicare: \$213 million annually
- Commercial: \$378 million annually

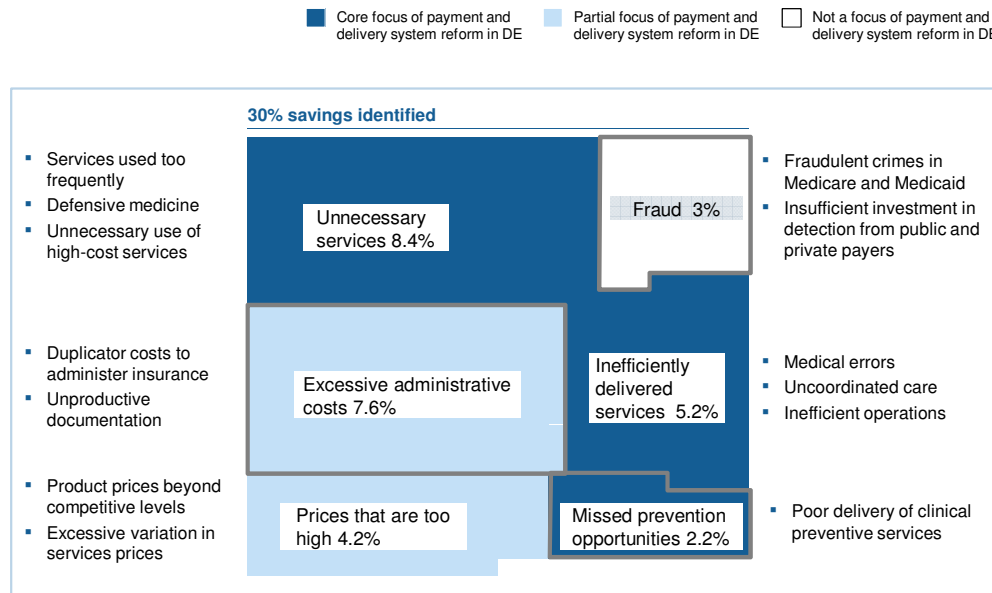
5.5.1 Potential impact

Many reports have identified the potential impact that can be achieved from changing how healthcare is delivered. The Institute of Medicine in a landmark report cited that up to 30% could be saved based on a systematic review of the evidence. We have explicitly targeted the categories of “unnecessary services,” “inefficiently delivered services,” and “missed prevention opportunities” as areas



of prime focus in Delaware. Combined, these represent potential impact of 15.8% in savings we are actively pursuing as a core focus.

EXHIBIT 52: SOURCES OF VALUE FROM PAYMENT AND DELIVERY SYSTEM REFORM (INSTITUTE OF MEDICINE)



SOURCE: The Institute of Medicine, <http://resources.iom.edu/widgets/vsrt/healthcare-waste.html>

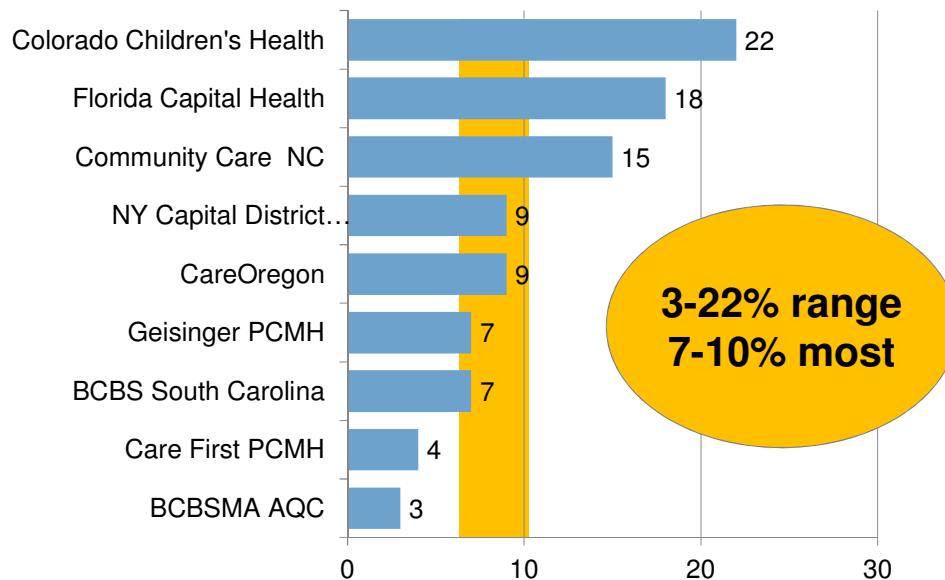
The evidence across existing programs shows a wide range of savings is possible, with impact from 3% to 22% and a concentration around the 7% to 10% mark. We have for purposes of estimate assumed up to 9% gross impact. The exhibit below illustrates this potential impact range across initiatives.⁵⁵

⁵⁵ There are many coordinated care programs demonstrating results. The Exhibit below displays examples of these. Additional examples include Group Health Cooperative, Horizon BCBS of NJ PCMH, NY Care Coordination Program, Sacramento ACO, and Minnesota Health Partners.



EXHIBIT 53: POTENTIAL IMPACT OF INNOVATIVE MODELS

Cost savings as %



NOTES: Reduction in non-emergency costs for Colorado; Savings from BCBSMA AQC vary depending on comparison point, with some groups (that started with FFS) achieving 6-10% over their first years

SOURCE: PCPCC, Benefits of Implementing the Patient-Centered Medical Home: A Review of Cost and Quality results, 2012; Commonwealth Case Study, Colorado Children's Healthcare Access Program, 2010; <https://www.bluecrossma.com/visitor/pdf/aqc-results-white-paper.pdf>; Milliman, Analysis of Community Care of North Carolina Cost Savings (2011)

5.5.2 Participation in new payment and delivery models and ramp up of impact

Healthcare transformation is not a switch that can be flicked on or off. As outlined above in payment section, our change model is predicated on payers moving to two sorts of payment models: a Pay for Value (P4V) model and a Total Cost of Care (TCC) model. We have assumed that these are not mandatory payment mechanisms but ones that providers can elect to join. We have then assumed that there is an initial movement into P4V and TCC models which over time leads providers to move into TCC models so that the end point is 90% of providers are in TCC models, 5% are in P4V and 5% remain outside these new models. These assumptions are set out in **Exhibit 50** above.

We have assumed that there is a different level of impact between these two models and a ramp up of impact over time. We assume the total cost of care models achieve full impact of 9% gross savings and that the pay for value models achieve only 3% gross savings. The reason for this is that the total cost of care model puts in place a much stronger incentive for providers and therefore we assume delivers more impact. We also have assumed that impact ramps up over



a 5 year period in a straight line from 0% to 3% for P4V and 0% to 9% for TCC. We have assumed that this ramp up in impact starts from the point of entry of a provider into the new payment model.

In our projection we have considered then 1) an increase in adoption of new payment models and shift to TCC over time, 2) a ramp up in the impact of new payment models. Combined these two impacts result in a 7 year ramp up to full impact of our State Health Care Innovation, as is seen in the bottom line on **Exhibit 50**.

5.5.3 Recurrent spending on care coordination and shared savings

New forms of delivery and incentives are required in order to achieve these savings. We have explicitly provided care coordination fees to cover the need for new delivery models that coordinate the care of complex patients. We have calculated these costs by making an assumption about the focusing of care coordinators on the complex patients and then applied that as 0.5% of Medicaid and Commercial costs and 2% of Medicare costs. The reason for a higher cost assumption for Medicare is because comorbidity increases with age and hence the need for care coordination is more intense for an older population.

Fundamental to the notion of the new payment models is the assumption of shared savings with providers. We have explicitly provided for sharing of savings each year with providers. We have not assumed that this is an annuity but rather that each year as savings are made they are shared and then a new baseline is calculated. As a result, there is a peak in shared savings as gross savings ramp up and then it declines over time. See **Exhibit 51** for further details.

5.5.4 One time investments in transformation

In addition to recurrent costs we also have provided for non-recurrent costs for transformation. These include:

- New investments in IT
- Investment in practice transformation
- Investment in workforce
- Support to complete and implement the supporting initiatives in Payment, Delivery, Data, Population Health, and Workforce.



These costs are summarized in **Exhibit 51**.

5.5.5 Plan to sustain model over time

Successfully implementing this plan will require significant investment. Many of these costs, described in section 5.6.4 are “one time” costs. These are investments in the infrastructure and capabilities needed to deliver on Delaware’s vision. The recurrent costs described in section 5.6.3 will be driven by savings generated versus expected levels of spending. Two organizations have responsibility for ensuring the sustainability of funding over time:

- Delaware Center for Health Innovation: this organization, described in depth in section 5.1, will have overall responsibility for ensuring the sustainable implementation.
- Delaware Health Information Network (DHIN): this organization will lead the implementation of the information infrastructure, and as part of this will focus on ensuring a sustainable funding model for data analytics requirements in Delaware.

Delaware has a positive track record in establishing sustainable investments in its health system. The DHIN, which was initially established with a mix of Federal, State, and private funding, has now transitioned to a self-sustaining model.



6.0 Distinctiveness of the plan

Delaware's State Health Care Innovation Plan connects with the broader approach to health care transformation ongoing across the State. It connects with the Health Insurance Marketplace, the State Health Information Technology strategy, the Medicaid Expansion, and other elements of health care reform and innovation to form an integrated approach to improving the health of Delawareans and achieving the Triple Aim.

Delaware's plan is a truly innovative model for health system transformation. While it draws upon lessons from both inside and outside the State, the emerging model is uniquely Delaware's. Importantly, it is innovative on dimensions that reflect the input and needs of Delawareans: it blends accountability with support, optimizes for flexibility, builds from strengths, and transitions in a measured way. Delaware's plan has eight particularly distinguishing features:

- **Scalable and replicable:** since Delaware represents a microcosm of the United States in many respects, an approach tailored to the First State can also serve as a model for health innovation across the country.
- **Industry-leading HIE to accelerate transformation:** Delaware's vision builds on its leading health IT infrastructure to enable patients, providers, payers, and the state to meaningfully improve against the Triple Aim through creating transparency and enabling outcomes-based payment.
- **Connecting across reform efforts:** As this effort has progressed, there has been a proactive consideration of, and linking to, the other state-based reform efforts (e.g., expansion, marketplace, innovation). This process has, and will continue to both align and magnify the focus on access, quality, and cost.
- **Catalyst for innovation and research:** Delaware's plan puts in place a foundation to drive continuous improvement across the health system. The Delaware Center for Health Innovation will serve as a forum to bring together the state's health care community in an ongoing dialogue about innovation. The focus on transparency and foundation for an all payer claims database will also empower Delaware's research community to improve health care over time.
- **Flexible and inclusive of all providers:** This plan recognizes the challenge of transformation, and the differing states at which different providers enter this effort. By offering providers multiple options for integrating to take



accountability for quality and cost, Delaware is more likely to engage all providers in transformation.

- **Breadth and depth of stakeholder engagement:** Delaware's vision is particularly distinctive in the approach to engaging stakeholders in its development. Clinical leaders from across the state, senior leaders of multiple government agencies, community organizations, *all* health systems and FQHCs, *all* payers, including the Medicaid Managed Care Organizations, and of course, individuals in their roles as consumers, patients, and taxpayers have all contributed to the development of this emerging vision for health system transformation. This level of participation across providers, health systems, and payers truly represents innovation at scale.
- **Commitment of the State.** There has been distinctive engagement of State actors as well, including leadership from the Governor's office, the Secretary of the Department of Health and Social Services, the Health Care Commission, Office of Management and Budget, the State Medicaid Director, the Director of the Division of Public Health, and others. This significant commitment of leaders across State government is indicative of the support this transformation will have moving forward.
- **Shared services and resources:** While some states do offer some level of support to providers, the shared platforms proposed in this plan represent a unique level of commitment to enabling the transformation required to achieve Delaware's vision.



7.0 Appendix

7.1 GLOSSARY OF TERMS

- **Accountable Care Organization:** A network of health care providers that band together to provide the full continuum of health care services for patients. The network would receive a payment for all care provided to a patient, and would be held accountable for the quality and cost of care. This provides financial incentives for these organizations to improve quality and reduce costs by allowing them to share in any savings achieved as a result of these efforts.⁵⁶
- **Capitation:** A method of paying for health care services under which providers receive a set payment for each person or “covered life” instead of receiving payment based on the number of services provided or the costs of the services rendered. These payments can be adjusted based on the demographic characteristics, such as age and gender, or the expected costs of the members.⁵⁷
- **Care coordinator:** A worker who enables team-based care by coordinating among providers, community leaders, and families to support patients in engaging in their own health
- **CMMI:** The Center for Medicare and Medicaid Innovation (CMMI) is part of the Center for Medicare and Medicaid Services (CMS) the federal department that oversees Medicare and Medicaid. CMMI is the sponsor of the State Innovation Models initiative, the grant program which has helped catalyze Delaware’s effort for health transformation
- **Fee-for-service (FFS):** the predominant form of payment for health care today is fee-for-service, which means that payment is made for each activity that occurs in the health system (e.g., for an office visit or procedure).
- **Pay-for-Value (P4V):** this refers to a form of outcomes-based payment, where providers qualify for incentives based on patient experience and quality of care metrics, with bonuses linked to resource utilization

⁵⁶ KFF, Glossary of Key Health Reform Terms

⁵⁷ KFF, Glossary of Key Health Reform Terms



- **Percent of charges:** this is an approach to setting the level of provider reimbursement, where reimbursements are set as a percentage above charges (charges are meant to reflect costs).
- **SIM:** the State Innovation Models Initiative (SIM) is the grant program administered by CMMI which aims to promote innovation in health care payment and delivery on multi-stakeholder basis.
- **Total cost of care (TCC):** this refers to a form of outcomes-based payment where incentives are linked to ability to manage total medical expenditures for the attributed population. There are several types of total cost of care models, including **shared savings** (where providers share a percentage of savings generated from reducing cost, but bear no downside risk), upside and downside risk (where providers share savings generated and also have some risk if costs exceed expectations), and prospective payment (where providers are paid a set amount at the beginning of a period, retaining all savings and bearing all risk beyond that set amount). Any of these total cost of care models may be accompanied by many technical design details that affect how they operate in practice.
- **Triple Aim:** these are a set of goals described by the Institute of Medicine that define an aspiration for improving the health system. Specifically, the Triple Aim refers to improving health, improving the experience of care, and reducing health care costs.



7.2 REFERENCE TO NOTICE OF GRANT AWARD REQUIREMENTS

Notice of Grant Award required sections	Delaware State Health Care Innovation Plan Sections
A. State Goals	<ul style="list-style-type: none"> ■ 4.0 Delaware's plan
A.1. A vision statement for health system transformation	<ul style="list-style-type: none"> ■ 4.0 Delaware's plan
A.2. Description of health system models in "current as is" and "future to be" conditions	<ul style="list-style-type: none"> ■ 1.1 Delaware's strengths ■ 2.0 Delaware's health care system ■ 4.1 Delivery system
A.3. Description of delivery system payment methods both "current as is" and "future to be" payment methods	<ul style="list-style-type: none"> ■ 1.3 Barriers ■ 2.3 Payer structure ■ 4.3 Payment model
B. Description of state health care environment	<ul style="list-style-type: none"> ■ 1.0 Case for Change ■ 2.0 Delaware's health care system
B.1. Population demographics including profile of insurance coverage by major payers	<ul style="list-style-type: none"> ■ 2.1 State profile and demographics ■ 2.3 Payer structure
B.2. Population health status and major issues / barriers	<ul style="list-style-type: none"> ■ 1.2.2 Outcomes do not measure up ■ 1.3 Barriers ■ 4.5.1 Context (population health)
B.3. Opportunities/challenges on HIE/HER adoptions; approaches to improve use of HIT	<ul style="list-style-type: none"> ■ 2.5 HIE/HER adoptions and approaches to improve use of HIT in Delaware
B.4. Health care cost trends and influencing factors	<ul style="list-style-type: none"> ■ 1.2.1 Unsustainable health care spending ■ 1.3 Barriers
B.5. Quality performance by key indicators and factors affecting quality performance	<ul style="list-style-type: none"> ■ 1.2.2 Outcomes do not measure up ■ 1.2.4 Health status ■ 1.3 Barriers
B.6. Population health status measures, social/economic determinants of health, and influencing factors	<ul style="list-style-type: none"> ■ 1.2 Outcomes do not measure up ■ 1.3 Barriers ■ 4.5.1 Context (population health)



B.7. Special needs populations by payer type and factors influencing health, care and cost	<ul style="list-style-type: none"> ■ 2.4 Special needs populations in Delaware
B.8. Current federally supported initiatives (CDC, CMMI, CMCS, ONC, HRSA, SAMHSA)	<ul style="list-style-type: none"> ■ 1.1 Delaware's strengths ■ 2.7 Ongoing Innovation and Federal Grants
B.9. Existing demonstration and waivers granted by CMS	<ul style="list-style-type: none"> ■ 2.6 Existing demonstrations and waivers granted by CMS
C. Report on design process deliberations	<ul style="list-style-type: none"> ■ 3.0 Approach taken in design process ■ 3.1 Goals ■ 3.2 Developing the plan ■ 3.3 Leadership ■ 3.4 Stakeholder engagement ■ 3.5 Methodology ■ 4.1.2, 4.3.2, 4.4.2, 4.5.2, 4.6.2, 4.7.2 (Options considered for each component of the plan)
D. Health system design and performance objectives	<ul style="list-style-type: none"> ■ 4.0 Delaware's plan
D.1. Description of performance targets for cost, quality, and population health	<ul style="list-style-type: none"> ■ 4.0 Delaware's plan
D.2. Goals for improving care and population health, reducing costs	<ul style="list-style-type: none"> ■ 4.0 Delaware's plan ■ 5.3 Drivers of action for each stakeholder
E. Proposed Payment and Delivery System Models	<ul style="list-style-type: none"> ■ 4.0 Delaware's plan
E.1. Proposed payment and delivery system models	<ul style="list-style-type: none"> ■ 4.0 Delaware's plan ■ 4.1.3 Delivery system ■ 4.2 Patient engagement ■ 4.3.3 Payment model ■ 4.5.3 Population health
E.2. State use of levers to drive change	<ul style="list-style-type: none"> ■ 4.7 Policy Levers ■ 5.1 Governance



	<ul style="list-style-type: none"> ■ 5.3 Drivers of action for each stakeholder
F. Health Information Technology	<ul style="list-style-type: none"> ■ 4.4 Data and analytics
G. Workforce development	<ul style="list-style-type: none"> ■ 4.6 Workforce
H. Financial analysis	<ul style="list-style-type: none"> ■ 5.6 Budget and potential impact
H (i) populations addressed and total costs (pmpm and total)	<ul style="list-style-type: none"> ■ 4.1 Delivery system ■ 5.6 Budget and potential impact
H (ii) estimated cost of investments	<ul style="list-style-type: none"> ■ 5.6 Budget and potential impact ■ 5.6.3 Recurrent spending on care coordination and shared savings ■ 5.6.4 One time investments in transformation
H (iii) anticipated savings from specified interventions (including types and by target population)	<ul style="list-style-type: none"> ■ 4.1 Delivery system ■ 5.6 Budget and potential impact ■ 5.6.1 Potential impact ■ 5.6.2 Participation in new payment and delivery models and ramp up of impact
H (iv) expected total costs savings and return on investment during project period and basis	<ul style="list-style-type: none"> ■ 5.6 Budget and potential impact ■ 5.6.1 Potential impact ■ 5.6.2 Participation in new payment and delivery models and ramp up of impact
H (v) plan for sustaining model over time	<ul style="list-style-type: none"> ■ 5.6.5 Plan to sustain model over time ■ 5.1 Governance
I. Evaluation Plans	<ul style="list-style-type: none"> ■ 5.4 Evaluation
I.1. Plan to enable CMS access to data	<ul style="list-style-type: none"> ■ 5.4.1 Measures ■ 5.4.3 Method for continuous improvement and evaluation
I.2. Identification of data sources	<ul style="list-style-type: none"> ■ 5.4.1 Measures ■ 5.4.2 Data sources



I.3. Plan to participate in continuous improvement and evaluation	<ul style="list-style-type: none"> ■ 5.4.3 Method for continuous improvement and evaluation
J. Roadmap for health system transformation	<ul style="list-style-type: none"> ■ 5.0 Implementation, 4.7 Policy levers
J.1. Timeline	<ul style="list-style-type: none"> ■ 4.1.4, 4.2.2, 4.3.4, 4.4.4, 4.5.4, 4.6.4, 4.7.4 Approach to rollout (for each component of the plan) ■ 5.1.4 Timeline for implementation (Governance) ■ 5.2 High level timeline ■ Executive Summary path forward
J.2. Milestones and opportunities	<ul style="list-style-type: none"> ■ 5.2.3 Milestones
J.3. Policy, regulatory, legislative changes necessary for transformation	<ul style="list-style-type: none"> ■ 4.7 Policy levers
J.4. Federal waiver or state plan amendment requirements needed and timing	<ul style="list-style-type: none"> ■ 4.7.3 Proposed plan (policy)

