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DELAWARE

State Innovation Model Annual Progress Report

May 1, 2017

Award Year 2 (AY2) of Delaware's State Innovation Model Test Cooperative Agreement (February 2016 through January 2017) served as a transition from planning to implementation of initiatives that are focused on helping Delaware achieve the Triple Aim Plus One: better health, improved health care quality and patient experience, lower growth in per capita health care costs, and an enhanced provider experience that promotes patient-centered engagement. Several initiatives launched throughout the year and strategies that were originally envisioned in theory started to take shape on the ground. The following report will summarize Delaware's accomplishments, challenges, and plans to continue the momentum built in the first half of the award period.

Summary of Accomplishments and Milestones

Infrastructure and Stakeholder Engagement

Throughout AY2, the Delaware Health Care Commission (HCC) and Delaware Center for Health Innovation (DCHI) created and capitalized on opportunities to engage a broad range of stakeholders.

DCHI, the non-profit organization established to guide the implementation of the state's SIM goals, continued to serve as a forum for stakeholder engagement and consensus building. The board of DCHI is comprised of stakeholders representing providers, payers, consumers, health systems, and state officials and has five standing committees focused on various strategic initiatives of SIM. Throughout AY2, DCHI held two cross-committee meetings as a way to engage members of all five DCHI committees and the general public in the organization's work and in shaping the statewide initiative. The half-day meeting agendas included deep dives into topics such as access to claims data and behavioral health integration, and updates from payers regarding new payment models. With over 70 attendees each, the events reaffirmed the value of DCHI as a convener of key stakeholders.

Working with a SIM-funded media and public relations firm, DCHI led a series of community forums designed to introduce the public and additional stakeholders to the work of SIM. Six forums were held throughout the state in Q1 and Q2 to introduce stakeholders to the various initiatives and outline

Delaware's goals in achieving the Triple Aim Plus One. Approximately 200 individuals attended these community forums, which provided key learnings for future engagement.

In Q4, the HCC and DCHI facilitated a Practice Transformation Learning Collaborative targeted towards primary care providers and their practice staff and received very positive feedback on the event. Over 100 stakeholders attended the event and participated in interactive discussions on the future of primary care in Delaware, team-based care, and payment reform. Tools and resources currently available to practices to assist in their transformation efforts were also highlighted.

Stakeholders were also critical in guiding specific initiatives throughout the year. For instance, DCHI convened stakeholders to investigate the potential application of a health care claims database in Delaware. A working group of the DCHI Payment Model Monitoring Committee was established and included individuals not previously engaged with the HCC and/or DCHI. The input from this broader group of stakeholders led to a thorough and inclusive consensus paper on increasing access to claims data to support health innovation¹ that was brought to the DCHI Board for discussion. This paper was ultimately approved and informed the development of SB 238, which called for the implementation of a Health Care Claims Database (HCCD) in Delaware. SB 238 was passed by the Delaware General Assembly in June 2016 and signed by then Governor Jack Markell, providing the statutory authority for the Delaware Health Information Network (DHIN) to develop and maintain a claims database in Delaware.

Another group of broad stakeholders were engaged to identify the location of the first Healthy Neighborhood launch. Through stakeholder feedback and direct outreach to various organizations located across Delaware, these stakeholders prioritized West/Central Sussex as the first Healthy Neighborhood to launch. This is a rural area of the state with existing partnerships and coalition infrastructure in place, making it an ideal first Healthy Neighborhood.

Patient and Consumer Advisory

The DCHI Patient and Consumer Advisory Committee, which represents the patient perspective in all initiatives, was instrumental in the planning and implementation of the six community forums discussed above. The Committee worked with ab+c Creative Intelligence to develop the community forum structure, agendas, and operations. The Committee also developed a consensus paper on achieving meaningful patient and consumer engagement.² The purpose of the consensus paper was to identify for the DCHI Board, other interested stakeholders, and the public, the Committee's overarching vision for patient and consumer engagement within the health innovation work and to highlight those principles and strategies essential to driving productive and meaningful engagement. Because patient and consumer engagement is central to the work of each of the DCHI's five committees, this paper is intended to offer insights and recommendations to be considered by the other committees as they execute their respective efforts toward achieving the Triple Aim Plus One.

The Patient and Consumer Advisory Committee also established a new operational structure at the end of AY2. Going forward, the Committee will meet on a quarterly basis instead of coming together each month. Each Committee member is assigned to another DCHI Committee and is responsible for attending these meetings to actively listen for the inclusion of the patient and consumer perspective in

¹ Available at http://dhss.delaware.gov/dhcc/files/increasing_access.pdf

² Available at http://dhss.delaware.gov/dhcc/files/consumer_engagement.pdf

other DCHI initiatives. The Patient and Consumer Advisory Committee members will then reconvene once a quarter to share their observations.

Healthy Neighborhoods/Population Health

In AY2, Delaware stakeholders identified and launched the first Healthy Neighborhood in West/Central Sussex. West/Central Sussex has many key features that made it ideal as the first Neighborhood. First, this area has a high level of need with many health indicators and social determinants of health below the U.S. average and in some cases, even lower than the Delaware average. Second, there is a vibrant and strong community coalition group, the Sussex County Health Coalition, which for many years has coalesced community organizations around the County's health needs. Third, there is a collaborative set of health systems working together to identify and address population health needs through its own organization, Healthier Sussex County. After its formation, the Sussex County Local Council transitioned its location to be more central in the county and increased the Local Council membership in Q4. The Sussex County Council has also been working on its Community Plan, which is now 90% complete.

The Wilmington/Claymont Healthy Neighborhood was selected by stakeholders as the second to launch. The Local Council structure was approved by the DCHI Healthy Neighborhoods Committee and recruitment began for Council leadership. The Committee suggested the structure must be unifying, logical, sustainable, community engaged, and data driven. The Wilmington/Claymont Council rolled out a soft launch in January 2016 and formed a behavioral health task group in addition to forming groups focused on maternal child health and chronic disease. Finally, the Dover/Smyrna Local Council working group was established in AY2.

DCHI's Healthy Neighborhoods Committee transitioned away from the visionary structure that was required in the formation and development of the Healthy Neighborhoods concept to an operational governance structure in AY2, reflecting the shift to implementation. This work allowed for the formation and implementation of three sub-committees to address the following issues:

- Data support and evaluation
- Resource and sustainability
- Clinical advisory

These subcommittees will support and provide resources and guidance to each Local Council throughout the state. The Healthy Neighborhoods Committee also enhanced its strategic partnerships statewide through Committee member composition.

Throughout AY2, DCHI developed and expanded its Healthy Neighborhoods infrastructure by hiring Council Leads for the two first Neighborhoods and also independently contracted with a Healthy Neighborhoods Program Director to ensure the long-term sustainability of the initiative.

Clinical/Delivery Transformation

Delaware launched its **Practice Transformation (PT)** resources in AY1. Support of practices continued and expanded in AY2. As of January 2017, a total of 104 practices and 351 providers enrolled in Practice Transformation support services, putting Delaware 35% of the way to its original goal of enrolling 1,000 providers. Providers enrolled in PT are MDs/DOs, NPs, and PAs and the majority are in family practice.

In AY2, the HCC initiated a redesign of the PT vendor data reporting tools and developed a system by which to evaluate practice progress toward achieving the nine milestones identified by the DCHI Clinical Committee in AY1. Qualitative data is submitted on a monthly basis using the Monthly Progress

Reporting Tool (MPRT). The MPRT yields substantially more detailed information about how practices measure against the nine PT milestones than was available previously. Additionally, the MPRT allows HCC to monitor progress toward milestones and identify priority areas (both geographic and skill-based) where expanded PT training is warranted.

The MPRT focuses on three pre-determined sub-criteria for each of the nine milestones, resulting in 27 total sub-criteria. HCC defined the three sub-criteria for each milestone using standards employed by the National Committee on Quality Assurance’s Patient Centered Medical Home (PCMH) certification program and the Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015 (MACRA).

Each month, vendors score practices across the 27 sub-criteria using the following three-category scale:

1	Practice has not yet started the associated activities
2	Practice is in the process of implementing, or partially operating, the associated activities
3	Practice is fully performing the associated activities

HCC uses MPRT data to calculate monthly average practice scores (APS) for each sub-criterion and milestone. HCC computes a monthly APS for each sub-criterion by averaging values for each practice. To calculate the APS for a milestone, HCC averages the three sub-criterion APS values that correspond to that particular milestone.

APS values range from a minimum of 1.00 to a maximum of 3.00. An APS of 1.00 indicates that none of the enrolled practices have started the associated activities for that sub-criterion or milestone. An APS of 3.00 indicates that all enrolled practices are fully performing the associated activities for that sub-criterion or milestone.

HCC uses monthly APS data to assess (a) how enrolled practices currently measure against PT milestones and (b) the level of progress practices made toward milestones over the past several months. Current milestone status is indicated by monthly APS values. To assess practice improvement over time, HCC calculates percentage change scores (PCS) for each milestone. PCS values are calculated using a two-step process: HCC (a) calculates the difference in APS values between the first and last month of the desired time period and (b) divides that difference by the APS for the first month of the time period. Resulting values are multiplied by 100 to convert to percentages.

Table 1: Average Practice Scores (APS) and Percentage Change Scores (PCS) by PT Milestone, Sep 2016 – Jan 2017

	APS Sep 2016	APS Oct 2016	APS Nov 2016	APS Dec 2016	APS Jan 2017	Sep 2016 – Jan 2017 PCS
Milestone 1	2.03	2.07	2.10	2.22	2.33	15.1%
Milestone 2	2.18	2.30	2.33	2.49	2.54	16.3%
Milestone 3	1.97	2.10	2.14	2.38	2.44	23.9%
Milestone 4	2.04	2.07	2.17	2.30	2.38	16.5%
Milestone 5	1.67	1.69	1.71	1.91	1.95	16.7%
Milestone 6	2.04	2.08	2.11	2.23	2.30	12.5%
Milestone 7	1.87	1.99	2.01	2.18	2.17	16.1%
Milestone 8	1.55	1.59	1.60	1.72	1.69	9.0%
Milestone 9	1.48	1.49	1.51	1.67	1.69	14.0%

Enrolled practices demonstrated measurable progress toward each of the nine PT milestones from September 2016, when the MRPT was launched, through January 2017. Milestone 3 (*Implement a process of following-up after patient hospital discharge*) displayed the greatest improvements from September 2016 through January 2017, as evidenced by a PCS value of 23.9%. During the same time period, PCS values were remarkably similar among Milestone 2 (*Provide same-day appointments and/or extended access to care*), Milestone 4 (*Supply voice-to-voice coverage to panel members 24/7*), Milestone 5 (*Document sourcing and implementation plan for launching a multi-disciplinary team working with highest-risk patients to develop care plans*), and Milestone 7 (*Implement the process of contacting patients who did not receive appropriate preventive care*) (range: 16.1% - 16.7%).

Considering performance dimensions in tandem (i.e., APS in conjunction with PCS) highlights milestones for which practices are particularly excelling or struggling. For example, Milestone 8 (*Implement a multi-disciplinary team working with highest-risk patients to develop care plans*) had the lowest APS for January 2017 (1.69), as well as the lowest PCS from September 2016 through January 2017 (9%). Considered together, these data suggest that, on average, enrolled practices began the SIM PT initiative with comparatively low performance values on Milestone 8; additionally, progress toward meeting Milestone 8 has been comparatively slower than that for other milestones.

Practice Transformation vendors also submit qualitative data to HCC using a standardized, semi-structured questionnaire template. On a monthly basis, vendors use the updated reporting tool to provide DHCC with condensed, qualitative responses (500 words maximum) related to four main program areas: (a) Progress Summary; (b) Challenges and/or Barriers to PT Activities; (c) MPRT Usage / Technical Support Issues; and (d) Enrolled Practices with Associated Risk Reports. Qualitative data is particularly useful for evaluating program implementation details that are not easily-captured using quantitative methods. Additionally, the opportunity to submit monthly qualitative data provides vendors with an open channel in which to communicate with HCC, as well as formally document, any achievements, concerns, upcoming events, or other important notices.

During AY2, the DCHI Clinical Committee began to develop an implementation plan for **Behavioral Health Integration** (BHI). The Committee formed a small sub-group to interview approximately 20 stakeholders throughout the care delivery system. The DCHI Clinical Committee developed its BHI implementation plan in Q2 and refined and finalized the program in Q3. The Committee envisioned a

BHI program that includes the following elements: self-directed resources, data and reporting support, advisory group, training, infrastructure and technical assistance, outcomes (clinical) payment, and vendor performance management (process). These elements are detailed in a consensus paper³ that was approved by the DCHI Board in Q3. DCHI has an “interest application” open to allow interested behavioral health and primary care providers to express interest and be contacted in advance of a program launch.

Members of the DCHI Clinical Committee also worked on developing a BHI business use case tool, which is meant to estimate the potential profit or loss that a practice can expect to generate through BHI. The tool is driven based on the assumptions a practice inputs. It is not a forecast of expected revenue, rather, it is intended to help a practice translate their own information (panel size, number of clinicians) into a business case. HCC and DCHI will use this tool to support practices as they consider models for integration.

The HCC also released two rounds of an RFP for the **Behavioral Health Electronic Medical Records (EMR) Assistance Program**, one in Q3 and one in Q4. The program provided funding for Behavioral Health providers in two categories: Category 1 provided funding to Behavioral Health providers who do not have an EMR system with funding ranging from \$15,000 to \$20,000 depending on the size of the practice; Category 2 provided funding to Behavioral Health providers to upgrade or enhance their current EMR system with funding ranging from \$10,000 to \$15,000 depending on the size of the practice. Through the two rounds of RFPs, HCC selected six behavioral health practices including a total of 68 providers to receive assistance. Due to the timing of the release of the RFPs in the second half of the end of the award year, practices were unable to achieve all of the required milestones within AY2, and this activity will carry over into AY3.

Payment Models

The DCHI Payment Model Monitoring Committee spent a significant amount of time early in AY2 focused on developing a perspective on increasing access to claims data to support health innovation. The Committee formed a Transparency Working Group (TWG) which is comprised of a diverse group of payers, providers, community members, and policy makers, to conduct extensive research utilizing resources from the APCD Council and perform an analysis of the Delaware landscape. This research was compiled into a white paper and was shared broadly with stakeholders for feedback. The DCHI Board approved this paper in May and it was used as input into the development of legislation for a multi-payer claims database in Delaware. The TWG has plans to meet on an ad hoc basis to assist the DHIN as they operationalize Delaware’s Health Care Claims Database.

The Payment Model Monitoring Committee also completed work on a consensus paper on outcomes based payment for population health management⁴. This paper outlines a vision for outcomes-based payment for population health management, principles for payment model design and implementation, and strategies to promote availability and adoption of outcomes-based payment in accordance with these principles.

Delaware’s payer community also enhanced its role in accelerating the adoption of value-based payment models. Highmark launched its pay-for-value model, True Performance, to a small number of Medicaid providers (14 throughout the state) on July 1, 2016. This pilot included approximately 10,000

³ Available at http://dhss.delaware.gov/dhcc/files/integration_plan.pdf

⁴ Available at http://dhss.delaware.gov/dhcc/files/outcomes_based_payment.pdf

beneficiaries and gave SIM leadership and these providers an opportunity to preview how the model would function once made available to practices statewide. Highmark began initial outreach to primary care providers regarding its True Performance Model in Q2 and began contracting in Q3. United Healthcare began enrolling primary care providers in its Basic Quality Model and Accountable Care Shared Savings (ACSS) model during AY2.

With the introduction of new value-based payment models catering to various types of providers (United's extension to pediatric and quality shared savings and Highmark's True Performance for Medicaid and commercial), AY2 brought an acceleration in the adoption of value-based payment models among providers in the state. At the end of AY2, Delaware had more than 30% adoption of value-based payment for primary care, meaning that more than 30% of Medicare, Medicaid, and Commercially insured populations in Delaware are attributed to primary care providers under value-based contracts. While these efforts have been directly led by individual payers and the providers with whom they contract, DCHI has played a meaningful role in accelerating the pace of adoption in Delaware through active and consistent engagement with the state's main payers.

The Committee also identified opportunities and challenges ahead, which included feedback from stakeholders that the shift to value-based payment has been slower than desired. Several factors, such as significant state budget pressures and a desire for accelerated adoption of innovative payment models, highlight the need for change in the state. The Payment Model Monitoring Committee began a series of virtual meetings on innovative payment models in other states in response to this feedback and will leverage best practices and lessons learned from other states to guide payment reform efforts in Delaware.

Workforce and Education

The HCC released an RFP for facilitation of a **graduate health professional consortium** and development and implementation of a health care **workforce learning and relearning curriculum** in AY2. Vendors were contracted for these two scopes of work; Christiana Care Health System was contracted to facilitate the graduate health professional education consortium, while the University of Delaware was contracted to develop and implement a health care workforce learning and re-learning training curriculum.

During AY2, Christiana Care launched its work by convening a Steer Committee and evaluating the current landscape with a mission to promote, support and advance health professionals education throughout the state. They also began work on facilitating the establishment of a 501(c)(3) non-profit as the home of the Consortium to ensure long-term sustainability. In Q4, they hired an Executive Director and a Project Manager. Christiana Care has four strategic areas of focus to accomplish this work: 1) Establish new training programs; 2) Maintain existing programs and experiences; 3) Create faculty development structure and offerings; 4) Create Health Professions Training Network to ensure sustainability to support and promote a "learning state." Work is planned to continue in AY3 with the use of carry over funds.

The University of Delaware kicked off its work through a round of stakeholder presentations and information sessions to inform the development of the Modules to be included in the Health Care Workforce Learning and Re-Learning Curriculum⁵. The curriculum was highlighted at the previously mentioned Practice Transformation Learning Collaborative, and the curriculum's first module was also

⁵ More information available at <http://www.choosehealthde.com/Providers/Learning-And-Relearning-Curriculum>

launched in Q4. An estimated 55 attendees participated in the Module 1 session about forming quality improvement teams within a practice. Several practices are just beginning to become aware of the curriculum offering, so the DCHI and HCC will work to enhance awareness across the primary care provider community in AY3. Additionally, the curriculum vendor continues to work with the Practice Transformation vendors to identify potential integration points to streamline the transformation process for providers and practices.

The DCHI Workforce and Education Committee finalized and received DCHI Board approval on its consensus paper on **licensing and credentialing health care providers**⁶. In this consensus paper, the Workforce and Education Committee summarized the consensus of local stakeholders, with respect to streamlining credentialing processes for health care providers. Specifically, the Committee (1) addressed and provided a high-level overview of the provider licensing process; (2) outlined the rationale for consolidating health care credentialing processes; (3) summarized credentialing strategies utilized by peer states; and (4) recommended Delaware-specific guidelines for streamlining the health care credentialing processes.

The DCHI Workforce and Education Committee also finalized its consensus paper internally on developing a framework for **sustainable workforce capacity assessments** and introduced the paper to the DCHI Board in Q4 for discussion and feedback. The purpose of this consensus paper is to recommend the development of a framework for sustainable workforce capacity assessments that will aid in the projection of what workforce will be needed to deliver care in the future. Similarly, an understanding of the current and future number of providers is needed to account for the supply of providers in the health care workforce. This consensus paper begins with an identification of currently available Delaware health care workforce data sources to stress the necessity of a centralized, sustainable workforce capacity assessment before recommending data elements to be included in the assessment. The Committee then describes anticipated outcomes stemming from the development and implementation of the assessment and analyzes how key health care workforce priority areas can expect to be impacted. Once approved, this consensus paper will inform work in AY3 and AY4.

Health Information Technology

Work on developing the next version of the provider **Common Scorecard** continued throughout AY2, with Version 2.0 being released initially to testing practices in Q2. The first release of Version 2.0 included data from Highmark Commercial and United Medicaid as well as patient attribution at the panel level and individual measure level. There were multiple challenges encountered in preparation for operationalizing V2.0, but DHIN and the SIM technical team met frequently with the development vendor and payers to standardize file submissions despite differences between payer reporting systems, establish data sharing agreements, improve data quality, and improve presentation of measure results.

Following release to the testing practices, the team prepared for the release of the Common Scorecard to primary care practices statewide. This included resolving data discrepancies identified during pilot testing, collecting new payer data, working with payers to add new data feeds, and completing development of new functionality. New functionality added included statewide aggregation of quality and utilization measures, comparison of measure performance against statewide goals and benchmarks developed with DCHI, and improved chart display for quality and utilization measures. Again, the technical team encountered many challenges in order to ensure payer data submissions adhered to high quality standards. Enrollment for the Common Scorecard was opened to practices statewide in Q3,

⁶ Available at <http://dhss.delaware.gov/dhcc/files/licensingcredentialing.pdf>

supported by a web-based form to collect relevant information from the practice and by informational webinars for new practices interested in learning more about the purpose of the Common Scorecard. The webinars and online provider enrollment platform can be accessed at <http://www.choosehealthde.com/Providers/Common-Scorecard>

DHIN continued to work with the payers on formatting data files for integration into the third release of the Scorecard, which did not include any new functionality, but did add an additional payer for a total of three whose data is included. The DHIN technical team and HCC leadership also explored adding display of Practice Transformation milestones into the Scorecard. However, after weighing the costs, technical complexity and value gained, the team decided not to pursue that functionality. Work also continued in preparation for Release 4, scheduled for Q1 2017. DHIN, HCC and the DCHI Clinical Committee also began to assess the options for updating measures annually. The DCHI Board continued to discuss the path forward for the Common Scorecard as questions remain regarding its long-term use and sustainability. A sub-group of DCHI Board and Committee members met to discuss potential long-term plans and shared this information with the DCHI Board. DCHI and HCC leadership continued to facilitate internal conversations on the use of the Common Scorecard moving forward.

After the passage of legislation enabling the creation and maintenance of a statewide **Health Care Claims Database (HCCD)** in Q2, DHIN worked internally, with its board, state leadership, and the DCHI Board to assess use cases and begin drafting regulations to guide the implementation and management of the technology. In Q4, DHIN engaged a consulting firm to provide an assessment of the current infrastructure and make any recommendations for how to implement the technology required to meet the goals of the HCCD.

[Leveraging State Authority](#)

The Governor's Office was highly engaged with the HCC and DCHI in support of the SIM initiative. The SIM leadership team provided a briefing to Governor Markell in March and began discussions at that time about further leveraging the State Employees Benefit Plan to accelerate changes in the payment landscape. The Governor's Office, through his General Counsel Meredith Tweedie, participated in the **APCD workgroup** of the Payment Committee and played a leadership role in the development of legislation that would enable an APCD in Delaware.

As mentioned above, on July 21, Governor Jack Markell signed SB 238 into law, establishing a Delaware HCCD. The legislation follows many of the recommendations outlined in DCHI's white paper on increasing access to claims data. The Database will be administered and operated within the existing framework of the DHIN, a key partner in many HIT initiatives of the SIM work, and whose CEO sits on the Health Care Commission and the DCHI Board. The Act requires certain claims data to be reported by specified mandatory reporting entities, including the state's Medicaid program, the State Group Health Insurance Program and any qualified health plan in the state's Health Insurance Marketplace.

The HCC, which oversees Delaware's Health Insurance Marketplace, updated its **Qualified Health Plan (QHP) standards** for plans sold on the Marketplace. The QHP standards, which in prior years were updated to ensure that all QHPs were making value-based payment models available to PCPs or ACOs, funding care coordination, and aligning at least 75% of quality and efficiency measures with the Common Scorecard, were further refined for 2018 to reflect the passage of SB 238, making explicit that QHPs are considered a mandatory reporting entity under the law and that claims data shall be submitted to the DHIN. These changes were approved by the HCC in Q4.

In Q3, the State Employee Benefits Committee issued a **Request for Proposals for a Medical Third Party Administrator (TPA)** with a focus on having the TPA provide innovative cost containment features including Accountable Care Organization payment methodology and value based care delivery strategies including meaningful trend and cost guarantees with risk sharing. In Q4, the State awarded plan administration of the First State Basic and Comprehensive PPO plans to Highmark and sole administration of the HMO and CDH plans to Aetna (previously both Highmark and Aetna administered an HMO and CDH plan). Included in the administration of the HMO plan through Aetna is an affiliation with Christiana Care's CareLink to provide health management. At a high level:

- Christiana Care Health System has agreed to participate in a risk share model for the members enrolled in the Aetna HMO using the CareLink care management platform;
- After the enrollment has been finalized, a baseline PMPM will be developed after adjustment for large claims and other standard adjustments;
- A trended PMPM target will be developed using industry accepted trend assumptions;
- At the end of the plan year (after allowing for claim run-off), a reconciliation will take place comparing actual claims experience to the developed PMPM target; and
- A settlement will take place once the reconciliation is complete.

These plans will be available to Delaware's 122,000 state employees and their dependents beginning on July 1, 2017.

In Q4, Delaware elected and inaugurated a new Governor, John Carney. Prior to becoming Governor, Carney served as Delaware's at-large Congressman for six years, and has been Delaware's Lieutenant Governor and Secretary of Finance. During his tenure as Lt. Gov., Carney served as Chair of the HCC. Gov. Carney appointed Dr. Kara Odom Walker, MD, MPH, MHSR, as Cabinet Secretary for the Department of Health and Social Services. The new state level administration is facing a \$348 million budget shortfall for the coming Fiscal Year and the cost of health care in the state is a major factor. This has led to a reexamination of how state policy can be used to reduce and control health care costs, both for the state as a payer, and for all Delawareans.

Summary of Challenges and Delays

There were several challenges encountered during this year related to the Common Scorecard. DHIN contracted with IMAT Solutions to produce Version 1 of the scorecard in AY1. As a result of challenges encountered in producing Version 1, changes to the contract between DHIN and IMAT were necessary to ensure that there are strong vendor management practices in place, including specific deliverables with intermediate milestones. Additional challenges occurred in the technical team's ability to receive files from the payers that consistently met all necessary specifications. One of the new functionalities of the Scorecard that was to come online during AY2 was patient attribution. This was delayed due to problems with payer files. The HCC and DHIN teams worked together to troubleshoot technical issues with the files and maintain communication with the payers to resolve the issues. To mitigate these challenges, HCC and DHIN have put in place escalation pathways and engaged additional organizational contacts to identify and resolve issues and support progress.

Since the beginning of 2015, the technical Scorecard team has been working with 21 testing practices to gather feedback and inform the statewide launch of the Common Scorecard. Testing practices that were members of larger health systems favored disaggregating the practices to view data at a site-specific level and gain more actionable information for each geographic site. Practice disaggregation maps

providers and patients to the site/location level and allows practices to view Scorecard performance, numerators/denominators for metrics, and practice transformation milestone completion for an individual site. Practice disaggregation was originally intended to be part of the statewide launch of the Common Scorecard, scheduled for Q3, however there were several challenges with operationalizing this functionality and the teams are reassessing the value and need for this aspect of the Scorecard.

The Common Scorecard was originally slated to launch September 19 and was delayed approximately one month to October 18. We experienced three main challenges during the statewide launch. First, the team had difficulty obtaining valid and acceptable data from payers in a timely manner, necessitating a manual correction of data deficiencies. HCC and DHIN mitigated this by working closely with payers in an iterative fashion to correct errors, resulting in vastly improved data quality during the most recent round of submissions. Second, while most of the planned new functionality was implemented as part of the October release, some functionality (specifically, disaggregation of quality performance to the level of sites within a practice) was difficult to implement given available data. Implementation of this functionality was postponed until feedback can be collected from stakeholders on the future direction of the Common Scorecard. Finally, there were pre-production and post-production bugs that negatively impacted the deployment timeline. Similar bugs will be mitigated in future releases through a revised plan and process for thoroughly testing prior to production deployment.

An additional challenge encountered this year was the lack of clarity on the Common Scorecard's path forward. Both the DCHI Board and Clinical Committee have been facilitating conversations on a number of potential uses for the Scorecard, including, but not limited to, using quality, utilization, and cost data to inform policymaking and monitor the impact of DCHI initiatives; being the source of truth for quality, utilization, and cost measures for payers to reference in value-based payment arrangements; making provider performance accessible to consumers; and use as a clinical performance improvement tool. HCC, DCHI and DHIN collaborated and recommended that DHIN will keep the Scorecard functioning in its current state until all options are considered and a decision is made regarding a path forward.

A consistent theme when engaging with providers on new initiatives of health system transformation has been "change fatigue". Payers are introducing new payment models, there are new Medicare rules under MACRA, and DCHI has a suite of supports aimed at assisting providers with the change, including the Common Scorecard, Practice Transformation activities, and the Health Care Workforce Learning and Re-Learning Curriculum. These efforts, while well-intentioned, can lead providers to feel overwhelmed, with limited time and resources to take on new programs. To alleviate this, DCHI's Clinical Committee is refocusing on provider engagement, understanding that communications to providers may be more effective if they are delivered by a fellow clinician.

There were several contracting challenges this year which resulted in initiative implementation delays. The contracts resulting from the HCC's Workforce RFP were delayed due to a longer than anticipated contraction negotiation process. The HCC and Workforce and Education Committee worked proactively with the selected vendor to ensure the consortium and curriculum were finalized as soon as possible. There were also delays in contracting with vendors for the Behavioral Health Electronic Medical Records Assistance project, which has led to frustration in the provider community.

Finally, the state faces close to a \$385 million budget shortfall for the coming Fiscal Year and this has led to some internal constraints and inability to guarantee sustainability of certain aspects of SIM initiatives. However, despite significant growth in mandatory costs in health care and education, Governor Carney's FY 18 budget maintains key investments in health care to ensure Delaware remains economically

competitive. The HCC, with the full support of new leadership in the state, purposefully explores viable funding opportunities to augment the work of SIM once the grant has ended.

Summary of Funding

Delaware was awarded \$11,531,082 in AY2 and also received \$3,971,829 in carryover from AY1, bringing the total budget to \$15,502,911. The following table shows that Delaware expended \$10,562,752.86 of those funds to support various initiatives as described above. The balance of unspent funds will be requested as carryover.

Year 2 (February 1, 2016 to January 31, 2017) Spending by Project Area:

	Total Expended
Population Health	\$1,000,000.00
Delivery/Clinical	\$3,130,362.50
Payment	\$1,725,000.00
Health IT	\$2,140,001.25
Workforce and Education	\$390,621.19
Patient and Consumer	\$468,145.88
Overall Management/Establishing Infrastructure	\$1,660,801.09
Travel	\$1,881.49
Supplies	\$16,170.94
Other/Admin	\$29,768.52
Total Expended	\$10,562,752.86
Year 2 award	\$15,502,910.88

Summary of State Led Evaluation

Delaware has contracted with Concept Systems, Inc. (CSI) to lead and conduct its state-level evaluation of the state’s SIM initiative (referred to as DE SIM). In collaboration with stakeholders, the state-led evaluation is expected to provide input on, track, and inform stakeholders of progress towards unique, state-specific implementation milestones and model outcomes. In doing so, a feedback loop will be created for Delaware to track implementation, make mid-course corrections, and meet program goals. Throughout AY2, CSI engaged stakeholders in a continuous improvement approach to examine the processes and outcomes of DE SIM.

During the implementation of DE SIM's model test year 1 (AY2), Delaware launched several initiatives aimed at supporting the core elements of the approved operational plan, including practice transformation support for primary care practice sites, a statewide common provider scorecard, a learning/re-learning curriculum for primary care providers, financial assistance for behavioral health providers' electronic medical records adoption, and the rollout of the first wave of Healthy Neighborhoods. DE SIM also maintained significant stakeholder engagement with monthly meetings of the HCC and the DCHI Board which are open to the public, monthly meetings of each of the five standing DCHI committees and the Technical Advisory Group, and periodic cross-committee meetings. HCC and DCHI also expanded communications efforts to reach out to the general public with six Community Forums conducted throughout the state over several months.

The evaluation indicates that infrastructure for facilitating healthcare transformation is being built and tasks outlined in the operational plan are progressing as expected given the complexity of the system. Processes are being established at the committee level that are enabling stakeholders to carry out activities necessary to drive transformation of the health care system in Delaware. As the work of committees and stakeholders moves forward, refinement and clarification of roles and responsibilities will be a continuous process.

The sustainability of DE SIM remains a foremost concern for stakeholders, and must be considered a central imperative in terms of building and maintaining DE SIM mechanisms and activities moving forward. Although some consideration of sustainability was referenced, expedited attention is required to ensure proper mechanisms are in place to promote the continuity of DE SIM beyond the life of the grant. In particular, laying the groundwork for transitioning expertise and guidance provided by external consultants to groups operating within DE SIM remains a priority for stakeholders.

Conversations with stakeholders suggested the presence of tension within DE SIM. Tension is a natural product of the interaction of actors within the system, and in turn, acts as the fuel that leads to change. While tension may be considered a negative characteristic which requires monitoring, it should not be extinguished nor dissuaded entirely. Tension denotes engagement within the system, and between system actors. Stakeholders acknowledge DE SIM is a complex process that requires the input of multiple diverse actors to progress the implementation of the initiative, and should accept or even welcome tension as a lever for change. No one described the work as something easy to do – they recognize it as quite a challenge and are not surprised that some things are slower than others. However, there may be a need to examine positions taken by stakeholders that have a negative impact on progress and search for solutions that result in a mutual gain.

While most current stakeholders remain engaged within DE SIM, there are concerns of potential burnout among the core group of individuals driving DE SIM, and providing a more robust stakeholder group to ensure DE SIM's success going forward. Recruitment of additional stakeholders, and managing the workload of current stakeholders will be of critical importance in promoting the sustainability of DE SIM going forward. Outside of the core group, there remains an opportunity for increased engagement with current stakeholders and committee members who remain on the periphery of the system. This is a point of particular importance, as it will further engagement of an existing stakeholder group, and help to ease the burden on those already highly involved, and are at risk of "change fatigue". Furthering the recruitment of key groups within Delaware, such as payers and consumers, will remain of significant importance moving forward, as their lack of inclusion may inhibit the progress of DE SIM.

Considering specific mechanisms of information feedback, updates, and efforts to foster system-wide understanding will be vital in engaging these stakeholders, and helping to build momentum towards unified progress. Several stakeholders have identified the cross-committee meeting as an important mechanism in understanding what is happening with DE SIM, and receiving information with regards to the initiative. Cross-committee communication is vital to fostering the engagement of stakeholders that remain on the periphery within DE SIM. Fostering cross committee communication, and system-wide communication, can help build opportunities for mutual gains, in which committees and stakeholders can identify ways to work together in achieving their goals. Specific thought as to how knowledge is to be managed and communicated across the system would help expedite engagement across the system, and help create a more unified understanding as to the goals, progress, and processes of DE SIM.

Policy can help provide powerful levers for enacting system wide change, and help to ensure the sustainability of DE SIM beyond the life of the grant. Lack of legislative engagement was viewed as a barrier to the implementation and development of DE SIM stakeholders, and a valuable avenue to explore moving forward. Expanding engagement to policymakers can help create further ownership within a group that can leverage policy into a mechanism to provide sustainability for the initiative. DE SIM must look forward beyond the life of the grant to ensure that funds are available to maintain the infrastructure and mechanisms built to propel healthcare transformation within the state. Engagement with policymakers may open avenues to funds, providing DE SIM a powerful lever for enacting further system changes, and a powerful tool for accessing funds to ensure the sustainability of DE SIM programs. Leveraging policy can become a powerful tool, while still maintaining the DE SIM effort as a community-led transformation, with shared responsibility with state government.

Finally, the feedback from stakeholders was offered as input for how to improve what is already a highly-valued initiative. A clear majority of stakeholders view DE SIM as an important and meaningful endeavor and one that the system should work to get right. As the health care system in Delaware moves from the transactional changes (i.e., doing things better) prescribed in the operational plan to more transformational changes (i.e., doing better things) to culture and values associated with health care, it may be useful to take stock of stakeholders' perceptions of what changes are likely to make the most impact in light of the allocation of resources.

The full report from the state-led evaluator is attached to this annual report as Appendix A.

Summary of Sustainability Strategies

DCHI and HCC took several steps this year to ensure the sustainability of SIM initiatives. The first example is the hiring of program directors and managers for the Healthy Neighborhoods program. The goal is to remove dependence on external consultants for project management, operational, and strategic planning support services. DCHI and HCC will continue to collaborate to determine which initiatives require a dedicated director or manager and which initiatives can be supported internally.

The DCHI Board approved its Strategic Plan⁷ in Q4 complete with twelve strategic imperatives to address in collaboration with the community. Two of these recommendations tie back to long-term sustainability:

⁷ Available at <http://pages.dehealthinnovation.org/dchi-strategic-plan>

- Continue to fund DCHI operations through stakeholder contributions, but augment this with grant funding for design and implementation of specific initiatives; and
- Continue staff hiring plan; rely on contractors for time-limited projects that require surge capacity and/or specialized expertise.

DCHI continued to broaden its base of financial contributors this year by clearly communicating value creation for stakeholders to secure ongoing support. DCHI will continue to work with the HCC to identify additional stakeholder types to engage who have not provided significant support to date.

The State also focused on including sustainability requirements into contracts and initiative white papers this year to ensure support for these programs will remain in place after external consultant support and grant funding expires. The State remains committed to long-term sustainability of SIM initiatives and will continue to leverage statewide contracts as a vehicle to ensure sustainability moving forward.

Conclusion

In AY2, Delaware began to implement its plan to achieve the Triple Aim Plus One by engaging a variety of stakeholders and leveraging existing infrastructure. While challenges and delays were encountered, the broad base of stakeholder support gained over the past several years has supported Delaware's ability to adjust and overcome these challenges. Delaware continues to make progress toward its goals of increasing the availability of value based payment models, supporting the transition of primary care providers, focusing on population health and community-based strategies, and ensuring engagement of providers and consumers, and Delaware is well positioned to continue and accelerate its work in AY3.