

## ***I. PROJECT NARRATIVE***

### **(1) PLAN FOR IMPROVING POPULATION HEALTH**

Delaware aspires to be one of the five healthiest states in the nation, as measured by its performance on core dimensions of Centers for Disease Control and Prevention’s (CDC) Healthy People 2020 goals. Although Delaware has strong public health, community, and health care programs and a track record of success on specific initiatives, Delaware spends 25% more per capita on health care than the U.S. average and outcomes remain average or below in many areas. As a result, Delawareans recognize an important need to improve both population health and health care. Stakeholders have coalesced around a community-based approach called “Healthy Neighborhoods” (Neighborhoods) as the foundation for our plan.

Delaware already has a thorough understanding of the current population health needs and assets, a well-developed and supported strategy for improving population health in its Healthy Neighborhoods strategy, and the governance needed to carry the Healthy Neighborhoods work forward and implement it successfully.

#### **Current state**

A review of health needs identified by hospital community health assessments, the Division of Public Health’s (DPH) State Health Improvement Plan, and comparisons against national averages and goals set by the CDC shows that Delaware’s most pressing health needs include: rising obesity, in particular for children (14.2% vs. 13.7% nationally); tobacco use; diabetes (9.6% prevalence; 7.6% pre-diabetes); cardiovascular disease; behavioral health (9<sup>th</sup> highest death rate from overdoses in U.S.); and dental care. Several of these needs are concentrated in “hot spots” (e.g., the East side of Wilmington).

The state has made progress in maternal health (reducing infant mortality by almost 14%)

and cancer (reducing mortality rate by 19% overall and 30% among African-Americans). The Governor's Council on Health Promotion and Disease Prevention (CHPDP) brings together leaders statewide to address important health challenges. Delaware has strong assets and infrastructure as a foundation for its plan, including active campaigns (e.g., United Way of Delaware's Live United 2015) and DPH's shift to a community-based capability building model.

The biggest challenge in improving health is supporting individuals in changing their behavior. These changes can be supported by providing information, incentives, and encouragement. The most powerful influencers are likely to be family, friends at work/school, and clinicians. Delaware faces additional barriers, including a lack of coordination among programs focused on improving health, limited awareness of existing resources, and payment models that do not incentivize integration of care.

### **Strategy for improving population health: Healthy Neighborhoods**

In the work leading up to the formation of the Healthy Neighborhoods Committee, Delaware convened its provider community, payers, community organizations, and relevant state agencies to address the state's population health needs, review current approaches and needs assessments, evaluate lessons learned from best practice across the state and the nation, and develop a strategy for improving population health. These leaders also identified existing barriers to improving population health, including a lack of connection and leadership across health initiatives, lack of awareness about existing resources among patients and providers, and payment that does not incentivize integration of care delivery with population health.

Delaware's strategy, which focuses on the highest impact interventions for the biggest health risks (smoking, diet, exercise), supports better management of chronic conditions, reduces disease progression, and prevents new disease. By attributing all patients to a PCP (defined as

primary care physicians – pediatrics, family medicine, general internal medicine – or advanced practice nurses working under Delaware’s Collaborative Agreement requirement) and incentivizing PCPs to address specific measures (obesity screening, smoking, diabetes control) as well as total cost, Delaware’s payers are shifting incentives to support population health. Delaware seeks to leverage local schools, employers, and community organizations to help influence individual behavior. Success is contingent upon getting close to the individual, and therefore Delaware’s focus is on creating “Healthy Neighborhoods” – local communities that come together to form a multi-stakeholder coalition to address Delaware’s pressing health needs. This strategy is based on a review of best practices (e.g., Montefiore ACO; Camden Coalition; Care Oregon). Successful programs typically set clear targets, prioritize specific interventions, convene people, improve access to information, and offer some funding.

Based on this work, Delawareans have coalesced around its Healthy Neighborhoods strategy to improving population health. Healthy Neighborhoods is a statewide program that will offer funding and resources for individual communities to: convene forums of community leaders; align on priority health areas of focus; assess existing resources; facilitate targeted interventions; and track performance. Below are the details for the approach to Healthy Neighborhoods.

**1) Structure:** Neighborhoods will: (a) have defined geographic boundaries of 50,000-100,000 individuals; (b) include schools, employers, community organizations, PCPs, behavioral health providers, Federally Qualified Health Centers (FQHC), and at least one health system; (c) designate a lead organization to convene and support ongoing activity; (d) agree on an initial plan for health improvement, including overall goals, 1-2 priority interventions, and existing assets; (e) create an inter-professional forum that brings together the workforce responsible for

coordinating care, including care coordinators and community health workers; and (f) establish a Healthy Neighborhood Council of leaders. Delaware's goal is for communities to self-organize and to apply to the Healthy Neighborhoods Committee for recognition as a Healthy Neighborhood.

The Department of Education is highly committed to Delaware's proposal for health transformation and its Healthy Neighborhoods program in particular. We have included a letter of support from the Department of Education to participate in this work. Employers are similarly committed to Delaware's proposal. Governor Markell and Delaware insurers hosted an employer roundtable on July 9, 2014 to discuss this work with the employer community, which expressed strong support and a desire to actively participate. Delaware's proposal included multiple letters of support from employers, including the State Chamber of Commerce and the Business Roundtable. The State and Christiana Care Health System both have been active participants and submitted strong letters of support. These two organizations represent the largest public and private employers in Delaware. Daryl Graham, Vice President of Global Philanthropy & Community Relations at JP Morgan Chase, was recently appointed to the Board of the Delaware Center for Health Innovation as well.

Program applicants will be required to partner with an FQHC. Delaware only has three FQHCs but collectively these organizations have more than ten sites across the state. Given Delaware's goal to scale statewide to ten Neighborhoods in the SIM period of performance, Delaware believes it is both feasible and important to include an FQHC in each Neighborhood.

**2) Process:** The Healthy Neighborhoods Committee (HNC) of the Delaware Center for Health Innovation (DCHI – Delaware's multi-stakeholder body that will work with the Health Care Commission (HCC) to lead implementation of Delaware's proposal) will lead the process of

scaling Healthy Neighborhoods across Delaware within the SIM period of performance as part of Delaware's proposal to achieve state-wide health transformation for the preponderance of care within Delaware. The specific process for scaling Healthy Neighborhoods is as follows:

**1. Define the application process:** the HNC will define application details, including eligibility criteria, timeline, and process for submitting applications.

**2. Develop informational materials to engage with communities and their leaders:** the HNC will develop marketing and informational materials that describe the approach for Healthy Neighborhoods that has already been developed, including the goals and structure of Neighborhoods and resources available to support Neighborhoods (e.g., access to data from the Division of Public Health). The HNC will reach out to community leaders to share this information and answer questions about the process and goals.

**3. Engage with communities:** the Governor's Office, Department of Health and Social Services (DHSS), HCC, and DCHI will engage community partners to build awareness. This may include individual meetings, town halls, emails, and webinars among other forms of outreach.

**4. Identify early adopters:** the HNC will identify 2-3 neighborhoods as early adopters to participate as the initial Neighborhoods.

**5. Review lessons learned and scale:** the HNC will review progress from the initial Neighborhoods and then review applications from additional neighborhoods to expand the program. The goal is to achieve 10 neighborhoods of 50,000-100,000 individuals across Delaware during the SIM period of performance.

**3) Resources:** DPH will develop community-specific datasets, building from ongoing work, that quantify and assess local health needs and track health performance/outcomes over time. It will

support inventories of resources, the development of materials to guide health programs, and Neighborhood trainings in mobilizing communities, including health equity training.

Delaware's Plan for Improving Population Health will build upon its Healthy Neighborhoods strategy. Delaware's goal is to achieve statewide coverage for Healthy Neighborhoods within the SIM period of performance. Communities will have incentives during the SIM period of performance to apply to become Healthy Neighborhoods (including access to funding as well as resources from the Delaware Division of Public Health), which will encourage achieving scale during the SIM period of performance. The specific timeline for scaling Delaware's Healthy Neighborhoods strategy is to achieve 10% of the population in Healthy Neighborhoods by 2016, 40% of the population in Healthy Neighborhoods by 2017, and 80% of the population in Healthy Neighborhoods by 2018.

### **Approach to developing Delaware's Plan for Improving Population Health**

Delaware will use its Healthy Neighborhoods strategy to develop a comprehensive Plan for Improving Population Health, in collaboration with the CDC (approach is described below).

**1) Methodology and timeline.** Delaware will pursue a five step approach: a) assess needs; b) define measures and goals (built from core measures, informed by common provider scorecard); c) prioritize potential interventions (with reference to best practice and experience with Healthy Neighborhoods); d) develop a draft; and e) syndicate and refine. In Year 1 (2015), Delaware will finalize goals, and ensure core measures are integrated with the common provider scorecard (current draft includes seven recommended population health measures). Delaware will then conduct a needs assessment, finalize details for Healthy Neighborhoods' structure and process, build DPH resources to support communities and local data collection, and select pilots. In Year 2 (2016), Delaware will develop a first draft of the Plan and syndicate it, as well as pilot initial

Healthy Neighborhoods. In Years 3 and 4 (2017-2018), Delaware will refresh its needs assessment, finalize the Plan, and begin to scale up Healthy Neighborhoods.

**2) Governance and leadership.** The HCC, DCHI, and DPH will set goals and lead the development of the Plan. The HNC of the DCHI will meet monthly to steer this process.

**3) Stakeholder engagement.** Delaware's population health strategy actively engaged a broad set of stakeholders statewide, including the Governor's Office, DHSS, DPH, health systems, FQHCs, community organizations, providers and provider organizations, and payers (insurers and employers). Stakeholders generally played four roles: 1) leading the multi-stakeholder workstream for population health; 2) participating in working sessions; 3) sharing feedback and best practices; and 4) identifying connections with ongoing initiatives. The HNC will continue to bring these stakeholders together to develop Delaware's plan in its regular meetings.

**4) Alignment with public health, care delivery, child wellness and prevention priorities.**

Delaware has established four mechanisms to ensure an integrated approach to population health. First, the HCC, DCHI, and Delaware Health Information Network (DHIN is Delaware's Health Information Exchange (HIE)) all have representation from the delivery system and community. Second, a FQHC and health system must be included in each Neighborhood. Third, the population health scorecard and common provider scorecard will have some measures that overlap to incentivize integration of care delivery and alignment with important child health priorities. Fourth, DHSS is part of the HCC, DCHI, and DHIN Boards, which will reinforce alignment with public health and child health strategies.

**Integration with the proposed payment and service delivery model**

Delaware's goal is for its transition to value-based payment models that support integrated care delivery to be highly integrated with its Plan for Improving Population Health

and Healthy Neighborhoods strategy. Four specific elements of Delaware's proposal will foster this integration. First, Delaware will align measures on its population health scorecard with those on its common provider scorecard so that providers and community organizations have common areas of focus. Second, Delaware's Healthy Neighborhoods strategy requires participation by one health system and one FQHC in each neighborhood to promote alignment with the delivery system. Third, one of the guiding principles for the transition across all payers to value-based payment models has been to create flexibility for many different types of provider organizations to participate in new models. This flexibility may allow providers to innovate in how they integrate with organizations focused on improving population health. Finally, Delaware's payment and service delivery model and population health approach both share the same focus on patient-centeredness and care coordination.

### **Collaboration across state agencies**

Delaware believes it is critical to have cross-agency collaboration to address social determinants of health. Bettina Tweardy Riveros, who is Chair of the Delaware Health Care Commission (HCC) and the Governor's Advisor on Health, has overall accountability for ensuring successful implementation of Delaware's plan. In her role as Advisor to Governor Markell, she regularly engages at Governor's staff meetings and Cabinet meetings with the leadership of agencies across the state to ensure coordination across the state. Collaboration is bolstered through the membership of the Health Care Commission, which includes among its Commissioners the Secretary of the Delaware Department of Services for Children, Youth and Their Families, the Secretary of the Delaware State Department of Finance, and the Insurance Commissioner. The Secretary of the Department of Health and Social Services (DHSS) is also a member of the HCC as well as the DCHI Board, and has provided active leadership throughout

Delaware's transformation. DHSS encompasses many of the agencies that address social determinants, including the Division of Substance Abuse and Mental Health, the Division of Medicaid and Medical Assistance (DMMA), the Division of Public Health (DPH), and the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). The Directors of DPH, DMMA, and DSAAPD continue to be active leaders in this program. Delaware has also had active participation from the Department of Corrections. Governor Markell established the Governor's Council on Health Promotion and Disease Prevention in 2010, which brings together public and private sector leaders to address a broad set of health issues, including social determinants. The Governor's Council includes participation from DHSS, the Delaware Department of Agriculture, the Delaware Economic Development Office, the Department of Services for Children, Youth, and their Families, the Delaware Department of Natural Resources and Environmental Control, and the Delaware Department of Education. The Health Care Commission continues to ensure close collaboration with the work of the Governor's Council to develop Delaware's strategy for population health.

## **(2) HEALTH CARE DELIVERY SYSTEM TRANSFORMATION PLAN**

Delaware's goal is to be in the top 10% of states on health care quality and patient experience within five years by focusing on more person-centered, team-based care. Delaware will prioritize integrated care (including with behavioral health) for high-risk individuals (i.e., the top 5-15% that account for 50% of costs) and more effective diagnosis and treatment for all patients. Delaware's plan supports independent providers as well as health systems. It is market-driven, and its goal is to support and accelerate adoption of existing models in the market.

## **Context**

Delaware's provider landscape is both highly concentrated among health systems (six health systems, Veterans Affairs hospital, and three FQHCs) and highly fragmented in primary care (75-80% of physicians practice in groups of five or fewer) and behavioral health.

Delaware's providers are currently adopting four general models of innovative care delivery: 1) co-location of services (e.g., Nemours Behavioral Health, University of Delaware (UD) STAR campus); 2) population-specific care coordination (e.g., Nemours Asthma CMMI, Christiana Care Ischemic Heart Disease CMMI); 3) Patient Centered Medical Homes (PCMH) (e.g., Westside FQHC, Medical Society of Delaware (MSD)-Highmark, Nanticoke PCMH ); and 4) Accountable Care Organizations (ACO), including physician-led ACOs and clinically-integrated health systems (e.g., MSD-Highmark, Beebe Medicare Shared Savings Program (MSSP), Bayhealth). Delaware is fortunate to have significant and increasing levels of adoption of innovative payment and delivery models among the state's providers and payers. Delaware's strategy for health care transformation has been to create a framework that enables multiples models to flourish. The approach to payment model design and to developing services to support provider transformation is intended to support and accelerate these emerging models. A description of many of the emerging models is provided below:

**Beebe Healthcare:** Beebe Healthcare has multiple innovative payment and delivery models. It recently began participating in the Medicare Shared Savings Program (MSSP). Beebe CAREs is a program that involves care coordination, access and advocacy, referrals, and empowerment for complex chronic patients. Beebe CAREs has 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. This program led to the establishment of the Delmarva Health Network in 2013, a clinically-integrated network based in Sussex County that consists of approximately 30 primary care providers and 15,000 patients who receive care coordination and optimization via a team of 6 care coordinators.

**Medical Society of Delaware – Highmark:** The Medical Society of Delaware and Highmark Blue Cross Blue Shield Delaware have been expanding their Patient Centered Medical Home program (recently extending an invitation to sixty additional primary care practices). The Medical Society of Delaware, through its subsidiary MedNet, has created an Accountable Care Organization with Highmark that launched in July 2014 that includes a total cost of care payment model. MedNet has also submitted a letter of intent to participate in the Medicare Shared Savings Program.

**Christiana Care Health System (CCHS):** CCHS has been leading several innovative payment and delivery models. CCHS has a CMMI grant that uses a clinically-integrated data platform to support care management programming for the ischemic heart disease population. 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. Christiana Care Quality Partners is developing a clinically-integrated network to provide more integrated care and to be a vehicle for participating in risk-based payment models. CCHS is a participant in the Independence at Home demonstration project, which serves home-based primary care services to 345 Medicare beneficiaries with multiple chronic illnesses.

**A.I. duPont Hospital for Children** has introduced a PCMH model for children with asthma who are on Medicaid, which involves a family-centered approach to care, with the goal of

promoting adherence to treatment and prevention simultaneously. This program is supported by a CMMI grant. The hospital has also piloted co-located behavioral health and primary care services.

**Westside Family Healthcare – Aetna/DPCI PCMH:** Westside Family Healthcare is an FQHC with multiple locations throughout Delaware that already include co-located services for primary care, behavioral health, podiatry, and dental care. In partnership with DPCI (a Medicaid MCO that is part of Aetna), Westside has been transforming its practice into a Patient Centered Medical Home.

**University of Delaware Nurse Managed Health Center** provides holistic primary care to patients via a multi-disciplinary model of care delivery. Nurse practitioners, physicians, physical therapists, and exercise physiologists work together to deliver coordinated care as well as mentor graduate students in the health sciences. The Nurse Managed Health Center also has a co-located office at a mental health care provider's office at Horizon House.

**Project ECHO:** this is a weekly telemedicine/telehealth conference to improve management of patients with complex conditions. Multi-disciplinary teams of specialists work together to educate and support PCPs.

**La Red FQHC:** Parkinson's Telemedicine Clinic provides telehealth services for Parkinson's patients who do not live near specialists.

**Nanticoke Health System PCMH:** Nanticoke's Patient Centered Medical Home program emphasizes coordination of care and action based on patient analytics (e.g., management of hypertension). Care coordinators provide organization and management of care. They also educate patients, families, and caregivers regarding the patient's care plan and self-care management responsibilities.

**Bayhealth clinically-integrated network:** Bayhealth has formed a clinically-integrated network to foster more data-driven, integrated care. Currently, there are more than 270 providers representing 60-plus practices throughout central and southern Delaware participating in the alliance.

**Delaware Cancer Consortium:** has developed a program to enable free cancer screening and treatment for those ineligible for insurance. Care coordinators guide patients through testing and treatment, and offer advice, emotional support and practical help.

While these models differ in approach, in general, they share common features: 1) voluntary participation; 2) focus on coordination for high risk individuals; 3) payment linked to value; 4) investments in practice transformation; and 5) using data to improve performance.

#### **Proposed model for delivery system transformation**

Delaware's plan emphasizes the role of primary care as a linchpin in the system that unites accountability for quality and cost for a defined panel of patients. Delaware's proposal creates a flexible framework so physicians that organize together into an ACO with a commercial payer can also participate with another commercial payer and in the MSSP. This approach builds on the success of programs advanced by Delaware's providers, including ACO models as organized by some of our health systems, and physician-led ACO and PCMH models supported by MSD, among others. Specific components of Delaware's plan include:

- **Voluntary participation** and support for small providers and large health systems.
- **Practice transformation support** funded partly by the Model Test Grant and partly by participating payers, with a modest co-payment from participating PCPs to demonstrate their own commitment to engage in the process. The goal is that practices will access practice transformation support from a third-party vendor (e.g., HealthTeamWorks, Quality

Insights of Delaware). Pending award of a SIM Testing Grant, DCHI will launch a request for proposal (RFP) process to prequalify or certify vendors in early 2015 and allow for practice enrollment and initiation of practice transformation support by [September](#) 2015.

- **Expansion of Learning Collaboratives** across the state, facilitated by DCHI working with providers and the Delaware Health Sciences Alliance.
- **Transition to value-based payment** models across all payers, which link to a common scorecard with measures commonly used across Delaware and by CMS, as well as additional payer-specific measures. This approach achieves quality measure alignment and administrative simplicity, as well as flexibility for innovation.
- **Care coordination support paid by payers to PCPs** (either through per-member-per-month fees or new CPT codes as established by Medicare) that may be used to hire staff or get external support. Some providers will build care coordination tools and resources directly, while others will engage third-parties, including capabilities offered by groups such as MedNet (subsidiary to MSD); local health systems; Highmark, Aetna, and other participating payers; and other third-party vendors. We hope for PCPs to have multi-payer funding for care coordination and to exercise choice as they resource care coordination so that they can establish a common solution across their patient panel, agnostic to payer.
- **Improved access to information.** Delaware's plan complements existing payer and provider investments in two ways. First, the DHIN continues to roll out Admit Discharge Transfer (ADT) notifications, which support providers in coordinating care (in particular post-discharge for Medicare patients). Second, the DHIN will help aggregate common measures so that providers can access one integrated view of their performance across all payers, with a single point of access for reports.

- **Engaging clinical leaders around clinical best practice.** To focus on more effective diagnosis and treatment, providers expressed the need to identify a few areas where high cost, variation in care, and lack of clarity among existing guidelines (or lack of guidelines) occurs. Working with Delaware’s medical associations, our goal is to convene clinical leaders, identify these areas, express a consensus perspective, and suggest measures for inclusion in the next version of the common scorecard. Development of specific guidelines would remain with current guidelines-focused organizations.
- **Engaging patients** in improving their health. Delaware’s plan starts with putting the patient first. Delaware’s transformation connects to and builds from several important patient engagement programs that are underway (e.g., Westside’s text4baby) or planned (e.g., DHIN’s proposal for patient mobile access to their health records).

By building on the momentum that already exists in the market and creating the flexibility for existing programs to expand and accelerate, this approach positions Delaware to achieve significant transformation in 3-5 years.

### **Workforce transformation**

Delaware will support delivery system transformation with a novel workforce strategy. We want to position Delaware as a “Learning State,” actively engaged in transforming our current workforce and training the next generation of workforce so it can provide a team-based approach to deliver coordinated integrated healthcare. Today, Delaware has tremendous health education assets (e.g., University of Delaware (UD) Healthcare Theatre, HCC State Loan Repayment Program). In the absence of a medical school, the Delaware Health Sciences Alliance (DHSA) was established as a research and training partnership of the UD and three health systems. Despite these resources, capacity shortages persist (HPSAs for primary care, behavioral

health, and dental care), there is a need for more coordination in curricula, and a burdensome accreditation process exists. In addition, providers report not always having the support to practice at the top of their license, and a gap exists in skills and capacity for coordinating care.

Delaware's workforce strategy will focus on retraining the current workforce, building sustainable workforce planning capabilities, and training the future workforce in the skills needed to deliver integrated care. Delaware began its retraining program with a symposium to: 1) learn from successful programs; 2) define core needs and skill gaps for coordinating care; and 3) prioritize methods for retraining the workforce. Over the next four years, Delaware's academic and health care communities will collaborate on a multi-year curriculum that includes:

- **Simulation-based learning modules** using UD's Healthcare Theatre that develop "before" and "after" scenarios for each core component of coordinated care. These scenarios will be accessible online so providers and their teams can improve coordination of care.
- **Local facilitated workshops on "team-based care,"** based on a common curriculum developed jointly by faculty at all of Delaware's academic institutions that focuses on the core skills identified in the initial symposium (e.g., interpersonal skills).
- **Development of core competencies for new roles** (e.g., care coordinators) that achieve consensus across the health community and are made available as a common resource.
- **Symposia** twice yearly to highlight novel approaches to integrating care and focus on cross-state needs (e.g., sessions on community engagement strategies for primary care).

### **(3) PAYMENT AND/OR SERVICE DELIVERY MODEL**

To enable care coordination and effective diagnosis and treatment, our goal is for most care in the state to transition to outcomes-based payments that incentivize both quality and management of total medical expenditures over the next five years. Delaware's plan is for all

payers to introduce at least one Pay for Value (P4V, with bonus payments tied to quality and utilization management for a panel of patients) and one Total Cost of Care (TCC, with shared savings linked to quality and total cost management for a panel of patients) payment model option to eligible PCPs beginning in [September](#) 2015. The approach will build from the different models in the system today. Core technical details will continue to be defined between payers and providers (e.g., shared savings level, minimum panel size), however all payers will support the following common principles to simplify participation for providers:

- **Attribution of all Delawareans to primary care physicians** (pediatrics, family medicine, general internal medicine) or advanced practice nurses working under Delaware's Collaborative Agreement requirement.
- **Flexibility to include independent primary care providers**, as well as those employed by or affiliated with a health system.
- **At least one P4V and one TCC model available from each payer**, with at least one model that has some form of funding for care coordination, whether in the form of per member per month fees or payments for non-visit based care management.
- **Payment tied to common scorecard** for all models, with a minimum percentage linked to common measures and the rest linked to performance on payer-specific measures.
- **Commitment by all payers to work with providers to achieve 80%** of payments in these models within five years.

Delaware's approach to payment is novel in its ability to accommodate and support independent providers and large systems, and create enough flexibility for existing innovations to flourish and expand across all payers. For providers and payers that have already entered into population-based payment models, no changes will be required other than to link their current scorecards

with the common provider scorecard, as described in Section 7.

Delaware's plan is to introduce new payment models across all payers that are linked to the common provider scorecard beginning in 2016. The State, through its procurement for Medicaid Managed Care services, is requiring payers to introduce these models and scale them to reach statewide implementation within the SIM period of performance. The State Employee Benefits program is similarly prepared to encourage adoption of these models. Delaware has also required introduction of these new models as part of its proposed certification standards for Qualified Health Plans. Delaware's payers and providers have supported and remain committed to scaling these new payment and delivery models. Delaware's plan also includes elements designed to encourage provider adoption of these models, including dedicated provider education and awareness campaigns. The specific timeline for rollout and participation in new payment models is to achieve 19-30% adoption (as a percent of spend) of total cost of care (TCC) payment models (varies by payer segment), with 60% of primary care providers participating in value-based payment models by 2016; 46-60% adoption of TCC payment models with 80% of primary care providers participating in value-based payment models by 2017; and 69-80% adoption of TCC payment models with 90% of primary care providers participating in value-based payment models by 2018.

**Scope: populations, beneficiaries, providers, and services**

Delaware's plan for value-based payment models targets most populations, a broad set of beneficiaries, all payers, and a broad set of services. Each is described below.

- **Populations:** Delaware's payment models include pediatric, adult, and elderly populations.

For Medicaid and CHIP, this includes all beneficiaries in Diamond State Health Plan and Delaware Children's Health Plan. The proposed approach includes all Medicare

populations. For State Employees, this includes active members and non-Medicare retirees. In addition, Delaware anticipates that the entire commercial population will participate.

- **Beneficiaries:** Across all payers, Delaware intends to include as many of the current 925,749 residents as possible in new payment models, including ~161,000 Medicare beneficiaries (~15,000 duals), ~223,000 Medicaid beneficiaries, and 117,000 State Employee beneficiaries (including ~96,000 active members and non-Medicare retirees), 14,397 Qualified Health Plan (QHP) beneficiaries, and approximately 356,450 other commercially fully insured and self-insured beneficiaries.
- **Providers:** Delaware’s approach will support all 1,267 primary care physicians (defined as pediatrics, family medicine, general internal medicine) or advanced practice nurses working under Delaware’s Collaborative Agreement requirement who may choose to participate.
- **Services:** While each payer will define specific services included in total cost of care with each provider, in general the aspiration is for as much of total cost to be included as possible. At a minimum, this means inpatient, outpatient, labs/imaging, and pharmacy.

### **Behavioral Health and Long Term Services and Support**

Delaware’s Model Testing proposal complements existing value-based models in DHSS focused on clients with behavioral health needs and in Long Term Services and Support (LTSS). DHSS developed the “PROMISE” program to coordinate care for approximately 2,400 beneficiaries with severe and persistent mental illness. Medicaid moved to managed care for its ~10,000 long-term care beneficiaries in 2012 and strengthened some Home and Community Based Services (HCBS), which increased the proportion of clients in HCBS from 40% to 50%. The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) complemented these efforts through early intervention, which avoided 90% of potential

admissions into state-owned long-term care over three years. Given the significant costs (~\$400M annually on LTSS), these programs are an important component in moving 80% of payments to value-based models.

### **Alignment with CMS models**

Delaware's approach from the start focused on aligning with existing Medicare models. This has included: 1) considering MSSP and Pioneer ACO when evaluating initial approaches to payment innovation; 2) reviewing CPC and CMMI core metrics for Delaware's common provider scorecard; and 3) referencing CPC for Delaware's initial transformation milestones.

Delaware anticipates that its multi-payer transition to population-based payment models will align with Medicare models in two important ways. First, it will increase adoption of MSSP and, if available, Pioneer ACO models in Delaware. Second, it will encourage providers to fully pursue post-discharge care coordination through the new CPT codes. Delaware asks Medicare to participate in its multi-payer reporting approach by contributing data for common measures so that providers can see aggregate performance across their entire panel of patients. Delaware also asks Medicare to consider applications from providers for the Pioneer ACO program.

### **Medicaid expansion and achieving 80% of payments to providers**

Building from Delaware's decision to expand Medicaid as part of the Affordable Care Act (ACA), Delaware is confident that it will transition at least 80% of payments to providers to value-based models within five years. Delaware Medicaid expanded eligibility to 100% FPL in 1996 and further expanded eligibility to 133% FPL as part of the ACA, providing coverage to an additional 6,626 Delawareans. With expansion, Delaware Medicaid covers approximately 24% of the population. State employees represent another 13% of the population.

By adopting an approach consistent with innovation in the market, Delaware's multi-

stakeholder approach from SIM has been a catalyst for adoption of innovative payment and delivery models, with progress accelerating significantly since the start of the design phase last spring (e.g., Beebe Health System's MSSP).

#### **(4) LEVERAGING REGULATORY AUTHORITY**

The approach to innovation in Delaware has been highly collaborative, participatory, and consensus-based from the start. DCHI was established as a nonprofit, public-private organization to work with the HCC to carry forward Delaware's consensus-based process. The State will support DCHI by leveraging regulatory authority in the following areas:

**Medicaid Managed Care Organizations (MCOs):** In December 2013, Delaware Medicaid released an RFP to procure MCO services for medical, pharmacy, and LTSS for ~83% of Medicaid beneficiaries. In the RFP, the State required active participation in SIM and the introduction of new delivery and payment models consistent with those described in Section 3 (e.g., payment linked to common scorecard). The procurement process is ongoing, with the new contract beginning January 1, 2015. Given the size of Delaware's Medicaid population covered by Managed Care, this RFP represents a critical component of the State's use of regulatory authority to enable Delaware's strategy.

**State Employees:** Delaware's State Employee Health Plan, which provides benefits to approximately 117,000 individuals (active employees, Medicare and non-Medicare retirees), has been an active participant in the development of Delaware's strategy to achieve the Triple Aim. Following the consensus-driven SIM design process and feedback from the two Third Party Administrators (TPAs), Delaware's State Employee Health Plan is encouraging the scale up of value-based payment models described in the State Health Care Innovation Plan (SHIP).

**Qualified Health Plans (QHPs):** In 2013, Delaware required QHPs to participate in SIM as a

condition for participating in the health insurance marketplace. Delaware also required QHPs to participate in the DHIN at the prevailing fee structure and for Delaware's Federally Qualified Health Centers to be paid a PPS rate to improve access to care. A workgroup was formed to review PY2015 standards and propose recommendations for PY2016. QHP state certification standards under consideration by HCC include the following requirements to support SIM: offering value-based payment models; linking payment to and requiring use of the common provider scorecard; and supporting care coordination, practice transformation, and telemedicine, as well as network adequacy requirements to address access to behavioral health services.

**Certificate of Need (CON):** The State deferred developing the next strategic plan for the Delaware Health Resources Board ("HRB," Delaware's CON Authority) in 2013 to ensure alignment with the SIM plan. The HRB previously made important changes that complement the scope of the SHIP (e.g., revising the approach for calculating long-term care capacity to include HCBS). Delaware also has leveraged its CON authority to promote access to primary care. As a result of an HRB condition on a new facility, nearly 200 individuals per quarter without a PCP were referred from the Emergency Department to PCPs.

**Health Care Commission (HCC):** As the main health policy organization in the state, the HCC convened stakeholders, championed the SIM process, and created public transparency around the entire effort. HCC also manages the State Loan Repayment Program and was recently awarded a four-fold increase in funding to expand this program based on workforce needs identified since the start of SIM design work.

**Workforce and education:** The State has a track record of taking important steps to enhance its health care workforce (e.g., passing legislation in 2012 to enhance access to dentists in FQHCs, extending Medicaid coverage for certain telehealth services). The State also served in a

convening role (e.g., bringing together the Graduate Medical Education consortium to identify opportunities to expand physician training). Delaware will explore steps to streamline the current credentialing process, including reducing duplicative background checks among payers, providers, and Department of State, and leveraging a common CAQH credentialing application.

**Insurance Regulations:** We believe that further insurance regulations mandating the adoption of value-based payment would be unnecessary for three reasons: (1) Medicaid and State Employees—each of which fully support payer adoption of our Plan—already comprise 40% of our population; (2) the leading payers in Medicaid, State Employees, and the Marketplace are already actively shaping our models and contributing to shared information technology and reporting that would extend to the rest of their fully insured and self-insured business; and (3) it is important for a small state like Delaware to limit unnecessary regulations when possible to promote a market attractive to new insurers.

**Transitions of Care:** As a major strategic initiative of DHSS, the Division of Medicaid and Medical Assistance and the Division of Services for Aging and Adults with Physical Disabilities have developed and implemented policies to support aging individuals as well as those with mental health needs and disabilities to receive care through Home and Community Based Services rather than in institutional settings. These policy initiatives have included establishing an Aging and Disability Resource Center (ADRC), transitioning coverage for Long Term Services and Supports to Managed Care, and implementing the “Money Follows the Person” program to support transitions back into the community.

The Delaware Health Care Commission (HCC) has responsibility for health policy across Delaware and also is the organization with accountability for successful implementation of Delaware’s proposal. In this dual role, the HCC ensures that these initiatives are integrated with

Delaware's proposal. Individual members of the Commission further promote this integration (e.g., Insurance Commissioner, Secretary of the Delaware State Department of Finance). The Secretary of DHSS is a member of the Commission and her Department also includes the Division of Medicaid and Medical Assistance which is embedding the new SIM payment models into its procurement of Managed Care services.

## **(5) HEALTH INFORMATION TECHNOLOGY**

**Current State of Technology Adoption:** Delaware has some of the country's highest rates of Health Information Technology (HIT) adoption: 98% of providers, 100% of hospitals and skilled nursing facilities enrolled in the Health Information Exchange (HIE), 83% of providers with Electronic Health Records (EHRs), a 98% e-prescribing rate, and 69% of providers meeting Meaningful Use requirements. Given this advanced starting point, Delaware will focus on opportunities to improve the value of HIT through the State's HIE system (DHIN), one of the most advanced networks in the country.

**Approach:** The State has already made significant progress in developing an overall approach to HIT. A Technical Advisory Group, with representatives from providers, payers, DHIN, and the State, has been meeting bi-weekly to more fully develop IT elements of the State Health Care Innovation Plan (SHIP) and define the implementation approach for the common scorecard. State HIT Leaders, including the state HIT coordinator, Medicaid IT Leadership, Governor's Health Policy Advisor, and the State CIO (as a member of the DHIN Board) were involved in the development of the SHIP and/or briefed.

The overall philosophy is to build on existing investments made by payers, providers, and the State to enable increased data sharing, improved transparency, and proactive monitoring and analysis to achieve a state-wide health transformation. The goal is to integrate current silos of

data that exist with the state, payers, and providers. The DHIN provides a tremendous foundation for enabling this data-driven care. Expansion of HIT adoption will accelerate with incentives and technical support across the state, including urban health centers and rural providers.

**Quality Data Infrastructure:** DHIN's high adoption 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 ADT reports and medication history, providing enhanced patient views and community health records to providers to improve efficiency and effectiveness of care. DHIN also offers Continuity of Care Documents (CCDs), and public health reporting on notifiable conditions, vaccinations, and syndromic surveillance (e.g., for early detection of flu outbreaks) to allow more rapid and targeted responses to public health issues. While there are already extensive capabilities at DHIN today, new capabilities will be added to support the statewide health transformation:

**1) Provider tools:** Provide practices with visual tools that will allow them to see their progress on improving quality and cost, integrated across all payers using the common scorecard. DHIN will facilitate the aggregation of metrics from payers and providers into the scorecard that is distributed to each practice. Over time, Delaware will introduce additional functionality for providers, including the ability to drill down and conduct analyses on their own data. Providers without EHR technology can submit quality metrics and practice transformation attestations (critical for enabling small and rural providers to realize program benefits).

**2) Expansion of the Community Health Record:** Expand clinical information in the DHIN from ambulatory providers, nursing homes, and home care facilities via support of CCD exchange, as well as alert services that smooth transitions of care.

**3) Multi-payer claims and clinical information data store:** Build on existing and planned

investments in a Medicaid / State-employee claims database to create a multi-payer data warehouse, aggregating government, commercial, and non-reimbursable claims. Integrating this with clinical data from DHIN will create the foundation for analysis of aggregate data on health levels, resource needs, cost drivers, and/or impact of initiatives.

**4) Patient engagement and transparency solutions:** Develop consumer engagement tools (e.g., portal, mobile apps) to enable patients to access their health information, building on Meaningful Use requirements and aggregating across multiple disparate sources. Providers and patients will have access to better information about quality and cost to engage in shared decision making.

**Expanding Coordination Across the Care Continuum:** Care coordination is an integral part of the overall state health transformation. Some providers will build on their existing investments while smaller providers may access third-party support. To support integration of behavioral health, EHR adoption incentives will be provided to these specialists. CCDs provide comprehensive clinical records that facilitate integrated, coordinated care. The Statewide Telehealth Coalition has been working to expand existing telemedicine practices for individuals with disabilities, mental health disorders, or chronic diseases so they can coordinate with specialists from another region. Health systems also have telehealth efforts under way and the Model Test plan will be an opportunity to further refine a statewide strategy.

**Technical Assistance:** Delaware will leverage existing assets in its Regional Extension Center (REC) and the DHIN. The REC (via a grant to Quality Insights of Delaware) has been successfully supporting providers adopting EHRs. Delaware will build on these relationships and processes to deliver assistance to providers wishing to enroll in the new payment models. In addition, DHIN will continue supporting providers to connect to current and planned resources.

**Governance:** As the state-designated HIE, the DHIN will have overall accountability for

Delaware's HIT approach and will work with the DCHI and Technical Advisory Group to design and implement the strategy. DHIN will be responsible for managing implementation of shared components (e.g., provider tools and common scorecard). Because DHIN has been operating since 2007, it has the governance in place needed to manage data sharing and data ownership. DHIN is a steward of the data, and its Data Use Agreements with each data sender allow for the use of that data according to mutually agreed-upon rules and regulations. The DHIN board is composed of private and public stakeholders that provide strategic guidance to the organization. The State HIT coordinator continues to be highly involved in the effort as the Director of DSAAPD, ensuring ongoing review and rationalization of federal IT investments.

The proposed technology applications will be managed by DHIN which has a track record of demonstrating its ability to secure payments for services that it provides. To complement the SIM funding for initial development of the systems, stakeholders would contribute funds that would be matched by Federal Medicaid. Ongoing costs would be borne by DHIN and paid for through fees charged to stakeholders (e.g., data senders, payers, and providers) for access to DHIN value-added services. This business model has been successful for DHIN thus far, and the future business plan for DHIN has incorporated offerings such as these in order to provide a full suite of services as the state's health information exchange.

**Policy:** Delaware has taken policy and regulatory steps to accelerate its already high health technology adoption rates. For example, all issuers participating in the state health insurance marketplace are required to participate in and utilize DHIN data use services and claims data submission services. Consistent with Delaware's inclusive process, stakeholders across the health care landscape, from individual practitioners to large health systems to payers, have been actively engaged and will continue to be engaged to develop statewide strategies to expand HIT.

## **(6) STAKEHOLDER ENGAGEMENT**

Delaware's approach to health innovation has been inclusive from the start. Stakeholders submitted more than 60 letters of support for Delaware's design grant application in 2012 and the high level of support and participation has continued to date. Since May of 2013, nearly 30 public meetings have been held statewide, including monthly HCC meetings with consistent attendance of 75-100 members of the public and health care and consumer communities. There also have been seven cross-workstream meetings which are typically half-day sessions with consistent attendance of 75-125 individuals. Presentations are posted on the HCC website and email updates are sent regularly to a list serve of more than 500 Delawareans. Governor Markell hosted an employer roundtable discussion on July 9, 2014. More than 125 people have responded to surveys (including 88 responses about the progress and challenges in better coordinating care). Delaware's workforce symposium had 125 attendees. Regular engagement has continued with individual stakeholders as well. As a result, Delaware's State Health Care Innovation Plan achieved broad support. At the February 2014 HCC meeting, stakeholders noted that the inclusivity and openness of the process distinguished Delaware's multi-stakeholder approach.

Governor Markell has provided active leadership throughout both the design phase and the work that has continued in recent months. Senior government leaders have actively led and been engaged, including briefings to the Governor's Cabinet, State legislators, and Delaware's U.S. Congressional Delegation.

### **Provider engagement strategy**

**1) Stakeholders and level of commitment:** Providers across Delaware – including physicians, behavioral-health providers, community-based and long-term care providers, every hospital and FQHC, provider organizations (including MSD and Delaware Healthcare Association –

Delaware's hospital organization), other providers, and the state — have worked together on this initiative. Physicians ranging from large physician networks to the Delaware Academy of Family Physicians to independent PCPs have all expressed strong support for Delaware's proposal. Every hospital, two FQHCs, the long-term care provider association, and the DSAAPD also strongly support the plan. Provider commitment has been demonstrated by active participation from senior leaders (e.g., CEOs, CMOs), strong letters of support, and increasing adoption of new payment models consistent with Delaware's proposal.

**2) Strategy going forward:** Delaware will engage providers through meetings of the HCC, DCHI (both the Board, which has 7 members across health systems, physicians, FQHCs, and behavioral health providers, and individual committees), and DHIN. In addition, Delaware will: 1) meet with provider organizations, working with them to reach out to providers; 2) attend local meetings of provider groups (e.g., at grand rounds); and 3) conduct regular discussion forums statewide. Through this engagement, Delaware will seek to incorporate provider clinical and operational expertise into the ongoing implementation of the plan, as well as share information to encourage participation in new payment, delivery, and population health models.

### **Payer and other stakeholder engagement strategy**

**1) Stakeholders and level of commitment:** Patients, insurers, (the largest commercial carriers, current MCOs, and employers), health advocates, consumer groups (e.g., AARP), colleges and universities, pharmaceutical organizations, DHSS, and local government officials have all been actively involved. Delaware's major commercial payers and the state have all committed to align quality measures and are already working on the technical details of a common scorecard.

**2) Strategy going forward:** In addition to the overall approach to stakeholder engagement, Delaware will work actively with payers on rolling out new payment models and aligning quality

measures (see Section 7). Delaware will continue regular meetings of the Employer Roundtable. The HCC and DCHI's Patient/Consumer Advisory Committee will establish regular meetings to engage with patients and consumers. The HNC will engage community organizations, local governments, DHSS, payers, and providers to develop the plan for population health.

### **Strategy for sustaining stakeholder engagement**

Delaware will continue the active stakeholder engagement that has been a hallmark of its approach so far. In order to ensure a sustainable, inclusive approach, Delaware has defined: 1) governance; and 2) approach and timeline.

**1) Governance.** The HCC, DHIN, and DCHI have primary responsibility for stakeholder engagement. DCHI was created as a new 501(c)(3) sponsored by the DHIN and HCC to provide a structure for systematically engaging leaders across the state to represent the best interests of Delawareans. Each entity has a multi-stakeholder structure that ensures broad representation across the health care community. They will convene public forums, lead engagement with individual stakeholders, and ensure an inclusive and open process.

**2) Approach and timeline.** Delaware will pursue a structured approach to stakeholder engagement. The foundation will include: monthly HCC meetings; meetings of the DCHI Board; and cross-workstream meetings. Committees of the DCHI and the Technical Advisory Group also will meet regularly to work on specific components of the strategy. The HCC and DCHI will post materials to their websites and use periodic surveys. The approach includes the following phases: 1) co-design final details of each element of the plan, concentrated over the next 18 months; 2) provider and consumer education and awareness (beginning this fall and periodically during the model test period; 3) enrollment support; 4) peer-to-peer learning through workforce development and learning collaboratives; and 5) continuous improvement.

## **(7) QUALITY MEASURE ALIGNMENT**

Delaware will introduce a common provider scorecard as the basis for the transition to value-based payment models across all payers. Currently, Delaware’s providers report frustration with too many “scorecards” and a general proliferation of quality measures. As a result, providers have started to work with payers to develop scorecards that improve upon the current state to reflect measures that represent strong indicators of improvements in quality and cost.

Delaware’s proposed common provider scorecard will balance the benefits of aligning measures across payers with the desire to build from ongoing performance measurement efforts led by providers. Specifically Delaware’s scorecard will have: 1) a set of primary-care based measures that are aggregated across all payers for each primary care practice’s full panel of patients; and 2) additional information reported separately for each payer that includes both provider performance on the common measures for that payer population and additional measures agreed to by each payer and provider. A minimum percentage of payment across all payers will be linked to performance on the common measures.

### **Proposed common measures**

Delaware’s scorecard builds on measures commonly used in the market today. Clinicians in Delaware used the following approach to develop the draft scorecard: 1) identify a broad baseline set of measures; 2) prioritize based on guiding principles (e.g., nationally recognized, ability to collect electronically); 3) refine to balance across dimensions of the Triple Aim and populations; 4) syndicate broadly; and 5) link to population health. Delaware took a similar approach in defining the transformation milestones component of the common scorecard. While providers and payers are currently working to refine the current draft of the scorecard based on ease to collect and report these measures, the current draft measures include:

- **Care improvement:** HbA1c control in diabetic patients; blood pressure control in hypertensive patients; appropriate medications for people with asthma; avoidance of antibiotics in adults and children with a URI; adherence to statin therapy for individuals with coronary artery disease; screening for clinical depression and follow-up plan; screening for tobacco use and cessation counseling; colorectal cancer screening; adult weight screening and follow-up; pediatric weight assessment and counseling; flu vaccination status for older adults; childhood immunization status; HbA1c testing for pediatric patients; oral fluoride supplementation for pediatric patients; patient satisfaction
- **Cost reduction:** risk adjusted total cost of care; inpatient admissions per 1000 patients; ED visits per 1000 patients; hospital all-cause unplanned readmissions
- **Transformation:** identification of high-priority patients; approach to same-day appointments and/or afterhours access to care; voice-to-voice coverage to panels members 24/7; multi-disciplinary team working with high risk patients to develop a care plan; approach to contact patients who did not get preventive care; documented investment in behavioral health integration

The current draft of the scorecard is well balanced. It includes seven CDC/SIM core measures, including three for diabetes, one for tobacco, and two for obesity. It also includes eleven CMMI core measures. The scorecard includes measures across pediatric and adult populations and across prevention and chronic disease management.

### **Performance reports**

Delaware's scorecard approach is distinctive because it will aggregate performance across all payers to produce a single integrated view for providers. Provider performance on the common measures will be displayed on the first page of an integrated quarterly performance

report for their entire panel of patients. Additional payer-specific information will follow on subsequent pages. Providers will be able to access the report through a simple access point.

### **Limiting administrative burden**

Delaware's common provider scorecard approach has minimized this burden in four ways. First, the structure of the scorecard (building from measures and scorecards in the market today) enables providers to have continuity with their existing innovations. Second, the focus has been on a limited number of total measures. Third, stakeholders have prioritized measures that can be captured and reported electronically. Fourth, for measures requiring data from providers, Delaware is developing an approach so that providers only have to report once for all payers.

### **Transparency strategy**

Delawareans agree on the value of performance transparency to inform decision making by both clinicians and consumers, shaping decisions among treatment options, choice of provider, referral decisions, and performance improvement initiatives. We also believe it is important to manage the transition to transparency in a thoughtful way, to ensure that data is accurate and measures are well understood by clinicians and consumers. As a principle, therefore, we have established with local stakeholders that any reporting by DHIN using the common scorecard will, for the first year, be shared directly with primary care providers themselves, so that payers and providers can work together during that year to test and improve the accuracy of the data (before this information would be shared with consumers). Throughout this process, DHIN and DCHI will consult provider organizations and payers to assess data quality and based on this will define the timeline and process for increasing transparency to consumers in the second year, based on the best interests of Delawareans.

## **(8) MONITORING AND EVALUATION PLAN**

Delaware has set out a robust monitoring and evaluation strategy to test the overall success of its approach, including the effectiveness of its policy and regulatory strategy. There are three core components: 1) governance; 2) measures; and 3) methodology.

### **1) Governance**

The Delaware Center for Health Innovation (DCHI) will have primary responsibility for monitoring and evaluation, reporting to the Health Care Commission, the DHIN, the legislature, and the Governor at least annually on overall progress. DCHI is well positioned for this responsibility because it is an independent 501(c)(3) nonprofit organization and its Board is composed of leaders from across the health system (including physicians, behavioral health, health systems, FQHCs, payers, and state leaders). The initial Board has been appointed and held its first meeting in July 2014.

The Delaware Health Care Commission has overall responsibility for health policy in the state and has overall accountability for administering the cooperative agreement. DCHI was established by the HCC and the DHIN as a public-private nonprofit organization specifically intended to bring together the senior level expertise required to ensure successful detailed design and implementation of the components of Delaware's State Health Care Innovation Plan. Its committees will bring together experts from across the health system to do the detailed work and make recommendations to the DCHI Board. The Board will facilitate multi-stakeholder input into detailed technical design decisions. It will work with the HCC for those decisions that require policy support. The DCHI Board also will work with payers and providers to facilitate voluntary adoption and participation in common components of Delaware's proposal. For example, DCHI, with input from its Clinical Committee, will recommend the measures

(including detailed technical specifications such as numerators and denominators and exclusions) and reporting approach for the common provider scorecard. DCHI will work with payers and providers to ensure broad alignment and support for the measures and work with the DHIN to develop the technical infrastructure required to create the report. It will work with the HCC to ensure that participation in the common scorecard is a requirement for QHPs.

All policy decisions and funding decisions will be made by the HCC while leveraging the best experts across Delaware. Delaware will work to ensure sufficient transfer of responsibilities to DCHI staff, both for monitoring and evaluation and for implementation of its plan, so that they are prepared to carry forward much of this work by years 3 and 4 of the SIM performance period.

Delaware plans for its transformation work to continue beyond the SIM period of performance and expects that the DCHI will continue its work well beyond the SIM period of performance as well. As a result, the proposed approach is to use stakeholder funding rather than SIM cooperative funding for staff positions so that there is an ongoing source of funding for these positions beyond the period of performance. Delaware is in the process of developing job descriptions for the Executive Director. Delaware anticipates posting for the Executive Director and staff in January 2015 and has already been receiving stakeholder input on potential candidates. The HCC and DCHI will ensure appropriate training for new staff, in addition to ensuring that contractors transfer capabilities to permanent staff.

The DCHI Board, along with its Committees and the Technical Advisory Group, will each have a critical role in monitoring and evaluation:

- **Board:** In consultation with the broad health care community, the Board will define measures and goals for an overall scorecard that will track Delaware's progress and

outcomes. It will review progress quarterly and upon consensus input from applicable committees, it will recommend any changes in approach to stakeholders. If necessary, the Board may work with the HCC and/or the DHIN for policy support to improve performance on aspects of Delaware's plan in which progress varies from expected.

- **Payment Model Monitoring Committee:** This Committee will review progress of adoption of new payment models across the health system. It will seek broad feedback to identify barriers to adoption and opportunities to accelerate participation.
- **Clinical Committee:** This Committee will track how providers are implementing team-based approaches to integrating care. It will work to identify opportunities to support providers as they transition to new delivery models. The Committee will review aggregate progress on the common provider scorecard and work with medical associations and the clinical community to refine measures over time.
- **Patient/Consumer Advisory Committee:** This Committee has two roles in monitoring and evaluation. First, it will ensure that a consistent focus on the patient and consumer is included in all aspects of Delaware's strategy (e.g., by providing input on consensus recommendations from other committees). Second, it will track progress on Delaware's patient engagement goals.
- **Workforce and Education:** This Committee will review Delaware's success in evolving educational programs to support the new skills needed to coordinate care. It also will evaluate how the current workforce has integrated these new skills into care delivery.
- **Healthy Neighborhoods:** This Committee has responsibility for the population health scorecard. It will define measures and set goals, as well as review progress against these goals. It also will evaluate the success of individual neighborhoods.

- **Technical Advisory Group:** TAG will make recommendations and monitor progress on implementing the core elements of Delaware’s data and analytics strategy.

## 2) Measures

A foundational element of Delaware’s monitoring and evaluation strategy is its overall scorecard, which includes two categories of measures: 1) measures across the Triple Aim; and 2) summary accountability measures to evaluate implementation. The scorecard integrates components of the common provider scorecard and the population health scorecard to provide an overall perspective on Delaware’s progress against its goals. The denominator for overall measures is the entire Delaware population. The scorecard will be updated at least annually and shared publicly. The proposed measures are described below:

### Triple Aim measures

- **Health Improvement:** Delaware’s rank in America’s Health Rankings; percent cigarette smoking; percent eating fruits and vegetables; percent who report physical inactivity; Hypertension prevalence; Diabetes prevalence; Obesity prevalence; Cancer death per 100,000; Coronary heart disease deaths; 30 Day Mortality Rate, all-cause, risk-adjusted post PCI intervention/cardiogenic shock/AMI; Infant mortality
- **Care Improvement:** Delaware’s ranking on the 14 care improvement measures from the common provider scorecard; percent of PCPs meeting goal for at least 10 out of 14 quality of care measures; survey for patient access and physician effectiveness (e.g., CAHPS)
- **Cost Reduction:** actual total cost of care per patient vs. expected total cost of care; risk-adjusted, total of cost of care per capita; inpatient admissions per 1000 patients; ED visits per 1000 patients; Hospital All-Cause Unplanned Readmissions, Risk Adjusted

## **Accountability measures**

- **Overall implementation:** percent of population with a care plan; percent of total healthcare spend linked to value-based payment; percent of primary care providers/organizations with staff attending workforce retraining programs; percent of population in Healthy Neighborhoods; percent of population with PCPs receiving the common provider scorecard
- **Provider transformation:** percent of population with PCPs offering expanded access to care; percent of patients needing care plans that have them
- **Payer performance:** average medical loss ratio (across payers); growth rate of healthcare premiums vs. growth rate of total cost of care in Delaware

## **3) Methodology**

DCHI will pursue a structured approach to monitoring and evaluation to ensure it has sufficient insight into progress and potential risks:

**Core analyses:** Across all measures, DCHI will conduct the following analyses: 1) comparison of overall progress versus goals and accountability targets; 2) comparison of progress for participating providers and payers versus those not yet enrolled in new models; and 3) breakdown of performance by geography.

**Sources of data:** Measures will be collected primarily from CDC and DPH surveillance, payers, and providers. DCHI will work with DHIN and health care stakeholders to create a streamlined process for collecting and reporting on these measures.

**Translating research into practice:** Consistent with the overall intent of Delaware's model testing proposal, Delaware intends to use insights from its monitoring and evaluation strategy to spur research and translate it into practice. Delaware is currently engaged in translational research work through its ACCEL initiative (focused seed funding for new research initiatives in

clinical and translational medicine) and has other initiatives focusing on supporting health innovation in the business sector (e.g., mHealth, focused health technology solutions).

**Timeline:** DCHI will expand its focus across measures over the Model Test period based on expectations for the rollout of new payment and delivery models, expected availability of data, and potential time to impact. In the first year, DCHI will focus on process measures of implementation and provider transformation. The second year will expand to process measures of improving population health and utilization. In years three and four, we expect to see movement on reducing growth in health care expenditures per capita.

## **(9) ALIGNMENT WITH STATE AND FEDERAL INNOVATION**

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

Delaware's proposal aligns with these in several ways. First, it creates opportunities to share lessons learned from this ongoing innovation (e.g., through learning collaboratives).

Second, it complements the impact they are having (e.g., transition to new payment models and funding for care coordination across all payers supports the care coordination for Ischemic heart disease at Christiana). Finally, it depends on current investments in ongoing innovation.

Delaware has conducted reviews to ensure that no federal funding will be used for duplicative activities or to supplant current federal or state funding. The State already reviewed its SIM approach with the Clearinghouse Committee of the General Assembly to ensure alignment across grant Delaware's grants. The HCC, in coordination with DCHI and DHIN, will periodically review all ongoing innovations to ensure that they are complementary to each other.