



# State Innovation Model Operational Plan

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*Model Test Year 2 (Award Year 3)*

*February 1, 2017 – January 31, 2018*

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## **I. Project Summary**

### **A. Summary of Model Test**

Through the State Innovation Model Cooperative Agreement and the design work that preceded it, Delawareans have come together in an unprecedented collaborative effort to develop and implement a multi-stakeholder plan to improve health, health care quality and patient experience, and reduce the growth rate in health care costs.

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

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

In our first implementation year (2016/AY2), Delaware launched several initiatives aimed at supporting the core elements of the plan as described above 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 first wave of Healthy Neighborhoods. We also maintained significant stakeholder engagement with monthly public meetings, monthly meetings of each of the five standing committees and the Technical Advisory Group and periodic cross-committee meetings. We also expanded our communications efforts to reach out to the general public with six Community Forums conducted throughout the state over several months.

The launch and subsequent operationalization of these above initiatives were not without challenges, however. While stakeholder engagement remained high through Year 2 as mentioned, recruiting of PCPs to participate in practice transformation was slower than anticipated. Throughout the year, we realized the extent to which “change fatigue” was impacting providers across the state. With new payment models, understanding and preparing

for MACRA, and a multitude of communications from well-intentioned sources, providers expressed feelings of being overwhelmed with limited time to take on new programs.

There were also challenges related to the technical aspects of implementing a statewide common scorecard. Delaware strived for at least 75% alignment of measures with its major payers, which we achieved (75% or more of quality measures used in payers pay for value programs are drawn from the Common Scorecard). But, receiving accurate data files, achieving alignment across payers on how sites and patients are identified proved to be more complicated and complex than originally thought, leading to delays in the release dates and a significant amount of troubleshooting to correct issues and solve problems as they arose.

Another challenge that impacted the timing and pacing of our SIM work was the complexity of the state contracting and funds unrestriction process. State contracting and procurement procedures require months from initiation to completion. With this timeline plus the addition of time needed for the unrestriction process with CMMI, Delaware experienced delays in deploying several programs in Year 2 such as the Learning/Re-learning curriculum, Healthy Neighborhoods, and behavioral health integration. This was particularly acute at the end of the grant year, as time did not allow for completion of all necessary steps prior to Jan. 31.

In Year 3 Delaware's SIM work will focus on supporting providers through refinement and maintenance of the Common Scorecard, the development of the Health Care Claims Database, enrollment in the Learning/Re-learning Curriculum, launch of the Behavioral Health Integration program, and continued availability of assistance to behavioral health providers for adopting EMRs. We will also support the launch of Wave 2 of Healthy Neighborhoods and continue to reach out to patients, consumers, and other stakeholders to support and inform our work.

## **B. End State Vision**

Delaware has developed a bold plan to improve on each dimension of the Triple Aim, plus one: to be one of the five healthiest states, to be among the top 10% of states in health care quality and patient experience, to bring the growth of health care costs in line with GDP growth, and to improve the provider experience.

The SIM initiative will support this vision by catalyzing provider participation in value-based payment models. Through the consensus of stakeholders from across the state, we outlined principles for value-based payments which were incorporated into the state's Medicaid MCOs and the State Employees Benefits Plan RFP. In addition, the rise of ACOs and CINs in Delaware and the continued engagement of the state and stakeholder leadership with commercial payers will continue to be critical to moving the majority of Delawareans to care paid for through value-based payment models.

Delaware has also put an emphasis on our population health efforts through the SIM initiative, investing resources in the planning and development of Healthy Neighborhoods which aims to coordinate community health initiatives with the efforts and resources of health systems for collective impact.

The SIM initiative in Delaware also aims to improve Health Information Technology in the state by creating a Common Scorecard for providers that is at least 75% with the measures used by the major payers in their value-based payment models. The passage of legislation enabling a Health Care Claims Database will also increase transparency and enable providers to take on greater risk. The availability of this technology coupled with the SIM-funded educational resources – practice transformation, learning/re-learning curriculum – will arm and prepare providers to practice in coordinated care teams and achieve greater health outcomes for all Delawareans.

### **C. Updated Driver Diagram**

The Year 3 Driver Diagram was updated from Year 2 to include a primary driver (Promote provider engagement) that reflects Delaware’s “plus One” of our overall objective: improved provider satisfaction. Also, the language in some primary and secondary drivers was revised to reflect our current strategy and progress on behavioral health integration, payment and transparency. Metrics were also updated to reflect current targets for project progress. The Driver Diagram can be accessed in the associated document “DE SIM Op Plan AY3 Appendices.xls”.

### **D. Master Timeline**

The Master Timeline for Delaware’s SIM initiative has been updated to reflect completed activities and milestones as well as planned activities and milestones for Years 3 and 4. The Master Timeline can be accessed in the associated document “DE SIM Op Plan AY3 Appendices.xls”.

## II. SIM Policy and Operational Areas

### A. SIM Governance

#### 1. Management Structure

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

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

- Manage the federal funds for all grant-related activities
- Contract with vendors for specific grant-related services
- Provide regular updates to the Governor and the public regarding the status of the initiative
- Liaise with other state agencies to promote and leverage resources in support of the SIM

**Delaware Health Information Network (DHIN)** is Delaware's health information exchange (HIE), providing Delaware with a nationally-leading HIT infrastructure. It serves as a steward for health data in the state, and electronic access to information provided through the DHIN enables higher quality care. It is centrally responsible for the development of HIT capabilities needed to implement the State Health Care Innovation

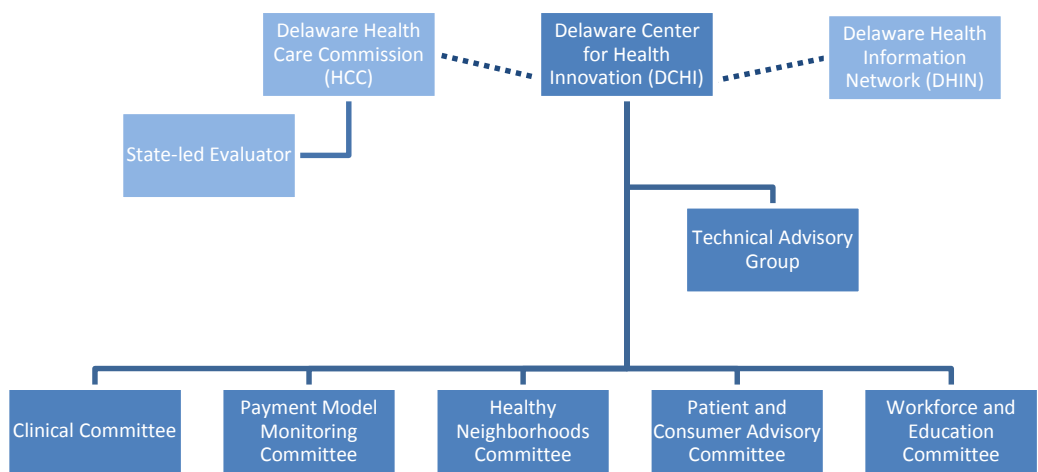
Plan (SHIP). Its board includes individuals from diverse organizations such as Delaware Health Sciences Alliance, State Chamber of Commerce, Delaware Office of the Controller General, and leaders from health systems and payers. The role of the DHIN in the SIM initiative is to:

- Provide leadership on issues related to health information technology

**Delaware Center for Health Innovation (DCHI)** is a non-profit entity with representatives from the public and private sectors that formalizes and sustains the deep involvement of stakeholders in the implementation of the State Health Care Innovation Plan. The multi-stakeholder board meets monthly and includes three permanent seats for state officials – HCC Chair, Secretary of Department of Health and Social Services (DHSS), and Director of the Office of Management and Budget (OMB). The CEO of the DHIN and Executive Director of the DCHI hold non-voting seats. The Board has five standing committees focused on delivering specific services, as well as a Technical Advisory Group (TAG) to coordinate with DHIN. The DCHI is privately funded through stakeholder contributions and in-kind services. Some SIM funding will be available to DCHI to support specific SIM deliverables. The following defines the role of the DCHI in the SIM initiative:

- Serve as the convenor of stakeholder groups
- Provide thought-leadership for all aspects of SIM related initiatives
- Provide a sustainable structure for the work beyond the grant award
- Implement the Healthy Neighborhoods program

*Exhibit 1: Delaware SIM Organizational Chart*



Collectively through the three leading organizations, Delaware's leadership team includes the primary state leaders responsible for health (Executive Director of HCC, Chair of HCC, Secretary of Department of Health and Social Services, Director of Division of Medicaid and Medical Assistance, Director of Division of Public Health, Director of Office of Management and Budget, Director of Statewide Benefits, CEO of DHIN), a variety of providers (large health systems, small health systems, Federally Qualified Health Centers, behavioral health practitioners, private practice physicians, nurses, and others), payers (public and commercial), businesses, and educational institutions (University of Delaware and Delaware Technical Community College). Governor Markell's Chief Legal Counsel Meredith Tweedie is also regularly involved in SIM discussions, providing guidance and input from the Administration. Stakeholder representatives are fully integrated into the SIM leadership team. The most senior leaders across all stakeholder groups in Delaware are committed to this initiative. Several hold DCHI board seats in addition to leading specific program areas and providing expertise, data, and in-kind staff support.

## **2. Leveraging Regulatory Authority**

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

- Delaware will use its purchasing authority through its Medicaid program and its State employee benefits program to require any payers in either program to implement value-based payment models.
  - The State Employee Benefits Committee (SEBC) released a Request for Proposals<sup>1</sup> on August 15, 2016, for a Medical Third Party Administrator for Group Health Insurance. DCHI and HCC worked closely with the SEBC and the Office of Management and Budget to strongly encourage respondents to incorporate value-based payment models into their submissions, and this was included as one of the selection criteria in the RFP. Plans will be made available to state employees through contracts awarded under this RFP during Award Year 3, with an effective date of July 1, 2017.
  - Goals for adoption of value-based payment were incorporated into contracts with the State's two Medicaid Managed Care Organizations (Highmark and United) that are consistent with Delaware's State Health Innovation Plan: 40% adoption of value based payment models in 2017 and 90% adoption by end of grant period, with interim goals set yearly.

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<sup>1</sup> Available at [http://bids.delaware.gov/closed\\_bids\\_detail.asp?i=4002](http://bids.delaware.gov/closed_bids_detail.asp?i=4002)



- Delaware will explore a variety of steps to streamline the current credentialing process for health providers, including reducing duplicative background checks among payers, providers, and the Department of State, and leveraging the common CAQH credentialing application to simplify the process.
- The Health Resources Management Plan (HRMP), which is used by the Health Resources Board (HRB) in the state's Certificate of Public Review process for new or expanding health facilities and significant capital or equipment expenditures, will be revised and updated to align with the goals of the SIM initiative. Updates will ensure alignment of Delaware's existing health planning framework with statewide efforts aimed at promoting health system improvement. The revised HRMP, which was released for public comment in Q4 2016, also includes Guiding Principles which align with the state's health care reform efforts and succinctly capture the coordinated approach to achieving the vision outlined in the State Health Care Innovation Plan. Specific Guiding Principles aligned with SIM include:
  - "...the board will review CPR applications and consider the proposal's relevance to access and continuity of care, chronic disease management, use of health information technology and affiliation with the Delaware Health Information Network (DHIN), care coordination and other strategies to facilitate Delaware's transition to value-based payment models to improve overall health outcomes."
  - "Projects which support a managed, coordinated approach to serving the health care needs of the person/population are encouraged."
  - "The HRB encourages CPR applicants to consider the impact of innovative technological advancements, especially in burgeoning areas of care such as Home and Community-Based Services (HCBS). Prevention activities such as early detection and the promotion of healthy lifestyles are essential to any effective health care system. Delaware's statewide health care reform efforts include a number of opportunities to improve the health status of Delawareans. The potential for a project to bring about progress in these areas will be viewed as a very positive attribute."
- The Health Care Commission adopted state-specific standards for the Qualified Health Plans sold on the state's Health Insurance Marketplace that include specific goals for the adoption of value-based payment models, use of the Common Scorecard, data submission requirements, and participation on the DCHI board. These standards are in effect through Plan Year 2018.
- Delaware's General Assembly is also a critical partner in identifying issues for which a legislative solution is warranted. To date, the legislature has passed legislation in support of delivering better care and increasing transparency and we will continue to work with them on issues requiring legislative action.

- In July 2015, the legislature passed House Bill 69 in July 2015. The bill mandates that insurers reimburse remote telemedicine services the same way they do for in-person equivalents.
- During the 2015 legislative session, the General Assembly eliminated the need for Advanced Practice Registered Nurses to practice under a collaborative agreement. This will increase the availability of PCPs throughout the state and will enable APRNs to function as a distinct part of the care team.
- In June 2016, the legislature passed and the Governor signed SB 238 which establishes the Delaware Health Care Claims Database, to be governed and managed by DHIN. This is the first step to increasing price and quality transparency for payers, providers and consumers and is a critical element of the state's HIT Operational Plan.

### 3. Stakeholder Engagement

Delaware has achieved and maintains an extremely high level of stakeholder engagement. Since the design phase, participants in the initiative have included senior leaders of the state's hospital systems, the state's two major commercial payers (Highmark and United Healthcare), professional societies/associations, and consumer advocates; many individuals from these groups serve on the volunteer board of directors of the DCHI as listed below. There are also others from these organizations who serve on Committees as described. And there are still others who are active and regular participants in public meetings, periodic touchpoint meetings, and as vendors of the services provided to the community through SIM funds.

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

The DCHI has led this stakeholder engagement since its formation and functions as the convener of the majority of the public meetings supporting the functional work of the plan. The DCHI was established in early 2014 to work with the Health Care Commission and DHIN to guide the State Innovation Model effort and track its progress. DCHI has a 17-member Board of Directors representing both the private and public sectors. As a group, the Board has experience working across Delaware's major providers, payers, state agencies, community organizations and the business community. Current members of the DCHI Board are:

- Julane Miller-Armbrister, Executive Director of DCHI – Ex Officio
- Dr. Jan Lee, CEO of DHIN – Ex-Officio
- Matt Swanson, Innovative Schools – Chairman of the Board and Co-Chair of Healthy Neighborhoods Committee

- Tom Brown, Nanticoke Health Services – Treasurer and Co-Chair of Payment Model Monitoring Committee
- Lolita Lopez, Westside Family Healthcare – Secretary and Co-Chair of Healthy Neighborhoods Committee
- Traci Bolander, Psy.D., Mid Atlantic Behavioral Health – Co-Chair of Payment Model Monitoring Committee
- Rita Landgraf, Secretary of Dept. of Health and Social Services – Chair of Patient & Consumer Advisory Committee
- Kathy Janvier, Delaware Technical Community College – Chair of Workforce and Education Committee
- Dr. Alan Greenglass, Christiana Care Health System – Co-Chair of Clinical Committee
- Dr. Nancy Fan, St. Francis Healthcare and Chair of Delaware Health Care Commission – Co-Chair of Clinical Committee
- Dr. Gary Siegelman, Bayhealth Medical Center – Chair of the Technical Advisory Group
- Timothy Constantine, Highmark Delaware, Inc.
- Debra Datta, United Healthcare
- Brenda Lakeman, Delaware Office of Statewide Benefits
- Dr. Steven Kushner, Christiana Care Health System

The DCHI Board has formed five committees focused on specific elements of Delaware's strategy for improving health and health care. Each committee meets monthly (with the exception of the Payment Model Monitoring Committee, which meets bi-monthly) and works toward the goals outlined in its individual charter. Each committee also guides and provides input on the initiatives and programs funded through SIM. Through the membership on each committee and the public meetings of the committees, the SIM initiative has participation from a variety of stakeholder groups.

**Healthy Neighborhoods Committee:** Delaware's population health strategy actively engages a broad set of stakeholders statewide, including the Department of Health and Social Services, Division of Public Health, health systems, FQHCs, community organizations, providers and provider organizations, and payers (insurers and employers). Stakeholders generally play four roles: 1) leading the multi-stakeholder workstream for population health; 2) participating in working sessions; 3) sharing feedback and best practices; and 4) identifying connections with ongoing initiatives. The HN work is communicated consistently and frequently to the other DCHI committees for alignment and consideration of integration of efforts. For example, currently the Workforce and HN Committees are jointly exploring how to broadly incorporate Community Health Workers into the workforce to ensure integration of the clinical and community based care and support. The Payment Committee is aggressively pursuing implementation of value-based payment models and how these models can help to support and sustain clinical transformation and the utilization of care coordination,

possibly including navigators that will work with the Healthy Neighborhoods community-based services to address social determinates of health. The Clinical committee is actively engaged with providers in support of practice transformation. Such support will facilitate transformation to team based care and care coordination, and alignment with HN services for augmenting patient care. The Patient and Consumer Committee members provide input for engagement in communities to promote population health strategies and to educate community-based stakeholders about the effort, such as through the community forums that were held across the state in AY2.

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

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

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

**Patient/Consumer Advisory Committee:** This committee, comprised of patient advocates, providers, faith leaders, and individuals representing stakeholder groups (i.e., Hispanic/Latino community, LGBT individuals), meets monthly to engage with patients and consumers. The patient/consumer is at the center of Delaware’s initiatives on health care innovation. Individual engagement in health and wellness is essential to achieving Delaware’s broader goals to improve the health of Delawareans, improve the quality of care and patient experience, and reduce health care cost growth. Each component of the SIM initiative depends upon successful engagement by individuals in their health and health care. The health care system will also be transformed to reach out to individuals and support them throughout their care experience.

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

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

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

Stakeholder input continues to be essential to the success of all SIM initiatives. Public meetings, including monthly Health Care Commission meetings, public DCHI Board and Committee meetings, posted minutes and presentations, as well as focus groups and community forums, are all utilized to continue to engage stakeholders in Delaware. Delaware will continue the active stakeholder engagement that has been a hallmark of its approach so far.

## **B. Health Care Delivery System Transformation Plan**

Delaware's plan promotes more coordinated and integrated care across the health system through a transition to Advanced Primary Care (including through adoption of Patient Centered Medical Homes or Accountable Care Organizations (ACOs)) and participation in value-based payment models across all payers. These models of care are built on a foundation of primary care and focus on integrating a multi-disciplinary team of providers across the medical neighborhood. The aspiration is for these models to be accessible to practices of all sizes and

structures (from solo practitioners to large practices that are part of a clinically integrated network or ACO). Delaware's strategy has seven core elements that contribute to the transformation of the health care delivery system:

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

Delaware's goal from the start of its SIM Design grant has been to achieve a more person-centered care delivery system. Delaware's approach incorporates elements that ensure the state's health care delivery system progresses towards that vision. First, the Health Care Commission's partner organization, the Delaware Center for Health Innovation (DCHI), has a Patient and Consumer Advisory Committee as one of its standing committees. This Committee focuses on providing the voice of the patient and consumer across all of the SIM transformation work and developing specific initiatives to engage patients in the health care delivery transformation process. Secondly, Delaware's approach from the start has been open and transparent. Delaware has numerous meetings open to the public each month and posts information about meetings of the Health Care Commission and the Board of the DCHI online, encouraging public input and comment.

In Year 3, the structure of the Patient and Consumer Advisory Committee will shift from a monthly meeting structure, to one of quarterly meetings with committee members attending various other standing DCHI Committees in the interim. This will allow Committee members to remain engaged and bring the consumer perspective directly to each committee. The Committee will continue its focus on health literacy, assessing the landscape of existing resources and leveraging collaborations to enable patients to engage in their own health and will make a recommendation for any additional resources necessary by Q4 2017.

### **2. Service Delivery Models**

Delaware's goal is to be in the top 10% of states on health care quality (based on Common Scorecard measures) and patient experience (based on Quality Compass) within five years by focusing on more person-centered, team-based care. In particular, Delaware's focus is on promoting adoption of models that integrate care for high-risk individuals (i.e., the top 5-15% that account for 50% of costs). Delaware's care delivery landscape has evolved significantly since the beginning of our work. Over the last several years, nearly 50 percent of primary care providers, and all health systems in Delaware have chosen to participate in one or more ACOs or Clinically Integrated Networks (CINs). Notwithstanding the recent formation of ACOs and CINs, care delivery in Delaware continues to be fragmented. Delaware's plan supports independent providers as well as providers affiliated with health systems. It is market-driven, and its goal is to support and accelerate adoption of existing models in the market. The plan emphasizes the role of primary care as a linchpin in the system that unites accountability for quality and cost for a defined panel of patients. Delaware's goal is for every Delawarean to have a primary care provider; Delaware will promote this

aspiration in the coming year by including PCP attribution in the set of metrics regularly reported to CMMI and encouraging payers and risk-bearing providers to identify members without PCPs and taking action to form or deepen PCP relationships with those patients.

HCC and DCHI are attuned to the need to ensure sustainability of changes to delivery models and payment models, particularly following the end of the SIM grant. Changes to the healthcare system are currently being implemented within the Delaware market, and underwritten by payers and providers. As these changes are market-driven and fully integrated into the regular business operations of these stakeholders, they are not reliant on SIM funding. Sustainable funding for delivery models will be bolstered by further adoption at scale of value-based payment models.

Sustainability of delivery system and payment model changes will also be strengthened by the operational capacity being built within the DCHI and state leadership. Throughout the design and implementation of the SIM in Delaware, many individuals have provided significant contributions of time and thought leadership that has allowed for the development of internal resources in support of the ongoing innovations. Specific sustainability strategies are discussed further in Section V of this document.

#### *a) Practice transformation*

Delaware's strategy is to support providers to deliver care in these new models by providing access to practice transformation resources. In the pre-implementation phase, DCHI adopted a consensus paper on practice transformation that identified the capabilities required for primary care to deliver more coordinated and integrated care, recommendations on the types of resources that would best support providers to achieve this, and a proposed set of milestones to measure whether providers have been making progress towards building the capabilities needed to deliver care differently<sup>2</sup>. The milestones represent important goals for participating in integrated or virtually integrated delivery models. Based on the recommendations of the DCHI and on feedback from a Request for Information (RFI) run by the Delaware Health Care Commission in 2015, the Delaware Health Care Commission issued and completed a Request for Proposals (RFP) for "practice transformation" vendors to support primary care providers across Delaware to transform their practices. Delaware selected four vendors to support practice transformation: MedAllies, Remedy, NJ Academy of Family Physicians, and the Medical Society of Delaware/Health Team Works.

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<sup>2</sup> Consensus paper is available online at <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Primary-Care-Practice-Transformation.pdf>

During Year 2, the milestones were formalized across all practice transformation vendors to include: 1) Identify 5% of panel that is at the highest risk and highest priority for care coordination, 2) Provide same-day appointments and/or extended access to care, 3) Implement a process of following-up after patient hospital discharge, 4) Supply voice-to-voice coverage to panel members 24/7 (e.g., patient can speak with a licensed health professional at any time), 5) Document sourcing and implementation plan for launching a multi-disciplinary team working with highest-risk patients to develop a care plan, 6) Document plan to reduce emergency room overutilization, 7) Implement the process of contacting patients who did not receive appropriate preventive care, 8) Implement a multi-disciplinary team working with highest-risk patients to develop care plans, and 9) Document plan for patients with behavioral health care needs.

In Year 2, Delaware made significant progress in promoting provider participation in practice transformation. Nearly one-third of primary care providers (100 practices including 345 providers) in Delaware have enrolled with one of the four practice transformation vendors. The overwhelming majority of providers shared positive feedback when the Health Care Commission issued a survey to participating primary care providers to get input on their initial experience with practice transformation.

Beginning in September 2016, the Practice Transformation vendors began submitting standardized qualitative and quantitative reporting on progress to HCC using a structured questionnaire which reports on enrollment and milestone achievement. As of September 2016 (the first reporting period), practices were performing well on a few measures (same day appointments/extended access, 24/7 voice coverage, and ED reduction plans), while most practices have not yet achieved other milestones (plan for BH patients, high-risk patient care planning, and reaching out to patients who did not receive preventative care). In Y3, we will have collected multiple quarters of data using this new reporting template, and will be able to quantitatively track practice progress against milestones. This new reporting will increase accountability and improve reporting to stakeholders.

As a complement to practice transformation, Delaware also selected a vendor to develop a learning and relearning curriculum for practitioners seeking to develop the skills and capabilities required to coordinate care effectively. The initial curriculum has been developed and the first modules will be available in Q1 2017. More information on this program can be found in the Workforce and Education section.



While Delaware has made significant progress developing the enabling infrastructure to support practices, we have also encountered several challenges. As payers in Delaware introduce their new payment models this year, and CMS introduces significant regulatory change (e.g., MACRA) designed to accelerate the transition to value-based models, providers have described feeling overwhelmed by the amount of change, and uncertainty about how the various support models (from HCC, DCHI, and private organizations) fit together to help them be successful. In addition, smaller providers have been difficult to reach and engage in healthcare innovation.

As a result, Delaware intends to build from its success in Year 2, and pursue the following approach in Year 3:

- Extend practice transformation support for currently participating providers for an additional year – currently enrolled practices will be eligible for a total of 18 – 24 months of vendor support
- More closely integrate the practice transformation and workforce learning and relearning curricula. The practice transformation vendors will host a learning collaborative in conjunction with the team responsible for workforce curriculum. This collaborative will be used both to deliver workforce content (e.g., capabilities to be successful in new payment models) and also as a recruiting tool
- Address emerging issues of interest (e.g., new payer payment models and MACRA) via a learning collaborative in Q1 2017 led by HCC and the PT vendors
- Launch a second wave of enrollment in Q1 2017, with additional outreach to small practices via the learning collaborative and through the provider engagement initiative that will be led by the Clinical Committee; practices that enroll during this wave will be eligible for 18 months of vendor support

***b) Promoting ongoing coordination of care***

Practice transformation lays the foundation for primary care providers to integrate across the medical neighborhood and coordinate care on an ongoing basis. Delaware has aligned on shared expectations about care coordination across payers and providers. DCHI approved a consensus paper on care coordination describing a common definition and shared expectations about the scope and intensity of care coordination<sup>3</sup>. It also sets out a perspective on what

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<sup>3</sup>Consensus paper is available online at <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-Care-Coordination.pdf>

resources, if any, may be required to support providers to coordinate care on an ongoing basis.

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

The DCHI Clinical Committee and Board both reaffirmed the importance of care coordination as an essential element in enabling new models of care to be effective. In part as a result of DCHI's catalyzing efforts, Delaware commercial and Medicaid payers are currently supporting care coordination. In addition, Delaware's five major ACOs and health systems are participating in care coordination. Delaware had originally intended to strive for a standardized and centralized approach to care coordination by pre-qualifying care coordination vendors. However, given the proliferation of ACOs and payer support models for care coordination, DCHI's clinical committee will reconsider future support and approach for care coordination during Year 3. Four options will be considered: 1) Centrally administered approach, 2) Standardized approach (vendor pre-qualification), 3) Set standards for care plans, 4) Decentralized approach, with Clinical Committee monitoring implementation. Given support for care coordination from payers, ACOs, and health systems, Delaware may be able to pivot the approach away from a centralized/standardized model and towards a guiding/monitoring model.

### ***c) Integration of Behavioral Health and Primary Care***

Delaware recognized in its State Health Innovation Plan that it would be necessary to foster close integration of primary care and behavioral health in order to transition to effective models of coordinated care. These interventions may be most important for individuals not currently well-engaged by a Community Mental Health Center; Delaware recognizes that an integrated PCP/BHP practice may be the optimal treatment setting for most but not all individuals, particularly the SMI population. Delaware has two primary strategies for accomplishing this: 1) promoting adoption of electronic records by

behavioral health providers and 2) supporting new models of integrated care between primary care and behavioral health providers.

### **Behavioral Health Electronic Medical Records Assistance Program**

In Year 2, the Health Care Commission, with input from the DCHI Clinical Committee and Behavioral Health Subcommittee, developed a plan for supporting behavioral health (BH) providers as they transition to electronic medical records (EMRs). In Year 2, HCC released two rounds of an RFP designed to provide assistance to BH providers in two categories: Category 1 will provide assistance to BH providers who do not have an EMR system in place with funding ranging from \$15,000 to \$20,000 depending on the size of the practice; Category 2 will provide assistance to BH providers to upgrade or enhance their current EMR system to enable better integration with primary care with funding ranging from \$10,000 to \$15,000 depending on the size of the practice.

Given the number of EMR systems available in the marketplace and the variations between those for medical and behavioral health practices, all systems affiliated with or purchased as a result of this funding must have interoperable capabilities with DHIN, the state's health information exchange. DHIN shares real-time clinical information with health care providers across the State to improve patient outcomes and patient-provider relationships, while reducing service duplication and the rate of increase in health care spending. DHIN currently has certified results delivery interfaces through twenty-five (25) different EMR vendors. DHIN can interface to any Electronic Medical Record (EMR) product that is capable of connecting via a web-service interface using HL7 (health level 7) standard language.

Funding for this program will continue in Year 3, with the goal of assisting 100 BH providers through the end of the project period.

### **Behavioral Health Integration Implementation Strategy**

In 2015, DCHI's Clinical Committee convened a behavioral health integration (BHI) advisory group consisting of members of the Committee as well as other experts across Delaware. The group was tasked with developing a common vision for integrating primary care and behavioral health, current challenges facing the state, the support required to achieve the vision (including, for example, technical assistance and common standards for reimbursement of integrated care delivery across all payers), and an implementation plan<sup>4</sup>. This

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<sup>4</sup> Consensus paper is available online at <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-Behavioral-Health-Primary-Care-Integration.pdf>

work is meant to complement Delaware's PROMISE program – which targets functionally limited individuals with home and community-based interventions – by encouraging primary care and behavioral health providers to refer appropriate individuals to the PROMISE program. There are no plans to integrate the two programs, given they involve different workforce groups and sites of interaction.

In 2016, DCHI continued the work of the BHI advisory group and developed an implementation plan for the first phase of its primary care-behavioral health integration support program<sup>5</sup>. This plan is slated to be implemented in Q1 of AY3 and includes the following components:

- **Approach:** the support program will aim to offer targeted support to practices at various stages of integration, including practices unfamiliar with behavioral health integration, practices who have begun to explore integration, and practices already pursuing integration. As such, implementation of the program will begin with an inventory to identify interested practices and understand their status and needs
- **Model availability:** behavioral health integration may take a number of forms based on practice readiness: 1) referral of patients with behavioral health needs by primary care to behavioral health practices with co-management of patients and separate billing; 2) co-location of behavioral health providers at primary care practices with co-management of patients and separate billing; or 3) employment/contract of behavioral health providers by primary care practices and billing for behavioral health services by primary care practices
- **Resources:** Several resources will be available to support practices with BHI, some of which will be supported with SIM funds and some from stakeholder funds that are under the direction of DCHI. The current proposal includes specific types of support for three provider types:
  1. **Practices currently uninformed about integration:** support will be aimed at making providers aware of BHI, its benefits to practices and patients, and how it might be implemented in their practices. Support would include a one-day training or learning collaborative (led by SIM-funded contracted training vendor)
  2. **Practices interested in integration:** support will be aimed at helping practices with an existing interest in/awareness of BHI to develop a plan for integration. Support will include technical assistance aligned with or possibly combined with SIM-funded practice transformation, as well as

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<sup>5</sup> Implementation plan is available online at <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Behavioral-Health-Integration-Implementation-Plan.pdf>

program management support that would enable “matchmaking” between primary care and behavioral health practices and collaboration with payers to collect information on reimbursement for integrated practices (program management and technical assistance to be SIM funded)

3. **Practices already pursuing integration:** for primary care practices that have already integrated with behavioral health, support will be focused on enhancing integration and promoting advancement to higher levels of integration. Support will include program management as above, training as needed (through SIM-funded contracted vendor), and expert consultation as needed (e.g., to support changing workflows, reimbursement systems) (through SIM-funded contracted vendor)
  4. **Additional self-directed resources:** practices will have access to a compendium of existing BHI resources (e.g., frameworks, clinical practice guidelines) to help practices implement BHI and an economic calculator to estimate the economic impact of BHI at the practice based on practice characteristics
  5. **Data/reporting:** Practices will have access to claims-based reporting to measure the impact of integration on utilization, cost, and quality of care; data will be reported for patients in the shared BHP/PCP panel where possible
  6. **Advisory group:** Practices will have access to a group of healthcare leaders in the state experienced with BHI theory, operations, payment, and policy for consultation/assistance related to implementing BHI
- **Profiling performance:** the secondary goal of the BHI program, beyond supporting practices pursuing integration, is to create case studies for BHI which will be shareable with other practices in the state. To that end, we will systemically study the results of practices currently pursuing integration and develop case studies which may provide guidance and best practices to other practices considering integration. Profiling will be performed by the BHI program manager (SIM-funded program management)

Delaware will continue developing the implementation plan for its Behavioral Health Integration program during Q1 2017 with the intention of launching at the end of Q1 2017.

### 3. Value-based payment models

#### Design principles and initial approach

Our goal is for most care in the state to transition to outcomes-based payments. The models will incentivize both quality and management of total medical expenditures over

the next five years. Delaware's plan is for all payers to introduce at least one Pay for Value (P4V) program that incorporates reimbursement tied to quality and utilization management for a panel of patients, and one Total Cost of Care (TCC) program with shared savings linked to quality and total cost management for a panel of patients, for eligible PCPs beginning in 2017. The approach will build from the different models in the system today and support the broader delivery system transformation underway (e.g., population health improvements, behavioral health access and integration). The DCHI Payment Committee's consensus paper "Outcomes-based payment for population health management" outlines design principles for both models, including but not limited to provider eligibility criteria, attribution methodology, minimum panel sizes, goals for payment, risk adjustment methodologies, and others. Core technical details will continue to be defined between payers and providers (e.g., shared savings level, minimum panel size), however all payers will support the following common principles to simplify participation for providers:

- Attribution of all Delawareans to primary care physicians (pediatrics, family medicine, general internal medicine) or advanced practice nurses. Delaware will rely on individual payer attribution methodologies as the basis for this attribution (these methodologies range from retrospective attribution based on the plurality of visits to assigned attribution at enrollment) and providers will agree to the payers' methods for attribution in the contracts they enter. Delaware is also working toward increasing understanding throughout the provider community regarding panel management. One of the capabilities Practice Transformation vendors are focused on with participating practices is understanding their patient panel and identifying those with high risk to ensure they receive appropriate care. This change management will also occur by collaboratively working with the state's payer community through regular working meetings.
- 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.
- Measure alignment between the Common Scorecard's 26 metrics and payers' payment model metrics.
- Commitment by all payers working in partnership with providers to achieve 80% of payments in these models within five years.

Delaware's State Innovation Model will catalyze the adoption of alternative payment models that reward quality and efficiency of care delivery for all Delawareans, with a particular emphasis on Advanced Primary Care. Our goals for adoption of value-based payment models are as follows:

- 40% of providers in at least one model by end of 2017
- 90% of providers in at least one model by the end of the grant period.

Our strategy is to encourage all payers to offer options which enable providers (or affiliated ACOs, systems, and networks) to take on increasing levels of risk, i.e., to offer both Pay-for-Value and Total Cost of Care. Though HCC and DCHI have limited formal authority over payers, regular monitoring and engagement have been relatively successful in encouraging adoption. While our strategy allows flexibility for payers to operationalize these models in different ways, there are several design parameters that we encourage all payers to adopt in the design of their models:

- **Pay-for-Value (P4V) – “Category 2”:** Payers will offer primary care providers the opportunity to earn bonus payments, incremental to fee-for-service payments, based on performance against a combination of both quality and efficiency targets. For Commercial and Medicaid Managed Care payers, measures of quality and efficiency shall be drawn primarily from a Common Scorecard established by the Delaware Center for Health Innovation and operationalized by the Delaware Health Information Network based on performance data provided by participating payers.
- **Total Cost of Care (TCC) – “Category 3”:** Payers shall offer primary care providers (or affiliated accountable care organizations, clinically integrated networks, and/or integrated delivery systems) the opportunity to earn a percentage of savings achieved relative to a target budget for total cost of care, as long as providers also achieve targets for quality of care, based on a set of quality measures drawn primarily from the DCHI Common Scorecard. We have already achieved 75-100% measure alignment between the Common Scorecard’s 26 metrics and payer’s payment model metrics, and will strive to maintain this degree of alignment as measures are introduced and retired. In some cases, participating providers may be at risk to repay a portion of any costs in excess of the target budget.

Further details can be found in DCHI’s “Outcomes-based payment for population health management” white paper<sup>6</sup>. The paper was adopted by the DCHI Board February 2016 board meeting and lays out 12 principles for payment models across dimensions such as measure choice, risk adjustment, and patient attribution.

Delaware’s further goal is that all payers will offer funding for care coordination—preferably in the form of a risk-adjusted per-member-per-month payment, but potentially including alternative forms such as the Chronic Care Management model adopted by Medicare—in conjunction with the P4V and/or TCC options, or as a more universal form of payment available to all primary care providers. Operational details

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<sup>6</sup> White paper available at <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-On-Outcomes-Based-Payment.pdf>

concerning care coordination are outlined extensively in a DCHI Consensus Paper on Care Coordination<sup>7</sup>, which was formally adopted in the January 2016 board meeting.

P4V and TCC variations of alternative payment, as established in the Delaware SIM Model, are meant to match the CMS definitions for “Category 2” and “Category 3” payment models, respectively. As providers in Delaware gain experience with these models, some may progress to global capitation (“Category 4”). However, we know of no current plans for providers to accept capitation.

Payers may begin in “Category 2” models with modest quality-based bonus payments and, when ready, transition to “Category 3”.

### **State role in catalyzing adoption**

In addition to encouraging payers to offer payment models, the State continues to play a critical role in catalyzing the adoption of value-based payment in several ways:

1. Goals for adoption of value-based payment were incorporated into contracts with the State’s two Medicaid Managed Care Organizations (Highmark and United), that are consistent with Delaware’s State Health Innovation Plan (as above, 40% adoption of value based payment models in 2017 and 90% adoption by end of grant period)
2. Requirements were incorporated into Delaware’s Qualified Health Plan standards for 2015-2018, and will be further reinforced in updates to these standards in successive years (Highmark and Aetna being the two carriers currently offering QHPs). QHP requirements in support of payment reform<sup>8</sup>:
  - a. By January 2017, payers shall make value based payment models available to primary care providers (PCPs) or accountable care organizations, networks, or systems with which they affiliate who are eligible based on a minimum set of criteria, meant to reward those providers for the quality and efficiency of care delivered to a population of attributed members spanning their interactions with the health care system. Each QHP should offer at least one pay-for-value model (with bonus payments tied to quality and utilization management for a panel of patients) and one total cost of care model (with shared savings linked to quality and total cost management for a panel of patients). Payers shall also provide a form of funding for care coordination for chronic disease management in at least one of the programs, whether in the form of per member per month fees or payments for non-visit based care management. Provider eligibility criteria

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<sup>7</sup>Consensus paper available at <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-Care-Coordination.pdf>

<sup>8</sup> Current QHP Standards available at <http://dhss.delaware.gov/dhss/dhcc/files/healthplanstandards.pdf>



(e.g., minimum quality requirements, minimum number of attributed members, ability to pool volume across other lines of business and/or with other providers), and the approach taken to provider outreach and enrollment should allow for the adoption of these models by providers sufficient to support of at least 60 percent of members to providers, with an effective date of January 1, 2017.

- b. Payers shall include incentives for quality as a part of both pay-for-value and total cost of care models. At least 75% of quality and efficiency measures tied to payment will be linked to performance on the accountable measures of the Common Scorecard and the rest linked to performance on payer-specific measures.
3. The State Employee Health Plan has communicated expectations for availability of value-based payment models to its two current carriers (Highmark and Aetna) and included expectations for introducing these types of models into the selection criteria for its current re-procurement for Third Party Administration of state employee benefits. The RFP issued by the State in August 2016 for December 2016 selection states that TPAs will be considered to present a stronger value proposition if they include current or planned value based payment arrangements, with a preference to TPAs including (in order of preference) existing downside risk, commitment to introducing downside risk, existing upside shared savings, and commitment to upside shared savings. Preference was also stated for TPAs with value based arrangements for larger portions of covered populations. The RFP also makes specific requests for description of payment models.
4. Leaders from DCHI, the Delaware Health Care Commission, the State Employees Health Plan, and Delaware Medicaid regularly meet with the major Medicaid and Commercial payers in the State to understand the financial and operational details of value-based payment models and coordinate communication to the provider community surrounding these models
5. The DCHI periodically formalizes its perspective on design principles and select operational details underpinning value-based payment in formal white papers that are available to local health care organizations and the public
6. DCHI regularly monitors the availability and adoption of value-based payment models for consistency with the principles reflected in Delaware's State Health Innovation Plan and SIM Project Narrative and further detailed in white papers publicly adopted by DCHI
7. State leaders regularly meet with leaders of five ACOs and CINs in Delaware who have organized to participate in the Medicare Shared Savings Program (MSSP), and have also indicated interest in supporting provider adoption of value-based payment for Commercial and Medicaid populations
8. DCHI and HCC are collaborating in the continuation of SIM-funded and TCPI-funded practice transformation support, in the process communicating to providers about value-based payment in conjunction with practice transformation.

## **Current status**

In early 2016, Delaware became the first state in the U.S. where all Medicare-participating hospitals are part of the Medicare Shared Savings Program, in addition to two other Medicare ACOs sponsored by independent physician organizations. Delaware primary care providers may fund care coordination for Medicare beneficiaries through the Medicare Chronic Care Management model, and/or other investments that MSSP-participating ACOs may make in care coordination based on the potential to achieve shared savings. Medicare Advantage penetration in Delaware is very low—less than 10%—and is therefore not a significant focus on the State’s efforts to drive adoption of value-based payment.

Highmark has launched a new Pay-for-Value payment model which will be rolled out to primary care providers with an effective date of 1/1/17 for its Medicaid members, Commercial members including those in Qualified Health Plans, other fully insured populations, the State Employee Health Plan, and other self-insured employers. Self-insured members will include both local employers as well as out-of-state Blue Card PPOs with members in Delaware who are attributable to primary care providers in Highmark’s Delaware provider network. Highmark Medicaid launched an initial rollout of the model as of 7/1/16 prior to its statewide launch. Highmark is currently contracting with providers for its statewide launch of the program across all lines of business. The details of the new model appear to be consistent with many of the design principles adopted by the State and by DCHI, including bonus payments tied to quality, utilization, and total cost of care in a manner consistent with CMS “Category 3” payment models; it also incorporates a risk-adjusted PMPM care coordination fee. The quality measures in this program are substantially aligned with the 26 measures in the DCHI Common Scorecard.

United has also met with the State to detail both a CMS “Category 2” quality incentive model as well as a CMS “Category 3” payment model, the latter of which is tied to quality, utilization, and total cost of care, and also incorporates a risk-adjusted PMPM payment for care coordination. These models are currently being introduced to primary care providers in United’s Delaware Medicaid network. United has committed to transitioning most providers that initially enroll in a category 2 model into a category 3 model in 2017, with most providers starting on 1/1/17.

For Highmark’s Commercial membership, patients will be attributed to primary care providers using a retrospective attribution methodology similar to the one used for the Medicare Shared Savings Program. For both Highmark and United, Medicaid members will be attributed to PCPs using prospective PCP selection or auto-assignment.

Aetna has shared with the State value-based payment models available to local providers. However, to date, participation in CMS “Category 3” payment models

consistent with the State's SIM goals has been very low for Aetna based on very low patient panel sizes given Aetna's small Commercial membership in Delaware.

### **Priorities for 2017**

**1) Monitor rollout of Commercial and Medicaid Payers' APMs.** 2017 is a critical year as it is the first year of performance for most new payment models. DCHI's Payment Model Monitoring Committee and HCC will track adoption and monitor performance of practices in these new models over the course of the year. DCHI holds bi-weekly or monthly meetings with payers, during which payers provide current enrollment numbers for value-based payment models, as well as a qualitative update on partnerships in progress. DCHI uses these meetings to reiterate mutually defined enrollment goals and encourage continued progress towards more advanced value-based payment models. This reporting mechanism is in addition to quarterly enrollment reporting for CMMI. In addition, DCHI and DMMA regularly share information on program enrollment to facilitate a coordinated approach to monitoring.

**2) Introduce new/refined State Employee Health Plan value-based models.** The requirements for value-based payment model implementation introduced by the State's re-procurement of Third Party Administration services will begin to take effect on 7/1/17. This will be an important milestone in ensuring the continued transition of payment into value-based models across all payers.

**3) Monitor and encourage transition to downside risk sharing models.** Delaware remains committed to the approach of having all payers introduce a Category 2 and Category 3 payment model available to all primary care providers (and their affiliated systems). Given the recent changes for Medicare introduced by MACRA, Delaware will reassess early in Year 3 whether to include a transition to downside risk sharing models in its approach to Category 3 Total Cost of Care Models. HCC and DCHI, specifically the Payment Model Monitoring Committee, will review quantitative data received from the payers through the quarterly reporting process to determine pace and progress in moving toward VBP. This assessment of the data will occur on a quarterly basis, concurrent with the submission of the QPR to CMMI. HCC and DCHI will use this information to determine the necessary steps to catalyze such a change if that is the recommended direction. Options under consideration for promotion of downside risk could include inclusion 1) specific monitoring of enrollment in Category 3b payment models using the same approach as regular payer participation monitoring as described above, 2) collaboration with new administration to more actively promote adoption of downside risk, 3) continued regular engagement between DCHI and payers and between DMMA and payers (bi-weekly or monthly meetings), and 4) DCHI involvement in state-level policy discussions.

HCC will partner with DCHI to accomplish each of these priorities in Year 3 through regular engagement with and reporting by the payers, meetings of the DCHI Payment Committee, and engagement with the State administration.

#### **4. Quality measure alignment**

Delaware aspires for at least 80% of payments to providers from all payers to be in fee-for-service alternatives that link payment to value. Delaware expects payers to introduce a pay-for-value model (with payment linked to quality and management of utilization) and a total cost of care model (with payment linked to quality and management of total cost) for primary care providers. Delaware intends for these new payment models to link quality to payment through a Common Scorecard across all payers. Delaware expects its payers to structure their value-based payment models so that the incentives in these models are based on performance on at least 75% of the measures on Delaware's scorecard (recognizing that some payers may have additional measures that need to be used to align with their national programs). Delaware's major Medicaid and Commercial payers (United Medicaid, Highmark Medicaid, Highmark Commercial, and Aetna Commercial) have committed to reporting on the Common Scorecard. The Scorecard includes measures of quality, patient experience, utilization, and cost and has been an important element of Delaware's approach to health care delivery transformation. It will help ensure that performance in quality and cost measures is consistently high. The Scorecard will be reported to providers on a quarterly basis so that providers can use data to drive health system processes and improvements.

Delaware has made significant progress in aligning quality measures across all payers in the state. Delaware received commitments from its three largest payers across Commercial and Medicaid to report on these measures beginning in 2016. Delaware expects payers to link their payments to these measures as models are introduced in 2017. A "beta" version of this scorecard was tested with 21 primary care practices representing approximately 120 primary care providers across the state during Years 1 and 2. In the pre-implementation phase, Delaware invested significant time and effort (including interviewing nearly all of the 21 testing practices) to ensure that the Scorecard could achieve significant alignment with individual payers' scorecards and that it limited administrative burden for providers and payers. On the basis of the feedback from the providers and the payers, Delaware developed a version 2.0 of the Scorecard (see Exhibit 2 below) and launched it statewide in Q3 2016. These measures are designed to accomplish four goals: 1) improve focus on women's health; 2) add additional focus on population health management; 3) reduce administrative burden by removing several measures that required CPT II codes; and 4) updating measures that had been changed or dropped by the national measure stewards. Delaware aspires for Medicare data to be included in this scorecard as well and has begun a conversation with CMS about how to accomplish that goal.

Early during 2017, the Clinical Committee will be making refinements to the Common Scorecard to reflect changes to HEDIS measures. There are no further changes to Common Scorecard functionality planned for 2017. Other future measure changes may include alignment with additional payers: the current Common Scorecard measure set was designed to align with Medicaid and commercial payers; future measure set evolution may include alignment with Medicare/MACRA.

*Exhibit 2: Common Scorecard V2.0<sup>9</sup>*

Category	Measures	Measure Type <sup>1</sup>
<b>Quality of Care</b>	Diabetes: HbA1c control <sup>2</sup>	Reporting
	Diabetes: Medical attention for nephropathy	Accountable
	Medication adherence in diabetes	Accountable
	Medication adherence in high blood pressure: RASA	Accountable
	Adherence to statin therapy for individuals with cardiovascular disease	Accountable
	Medication management for people with asthma	Accountable
	High risk medications in the elderly	Accountable
	Colorectal cancer screening	Accountable
	Cervical cancer screening	Accountable
	Breast cancer screening	Accountable
	BMI assessment	Reporting
	Screening and follow-up for clinical depression	Reporting
	Avoidance of antibiotic treatment in adults with 13 acute bronchitis	Accountable
	Appropriate treatment for children with URI	Accountable
	Childhood immunization status <sup>3</sup>	Accountable
	Developmental screening in the first three years of life	Reporting
	Fluoride varnish application for pediatric patients	Reporting
	HPV vaccination for female adolescents	Accountable
	Adolescent well-care visits	Accountable
	Well child care: 0-15 months	Accountable
	Well child care: 3-6 years	Accountable
<b>Utilization</b>	Follow-up within 7 days after hospital discharge <sup>4</sup>	Reporting
	Plan all-cause readmissions	Accountable
	Inpatient utilization	Accountable
	Emergency department utilization	Accountable
<b>Total Cost of Care</b>	Total cost of care per patient	Accountable

## 5. Workforce and education initiatives to enable transformation

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

<sup>9</sup> See also: <http://www.choosehealthde.com/Providers/Common-Scorecard#common-scorecard-measure-chart>

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

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

In parallel with retraining the current workforce, Delaware also needs to ensure that Delaware is able to educate, attract, and retain new members of the workforce that have the skills and capabilities required to deliver team-based, integrated care. Developing and maintaining an adequate and well-trained health care workforce is critical to ensuring access to care for all Delawareans. Currently Delaware has designated Primary Care and Dental Health Professional Shortage Areas (HPSAs) in the majority of the two lower counties and the City of Wilmington, as well as mental health HPSA in Sussex County. The Workforce and Education Committee’s responsibility over the next several years is to partner with the state’s and regional educational institutions to set out a comprehensive strategy for training that ensures a sustainable pipeline for Delaware health care workforce.

There are four primary components to Delaware’s workforce and education strategy that collectively aim to ensure there is an adequate health care workforce to meet state residents’ needs and that providers can perform at the top of their license and board certification. First, Delaware plans to implement a learning and re-learning curriculum for individuals currently in the workforce to develop the competencies needed to coordinate care. The DCHI adopted a consensus statement<sup>10</sup> for this learning and re-learning approach, and the Health Care Commission issued an RFP and selected a vendor (University of Delaware College of Health Sciences) to develop and implement the curriculum beginning in 2016. Over time, Delaware will develop approaches to ensure that the next generation of the health care workforce is trained with these skills. As identified in the Learning and Re-Learning Consensus Paper, the curriculum will specifically strengthen workforce competencies within the following six areas:

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<sup>10</sup> See <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-Workforce-Learning.pdf>

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

The University of Delaware College of Health Sciences is in the process of finalizing modules within the curriculum. There are six different modules which align with the six competencies identified above. UD may also design and facilitate additional in-person population-specific training opportunities not addressed within the six stated modules. These may be focused on aspects of the State Innovation Model including but not limited to: integration of mental health into primary care, primary care linkages to prevention and wellness, and outreach that extends into the community to enhance community and population health. The program will involve in-person workshops with training modules facilitated by healthcare theater and content experts. The workshops will be focused on various aspects of healthcare delivery, illustrating with simulated patient encounters challenges in healthcare delivery with our current model and then simulations of team approaches to care that deliver better patient outcomes through comprehensive care across a continuum.

Each module will be broken down into three unique training phases:

- A virtual pre-work session to introduce the module and training content;
- An intensive, in-person training session complete with live simulations and skills-based training; and
- An action group webinar series to allow practices the opportunity to dive into a particular training area in more detail. The intent of these action group webinar series is to eventually develop a statewide learning community.

The action group webinar series give practice regular access to an expert on a priority topic area. The general format of these webinars will begin with a brief introduction before sharing best practices for the remainder of the time. The webinar series will utilize interactive tools such as polls, surveys, and trivia to ensure attendee engagement. These webinars are also designed to be flexible in case the group decides to take the conversation in a particular direction or learn about another practice is approach a similar issue.

The intended audience for these trainings are all health care providers and practices in Delaware, but there is a particular emphasis on primary care practices, especially those that are engaged in the DCHI practice transformation initiative. UD and Health Team Works also encourage all members of the practice team to attend as there are certainly portions of the curriculum that align with and support various DCHI initiatives, with

primary care and behavioral health integration as a prime example. To that end, we will encourage primary care practices to attend with the behavioral health or therapist practice partners as well. The team from UD and Health Team Works will then target patients and their families, as well as students for inclusion in the training in addition to providers. Trainees can gain continuing medical education credits for participating in the training curriculum and are expected to gain valuable knowledge that will put their practice ahead of the curve on the new value-based payment models.

Second, Delaware intends to develop an ongoing workforce capacity planning capability that provides insight into workforce needs and accounts for how these needs may evolve as providers transition to value-based payment and care delivery models. The DCHI Workforce & Education Committee has drafted a Workforce Capacity Planning Consensus Paper. Since this activity was an original Year 2 goal, pending the availability of carryover funds, DHCC intends to issue an RFP for support for this capacity planning in Q3 2017. The vendor selected to carry out this work moving forward will be responsible for implementing a number of the recommendations included in the Committee's Consensus Paper regarding the development of a sustainable workforce capacity assessment. These include, but are not limited to:

- Development of a provider data set for inclusion in the sustainable workforce capacity assessment to allow for a better understanding of the supply of health care providers and a prediction of the workforce needed to best meet patient's needs in a transformed system of care. This information should be collected for a wide array of providers in addition to the primary care team to reflect DCHI's focus on a multi-disciplinary approach to transforming the health care delivery system. Information on provider demographics, provider background, provider education, and practice characteristics (i.e., participation in value-based payment models) should be collected.
- Similar to other DCHI initiatives, the initial focus on this comprehensive data collection will focus on members of the primary care teams across Delaware before collecting data from partners of these primary care teams and practices. For example, these partners can include behavioral health providers and physical therapists.
- A recurring analysis of health care training opportunities available to providers and other members of the health care workforce through state institutions to better understand available resources and their alignment with the principles of a transformed system of care in Delaware.

Third, Delaware has developed an approach to streamlining licensing and credentialing in the state<sup>11</sup> and continues discussions with payers, providers, and the Division of

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<sup>11</sup> See <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-Provider-Licensing-and-Credentialing.pdf>



Professional Regulation to accomplish this goal. The Committee's recommendations call for a determination of the feasibility of statewide legislation to set streamlined credentialing parameters for hospitals, provider networks, and payers. The Committee engaged a representative of the Division of Professional Regulation to serve as a Committee member and looks forward to leveraging this perspective to facilitate conversations with the stakeholders mentioned above. The Committee will also work with the Division of Professional Regulation to ensure providers new to Delaware continue to have access to licensing and credentialing resources.

Fourth, Delaware intends to expand graduate health professional training in the state through an innovative Health Professionals Consortium. The HCC issued an RFP for Graduate Health Professional Consortium Facilitation and selected Christiana Care Health System to facilitate this work. This work was an area that did not progress on the timeline planned in Year 2, and as a result will be targeted to continue using any approved carryover funds. Christiana Care Health System is in the process of finalizing the consortium's governance structure, which will provide direction and guidance during the establishment of new training programs and experiences in the second half of 2017.

Delaware has sequenced the rollout of the different elements of the model to align with the broader health care transformation. For example, Delaware prioritized the learning curriculum as an early focus, since that will be one of the mechanisms to provide individuals currently in the workforce with the skills and competencies needed for team-based, coordinated care.

## **6. Plan for Improving Population Health**

Healthy Neighborhoods is one of five core strategic initiatives designed to achieve the State's health care transformation goals set forth in the State Innovation Model Cooperative Agreement. It is an innovative approach to addressing population health challenges and to affecting sustainable interventions that will enable healthier lifestyles and better health outcomes. The program provides an elastic framework for developing local community capacity and building formal partnerships across organizations, bringing together community based organizations within geographically defined areas to achieve meaningful change through collective impact on the health of the community. The Healthy Neighborhoods program builds upon existing strengths and resources within communities and provides targeted support to participating organizations. The Delaware Center for Health Innovation (DCHI) Healthy Neighborhoods Committee – a standing committee – is responsible for oversight and support of the Healthy Neighborhoods program.

The aspiration is for nearly all Delawareans to live in a Healthy Neighborhoods Community within the next few years. The community-based model allows for the coverage and inclusion of broad populations while maximizing the flexibility of smaller

units of focus (neighborhood hubs) that can coalesce across issues and local programs that are relevant and recognizable to the targeted populations<sup>12</sup>.

The Healthy Neighborhoods model fosters the integration of population health, the health care delivery system, and community resources through three core strategies:

1. **A coalescing model of the Healthy Neighborhoods work:** This framework or model is used as a vehicle whereby population health, health care, and community resources are brought together and leveraged to form a collective impact based on a shared, common plan and strategies to address the communities' most pressing health care concerns and needs. The Delaware design is uniquely planned to allow for the three – population health, health care delivery systems, and community resources – to come together to identify local health needs and metrics, and to align activities, work to bridge gaps, foster sustained funding mechanisms, and measure impact.
2. **The Theory of Change (Social Ecological Theory of Change):** The theory is a proven mechanism to address population health and is applied to this work. It is played out on each ecological dimension, at the individual level, within the medical community that is targeting the person's health, the community at large that is supporting both the individual and health care community, and at the policy level, where mechanisms both locally and statewide are employed to support the work.
3. **Local control through a Lead Local Council:** The Lead Local Council is a microcosm of the Social Ecological framework theory. It positions individuals, health care providers and community resource providers as the drivers of Healthy Neighborhoods. It uses specialized sub-committees to work toward common goals, and to ensure an even tighter coalescing process, Clinical Advisory Councils are being developed in each area with major health providers and ACOs. These Clinical Advisory Councils will ensure that both the clinical lens and community lens are taken into account as community-based strategies are developed to address patient health care needs and the capacity of the systems to address those needs.

Five core elements guide the development and implementation of the Healthy Neighborhoods program within each area, as well as the establishment of Local Councils that will have the authority and responsibility of leading the work within each

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<sup>12</sup> Additional detail about the operating model for Healthy Neighborhoods can be found at <http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Healthy-Neighborhoods-Operating-Model.pdf>

designated Healthy Neighborhood. These strategic elements build upon learnings from national and international collaborative models of population health. They entail:

- Bringing organizations and leaders together – across sectors and areas of focus – to work together in new ways
- Ensuring that healthcare providers and systems integrate with community organizations to both identify problems, and create and execute shared solutions
- Dedicating full-time staff to convene stakeholders, support the Local Councils, facilitate the identification of community health needs and prioritization of initiatives, and ensure consistent implementation of collaborative programs.
- Providing shared access to resources and new opportunities for partnerships to support the work
- Pursuing a sustainable pathway for each Healthy Neighborhood, through capacity building for fund development and long-term sustainability, including through technical support for grant application and management. A sustainability work group is forming to identify potential for local sustainability of the Healthy Neighborhood. Over time, Healthy Neighborhoods will become increasingly relevant to the delivery system as data on their impact is demonstrated. However, the initial neighborhoods that are emerging cannot demonstrate that level of impact this early in the process, though some within the delivery systems have indicated a willingness to financially support programs that show proven outcomes towards wellness. The sustainability work group will seek a more diversified funding stream into the future.

These components foster engagement and opportunity for organizations to participate in the Healthy Neighborhoods program. Developing each of these elements to scale across all neighborhoods will provide unprecedented access to resources, partnerships, expertise, and funding to help sustain the work of Healthy Neighborhoods.

The organizations participating in the Healthy Neighborhoods program are encouraged to accelerate and/or expand upon existing initiatives that address local needs in one of four priority areas that have been identified as the highest areas of need across the state:

1. Healthy Lifestyles
2. Maternal and Child Health
3. Mental Health and Addiction
4. Chronic Disease Prevention and Management

The Healthy Neighborhoods Local Councils are charged with establishing a Neighborhood Task Force Committee (Task Force) for each of these priority areas. The Task Force members will bring expertise, experience, programs, and resources to help in

developing and implementing a three-year strategy to improve health in one or more of the priority areas of need. Development of the Task Force committees will begin in 2017.

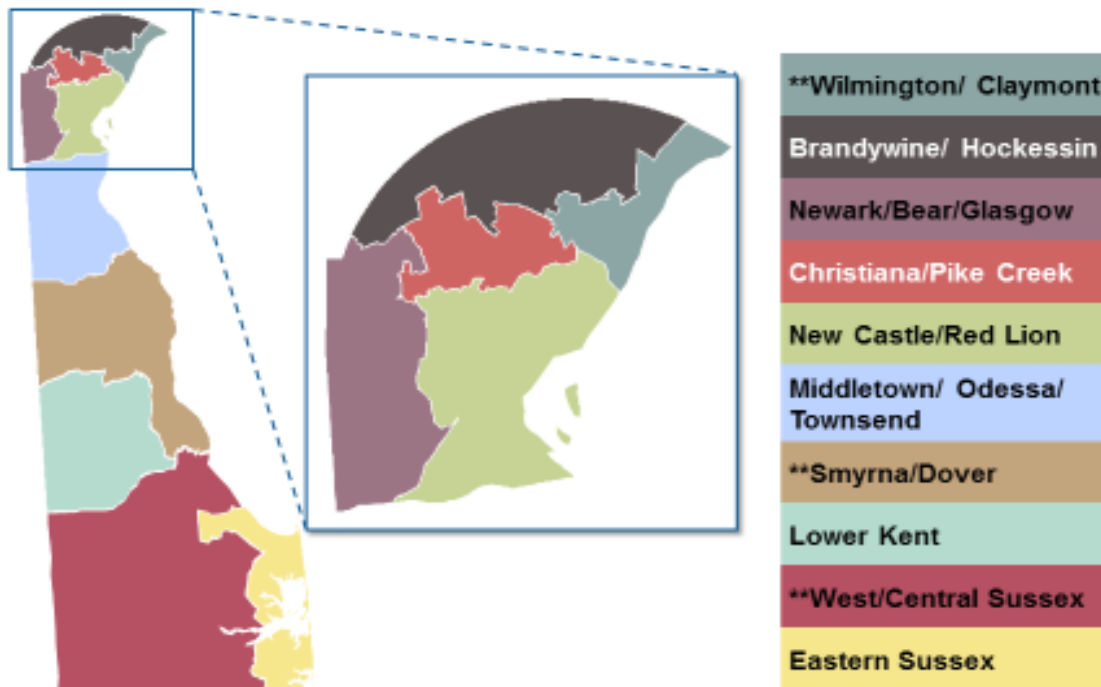
### **Status and progress from Years 1 and 2**

The DCHI Healthy Neighborhoods Committee identified ten non-overlapping communities of approximately 50,000- 100,000 residents, that constitute the intended geographic areas for each local Healthy Neighborhood. The designated communities have at least one hospital or FQHC physically located within the boundaries; each of them will be served by at least one of these providers. It is expected that many health systems and FQHCs may be active participants in multiple communities. In addition, health systems focused on specific populations, such as Nemours for the pediatric population or the Veterans Administration, may participate in all or most communities.

This year Delaware initiated implementation of the first wave (Wave 1) of Healthy Neighborhoods. The Wave 1 communities were chosen based on their demonstrated high level of need for each of the Healthy Neighborhoods' priority areas of focus (healthy lifestyle, maternal and child health, mental health and addiction, and chronic disease prevention and management). The map below identifies all of the proposed ten neighborhoods, including the Wave 1 communities in Wilmington/Claymont, Smyrna/Dover and West/Central Sussex County.

Exhibit 3: Healthy Neighborhoods Map

## Designated Healthy Neighborhoods in Delaware



SOURCE: Esri Geographical Information Services (ArcGIS)  
\*\* WAVE 1 NEIGHBORHOODS

The first of the Wave 1 Healthy Neighborhoods was launched in West/Central Sussex in the second quarter of this grant year. It was developed in partnership with the Sussex County Health Coalition, an existing community organization with an infrastructure that includes over 170 community based organizations and 404 members that participate on Task Force committees that address one or more of the four defined priority areas of need. The Healthy Neighborhoods Local Council in West/Central Sussex consists of 12 members representing key segments/organizations within that community, including a representative from the Healthy Sussex Task Force. The Healthy Sussex Task Force is an organization comprised of representatives from all of the health care delivery systems and FQHCs in the area. The Sussex Local Council has completed its community needs assessment and in collaboration with the Healthy Sussex Task Force they have aligned it with a separate needs assessment that was conducted jointly by the health care systems, leading to the identification of mutually agreed to priority areas of focus for their community, which include:

- Maternal and Child Health: Children meeting developmental milestones and babies born healthy
- Chronic Disease: Diabetes prevention & education
- Mental Health and Addiction: Drug overdose/access to treatment

- Healthy Lifestyles: Food access and children entering school ready to learn, and College & career readiness

The Local Council in West/Central Sussex is now designing a strategic plan for locally tailored interventions to address these priority areas of need. In addition, the Council is establishing metrics and measures to track the impact of planned interventions.

The other Wave 1 Healthy Neighborhoods, Wilmington/ Claymont and Smyrna/Dover will be ready for implementation in Q4 2016 and Q2 2017, respectively. Local Council members have been identified for the Wilmington/Claymont Healthy Neighborhood. A very careful and deliberate process of engaging participants and organizations in this area has resulted in the development of a consensus-driven framework for the structure of the Wilmington/Claymont Local Council. The proposed structure is intended to embrace and harness the many diverse and independent initiatives that are already occurring there. In addition, preliminary work is already underway to form the Task Force committees for that Council. Also, a regional Community Health Needs Assessment/Clinical Advisory Work Group (known as CHNA North) is being established to support the integration of efforts between the Healthy Neighborhoods Local Council and the health care systems in that area. The regional CHNA North Work Group is based on the Healthier Sussex County Task Force organization model, a model that is guiding the establishment of a statewide and smaller regional CHNA Work Groups to partner with Healthy Neighborhoods to ensure integration of clinical and community data for determining priority areas of need and developing complimentary interventions that address the clinical and social determinants of health. The CHNA Work Group model is described in further detail in the Year 3 goals for the Healthy Neighborhoods program.

In the Smyrna/Dover Healthy Neighborhood, meetings with local leaders and groups are being completed to gain an understanding of the community landscape and the initiatives that are already underway, as well as to identify interested and essential community members and leaders for the Healthy Neighborhoods Local Council. Meanwhile, data is being gathered to help align upon the health needs assessment and priorities for that area.

For each of the Wave 1 communities, Healthy Neighborhoods is providing dedicated staff support to help develop the Local Councils, execute formal partnership agreements, align resources, and develop the Communities' strategic plans for intervention and sustainability. DCHI has hired dedicated Healthy Neighborhoods' staff members to support the Councils in these efforts.

Furthermore, the DCHI Healthy Neighborhoods Committee has initiated steps to transition from a visioning working committee to one that is focused on the operational and capacity needs of the Local Councils, as well as long range planning for sustainability. The planned change in structure for the DCHI Healthy Neighborhoods

Committee is based on a collective impact model to align the approach and work of this leadership committee with the needs of the Local Council, thereby ensuring the ability of the DCHI Healthy Neighborhoods Committee to provide the appropriate and necessary guidance and resources to the Local Neighborhood Councils. The goal is to gain high-level buy in from multiple systems and stakeholders at the leadership level in order to provide sustainable support to the movement and align resources that can impact the social determinants of health. The change in structure and alignment of approach at the DCHI Healthy Neighborhoods Committee level includes the adoption of a new sub-committee structure (Work Groups) to focus on shared areas of need across all of the Councils: Data Collection, Sustainability and Health Integration. The new DCHI Healthy Neighborhoods sub-committee structure is in a nascent stage of development and will require expert support to manage the research and work of each of the sub-committees or Work Groups, which are:

- Data
- Sustainability
- Community Health Needs Assessment Group (CHNA)/Clinical Advisory Group

These sub-committees (Work Groups) of the DCHI Healthy Neighborhoods standing committee will be fully established in Year 3.

One of the key goals for Healthy Neighborhoods for 2016 was to create a population health scorecard. Upon consideration of the available data from multiple sources, DCHI Healthy Neighborhoods Committee adopted America's Health Rankings for the State of Delaware as the annual report card for tracking progress/impact across neighborhoods, focusing on the dimensions for health behaviors, the community and environmental determinants of health, and policy factors. The American Health Rankings Data is provided at the county level. However, Healthy Neighborhoods aspires to design and institute a more meaningful scorecard that reflects data at the local neighborhood level and that can drive real time decision making and interventions at the most consequential level possible. As such, a goal for Year 3 involves further development the Healthy Neighborhoods Scorecard, utilizing the expertise and resources of the members and organizations that will participate in the DCHI Healthy Neighborhoods Data Work Group.

### **Year 3 Plan**

The Wave 1 communities have different geographic profiles, levels of programming and available community services/organizations. Also, there are varying degrees of collaboration and alignment of resources among agencies and organizations within the communities. The dynamics within each of the communities affords an opportunity to generate lessons learned from these three distinct archetypes to guide the launch of the second wave of Healthy Neighborhood programs in 2017. As such, Healthy

Neighborhoods will conduct its first Learning Forum during the first quarter of 2017 to gather information from the Wave 1 neighborhoods to help guide the selection and establishment of the Wave 2 Healthy Neighborhoods. In addition, and building on the lessons learned, the following strategies/activities are planned for 2017:

#### *Launch 3-5 New Healthy Neighborhoods*

Preparation for the launch of Wave 2 Healthy Neighborhoods during 2017 includes performing a readiness assessment of the remaining proposed neighborhoods and weighing the needs of each community to determine the highest need communities. The DCHI Healthy Neighborhoods staff will work with the DCHI Healthy Neighborhoods Committee and other stakeholders to select the Wave 2 Healthy Neighborhoods based on the identified need and level of readiness to participate in Healthy Neighborhoods. The Healthy Neighborhoods Committee's Data workgroup will compile information on each community and its needs. This information, used in conjunction with a readiness rubric, will be used to identify the next three to five communities to establish. Identification of the next Wave will be completed by Q2. As in Wave 1, each of the proposed Wave 2 Local Councils must be able to demonstrate a commitment to collective impact, the formation of a diverse and active Local Council, a commitment to sharing outcomes on a regular basis, an established vision for the Community, and the ability to design a high-level project plan that includes a process for sustainability.

During this phase of establishing the Wave 2 Healthy Neighborhoods, Delaware intends to reassess the original plan for the number and geographic areas of responsibility for the Local Councils. While the goal remains for the establishment of ten Healthy Neighborhoods, DCHI is assessing the feasibility of more centralized Local Councils that could serve as the umbrella Council for multiple healthy neighborhoods within each county. We will explore the feasibility of this approach as a more sustainable model, but one that also still meets the intent of fostering local neighborhood control, as well as the responsibility and accountability for addressing population health needs.

#### *Establish Healthy Neighborhood Task Force Committees to the Local Councils*

In Year 3, the Healthy Neighborhoods Local Councils in both Wave 1 and Wave 2 communities will work with DCHI staff to create the local Healthy Neighborhoods Task Force Committees that will be responsible to the respective Local Councils. These Task Force committees will help plan and be responsible for implementing the strategic initiatives that aim to address one or more of the four identified priority areas of need in their communities. They may focus on smaller geographic areas within the Community or on targeted issues applicable to the entire community. The responsibilities of the Task Force Committees, in collaboration with the Local Council, may include:

- Determine existing initiatives/resources available to address identified community needs



- Identify gaps and barriers to accessing community-based support services
- Determine areas of need that influence health and health outcomes, as well as impact the ability of populations to comply with prescribed regimens of care by clinical providers once they return to the community from clinical settings
- Support the development of strategies and activities that will be incorporated into a detailed Community action plan to assist the community in reaching targeted goals
- Assist in identifying resources to help reach goals and seek funding when needed to increase community capacity to integrate solutions
- Assist in developing indicators, milestones, and outcome targets for reaching goals
- Report on and monitor outcomes
- Adjust plans as needs are met or desired changes are achieved across populations in targeted community

The Task Force committees will be comprised of multiple leaders and members of local organizations whose work directly pertains to the area of need and/or planned initiatives. The Task Force committees will meet monthly; set agendas, develop real time solutions to address identified needs, and set benchmarks and metrics to achieve outcomes at the local levels. They will participate in data collection and will report regularly to the Healthy Neighborhoods Local Councils.

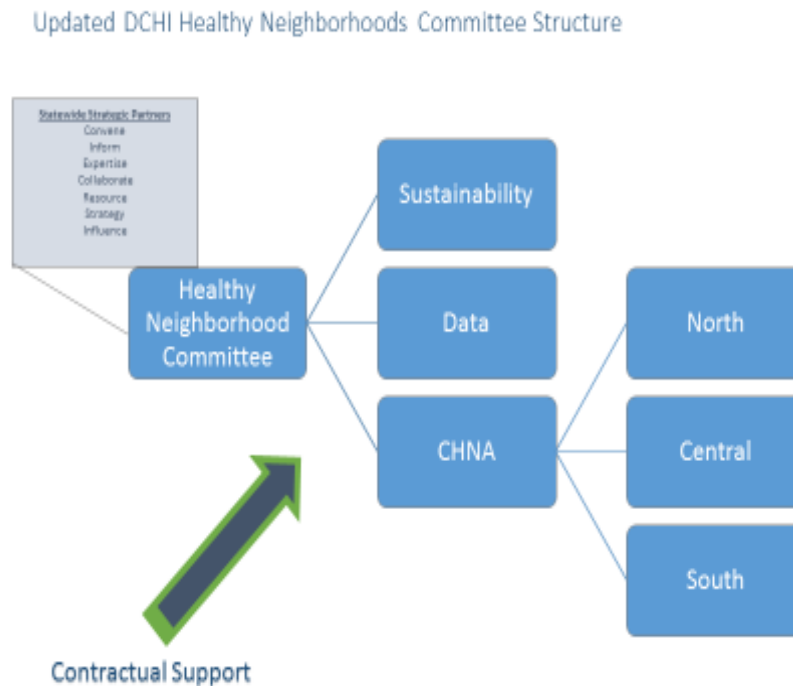
The West/Central Sussex Healthy Neighborhoods Local Council has already established five Task Force Committees that have initiated planning and the development of interventions to address the priority needs in their local neighborhoods.

*Augment the capacity of the DCHI Healthy Neighborhoods Committee to support the Local Councils and Healthy Neighborhoods in each area*

Delaware recognizes that to be successful, communities and community-based organizations need the tools to enhance capacity for collaboration, resource development and strategic planning, as well as program development, implementation, and monitoring. Thus, the DCHI Healthy Neighborhoods Committee is augmenting its capacity to support the Local Councils through the creation of three Work Groups that are directly responsible to the DCHI Healthy Neighborhoods Committee. These Work Groups will help to provide the tools and resources that will enable the success of each Healthy Neighborhood, through enhanced abilities for data collection and analysis, resource development for sustainability, and the integration of clinical and community priorities and services. In Year 3, the DCHI Healthy Neighborhoods Committee will formally establish the three Work Groups, which are described below. These Work Groups will support the Local Councils and Task Force committees across the state. One of the Work Groups – the Community Health Needs Assessment (CHNA)/Clinical Advisory Work Group – will have smaller regional sub-committees in each county of the

State: North, South and Central. Expert, dedicated support to ensure the management of each of these committees and the integration of their work with the DCHI Healthy Neighborhoods Committee is required and will be provided through DCHI in anticipation of funding support.

*Exhibit 4: Healthy Neighborhoods Committee Structure*



- **Sustainability Work Group**

DCHI is convening a statewide strategic workgroup to focus primarily on recommendations and solutions for sustainability of the Healthy Neighborhoods programs that are established across the state. The Sustainability Work Group will coalesce key statewide stakeholders to align and unify potential funding streams in targeted neighborhoods, bringing about a more holistic approach and shared resources to address population health issues. The DCHI Healthy Neighborhoods Committee recognizes that a core component for this project's success rests in multiple funding partners working to align strategies and available resources to support these at-risk communities in a more complete way.

- **Data Work Group**

Leaders across Delaware have reported that local organizations struggle to collect, analyze and translate findings into practice. Healthy Neighborhoods is convening a statewide Data Work Group of over 15 key stakeholders to help support Local Councils with a focused, consistent and viable plan for data collection and management, as well as to gauge and measure the success of planned strategies for improving population health. This Work Group will provide access to relevant data and train the Councils and Task Force Committees on the application of the data.

In addition, this collaborative approach around data will assist the Local Councils and the State in developing a common platform for the collection of population based information at the lowest level possible and to make this information available to organizations and clinical systems for planning and program development at more meaningful and useful levels for intervention.

The Data Work Group will make recommendations in respect to the data and analytics needed to design, manage and monitor the Healthy Neighborhood programs. These recommendations may be executed in the form of a public white paper and/or direct actions or policy to make the appropriate resources available.

- **Community Health Needs Assessment (CHNA)/Clinical Advisory Work Group**

Healthy Neighborhoods is establishing a Statewide Community Health Needs Assessment (CHNA)/Clinical Advisory Work Group that will report to the DCHI Healthy Neighborhoods Committee. Smaller regional sub-committees of the CHNA Work Group will also be established in each of the State's three counties under the auspices of the CHNA Work Group and the DCHI Healthy Neighborhoods Committee. These smaller regional CHNA committees, North, South and Central, will serve the Local Councils within each county and will designate members to participate on the larger statewide CHNA Work Group committee. The CHNA Work Group will oversee the integration of clinical data and the coalescing of common metrics across the clinical delivery systems and with community based organizations for the purpose of aligning strategic initiatives to address converging clinical needs and social determinants of health.

One of the local regional CHNA Work Groups (CHNA South) is already operating in partnership with the Healthy Neighborhoods Local Council in West/Central Sussex. During the planning and launch of the Healthy Neighborhoods in West/Central Sussex, community organizations and the local health care delivery systems there identified the disconnect between the clinical landscape and that of the community in identifying priority needs and the necessary

interventions/services to address those needs for lasting impact and benefit. The coalescing of the health sector in collaboration with the Healthier Sussex County Task Force to form the regional CHNA South Work Group was identified as paramount to the success of this process. It facilitates the local clinical community coming together to review and align their Community Health Needs Assessments in a collaborative manner and to match that information with true clinical data and the data that is generated by the community. This provides both the community organizations and the clinical providers with a more comprehensive perspective about the broader needs of community members. The clinical community can better design strategies to support those clinical needs while the community works in conjunction with the clinical groups to set up supports that will provide for greater access to services or create needed services that allow patients to meet their health goals. This synergistic level of work and intervention was not systemically in effect before Healthy Neighborhoods and this programmatic year will allow for this innovative process to be formed statewide.

Currently recruitment of all hospitals and FQHCs across the state is taking place to participate in the regional CHNA Work groups in their respective areas. The larger statewide CHNA Work Group that reports to the DCHI Healthy Neighborhoods Committee will be comprised of one to two representatives from each of the regional CHNA South, Central and North committees.

The graphic below depicts the structure for the CHNA Advisory Work Group and the smaller regional Work Groups.

*Exhibit 5: CHNA/Clinical Advisory Work Group Structure*



## **7. Health Information Technology**

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

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

The full Health Information Technology Operational Plan is a separate component accessed at “DE SIM AY3 HIT Ops Plan FINAL.doc”.

## **C. SIM Alignment with State and Federal Initiatives**

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

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

- **Presenting to the Delaware State Clearinghouse.** The State reviewed its SIM approach with the Clearinghouse Committee of the General Assembly to ensure alignment across Delaware's grants and returns to Clearinghouse at the beginning of each Award Year to review the funding.
- **Active engagement with health system leaders.** Delaware will continue this active engagement, since many of these institutions lead other significant health care innovation programs. Delaware has engaged these leaders through the DCHI Board and Committees, through regular meetings with the Delaware Healthcare Association, and by convening meetings with Delaware's Clinically Integrated Networks and ACOs. These meetings have been very important for aligning with Delaware's two HCIA grant programs, its MSSP programs, and its TCPI program. It will also be important to identify opportunities to align community benefit programs and community needs assessments in the future.
- **Active leadership by DHIN and DHSS.** The CEO of the DHIN and the Secretary of Health and Social Services are both members of the DHCC and of the DCHI Board. The DCHI Committees and advisory groups also include leadership from the Division of Public Health and the Division of Substance Abuse and Mental Health (both of which are part of the Department of Health and Social Services). This joint leadership has helped ensure coordination with Meaningful Use and HITECH, CDC and SAMHSA grants, and other local public health initiatives (e.g., the Governor's Council on Health Promotion and Disease Prevention).
- **Specific coordination with TCPI grant recipients.** Delaware's SIM leadership has established regular and on-going communications with HealthPartners Delmarva, a recipient of TCPI funding. HCC has communicated with its practice transformation vendors regarding expectations for coordination and cooperation between SIM-funded efforts and TCPI-funded efforts, including referring practices to the correct funder when approached. In Year 2, HealthPartners Delmarva and one of the SIM-funded practice transformation vendors held a joint learning collaborative and throughout the year, we have worked to inform each other's communications strategies, and shared lessons learned regarding vendor reporting and collecting information on practices' progress on milestones. This collaboration will continue in Year 3.

### III. Detailed SIM Operational Work Plans by Driver

<b>Goal/Driver 1: Engage patients in their health</b>				
Milestone/Measure of Success	Budget Activity	Action steps necessary to complete	Timeline	Expenditures and Responsible Party
Launch health literacy tools	Engage patients in their health	Review current activities and timelines across Committees to identify key needs related to health literacy; Determine existing resources that may be leveraged for current purposes; Revise and/or develop new materials to support health literacy needs; Work with marketing vendor to make content accessible and user friendly; Launch tools and materials on ChooseHealthDE website and make available in other formats as needed	Q3 2017	SIM Expenditures: \$150,000  Responsible: DCHI Patient & Consumer Advisory Committee, HCC through selected marketing vendor (ab+c)
Launch patient portal and other patient engagement tools	Engage patients in their health	Formalize identification of key patient engagement points across Committee efforts; Coordinate with DHIN to discuss alignment with key engagement points; Continue to beta test and update patient portal elements and functionality; Finalize adoption of community health record; Identify other patient engagement tools to be adopted or modified for adoption by DCHI; Make tools available on ChooseHealthDE website and through other channels as appropriate	Patient Portal available by Q1 2017	SIM Expenditures: N/A  Content: DCHI Patient & Consumer Advisory Committee, DCHI Board, DHIN  Technical: DHIN
Support advanced care planning	Engage patients in their health	Coordinate with DE Academy of Medicine on timeline and materials for DMOST campaign and promote through SIM channels; Work with DE Quality of Life Coalition to identify advance care planning tools relevant to SIM work; Determine how	Q1-Q4 2017	SIM Expenditures: N/A  Responsible: DCHI Patient & Consumer Advisory Committee,

		<p>promotion of advance care planning tools aligns with Committee work and reference appropriately</p> <p>DHIN to operationalize a registry of DMOST forms</p>	Q2 2017	<p>SIM Expenditures: N/A</p> <p>Responsible: DHIN</p>
<b>Goal/Driver 2: Launch Healthy Neighborhoods to improve integration among community organizations and the delivery system</b>				
Milestone/Measure of Success	Budget Activity	Action steps necessary to complete	Timeline	Expenditures and Responsible Party
Define waves of neighborhoods and for local councils to lead work in each community	<p>Continue strategic support for existing Wave 1 Healthy Neighborhoods</p> <p>Support the roll out of Wave 2 Healthy Neighborhoods</p> <p>Support the launch and execution of planned strategic interventions to address priority health needs in the Wave 2 communities</p>	<p>Identify and establish 3-5 additional Healthy Neighborhoods for Wave 2.</p> <p>Complete Consortium agreements for each Local Council</p> <p>Establish the Task Force Groups for each Healthy Neighborhood that will work with the Local Councils to facilitate planning and implementation of the strategic plan in each community</p>	<p>Q2 2017</p> <p>Q2 2017</p> <p>Q2-Q3 2017</p>	<p>SIM Expenditures: \$575,000</p> <p>Responsible: DCHI with oversight from DCHI Healthy Neighborhoods Committee</p>
Provide access to data and other tools to enable neighborhoods to prioritize needs and develop strategies	Provide expert support to the three Healthy Neighborhoods Work Groups: Data, Sustainability and CHNA/Clinical Advisory Work Group, for research and strategic support to the Local Councils	Establish three sub-committee Work Groups to the DCHI Healthy Neighborhoods Committee to support the development of tools and resources for the Local Healthy Neighborhoods and Councils	Q1 2017	<p>SIM Expenditures: N/A</p> <p>Responsible: DCHI with oversight from Healthy Neighborhoods Committee</p>



Create population health scorecard to track progress and ensure consistency of focus	Develop a common/shared/accessible population health data base for the state and research, design metrics based on real time data for DE to track progress	Re-assess Population Health Score Card and determine how metrics from each HN will drive development of Population Health Scorecard  Create Population Health Scorecard	Q2 2017  Q3 2017	SIM Expenditures: N/A  Responsible: DCHI with oversight from DCHI Healthy Neighborhoods Committee
<b>Goal/Driver 3: Implement patient centered medical homes and accountable care organizations that take responsibility for care coordination for high risk adults/elderly and children that is person-centered and team-based</b>				
Milestone/Measure of Success	Budget Activity	Action steps necessary to complete	Timeline	Expenditures and Responsible Party
Support practice transformation for primary care providers	Continue support for existing practices in practice transformation; Modify existing program to better address needs of practices while expanding support to new practices	Renew vendor contracts Engage stakeholders and Clinical Committee members to identify program improvements Modify program according to proposed changes and revised timeline Plan cross-state learning collaboratives to increase education/ awareness Open enrollment for second phase of support	Q1 2017 Q1 2017  Q1 2017 Q3 2017  Q1 2017	SIM Expenditures: \$1,600,000  Responsible: HCC and contracted PT vendors, with oversight from DCHI Clinical Committee
Provide shared tools/resources for care coordination	Develop a recommendation for updated care coordination fees	Survey practices receiving care coordination fees to assess sufficiency; analyze factors affecting fees (e.g., risk profile of panel, total cost of care, practice investments), engage payers to refine fees paid in programs	Q2 2017	SIM Expenditures: N/A  Responsibility: DCHI Clinical Committee
Continue to implement health care workforce learning and re-learning training curriculum	Develop a workforce strategy that focuses on innovative training and retraining, expands access to providers	Implement training Module 1  Implement training Module 2  Implement training Module 3	Q1 2017  Q2 2017  Q3 2017	Expenditures: \$300,000  Responsibility: HCC and Curriculum vendor (University of Delaware College of Health Sciences) with oversight from DCHI Clinical Committee

<b>Goal/Driver 4: Expand access to care</b>				
<b>Milestone/Measure of Success</b>	<b>Budget Activity</b>	<b>Action steps necessary to complete</b>	<b>Timeline</b>	<b>Expenditures and Responsible Party</b>
Streamline licensing and credentialing	Develop a workforce strategy that focuses on innovative training and retraining, expands access to providers	Meet with the Delaware Division of Professional Regulation to review DCHI consensus paper recommendations; engage hospital systems and payers to discuss credentialing application parameters; work with hospital systems and payers to determine feasibility of leveraging state legislation to set streamlined credentialing parameters	Q2-Q4 2017	SIM Expenditures: N/A  Responsible: DCHI Workforce and Education Committee, HCC
Build sustainable workforce capacity planning infrastructure to be able to anticipate and address workforce gaps over time	Develop a workforce strategy that focuses on innovative training and retraining, expands access to providers	Finalize workforce capacity planning consensus paper; present consensus paper to DCHI Board for approval; develop RFP for vendor to build sustainable workforce capacity planning model; select vendor and monitor vendor progress	Q3-Q4 2017	SIM Expenditures: \$400,000* <i>*(Targeted for Y2 Carryover Funds)</i>  Responsible: HCC through selected vendor, oversight from DCHI Workforce and Education Committee
Implement graduate health professionals consortium to increase number of health professionals who train and remain in Delaware	Develop a workforce strategy that focuses on innovative training and retraining, expands access to providers	Finalize consortium governance structure; establish new training programs and experiences; create faculty development structure and offerings; create health professionals training network	Q3-Q4 2017	SIM Expenditures: \$500,000* <i>*(Targeted for Y2 Carryover Funds)</i>  Responsible: HCC through contracted consortium vendor, oversight from DCHI Workforce and Education Committee

<b>Goal/Driver 5: Promote provider engagement</b>				
Milestone/Measure of Success	Budget Activity	Action steps necessary to complete	Timeline	Expenditures and Responsible Party
Conduct periodic provider outreach and awareness to promote adoption of new tools, resources, and programs	Develop a strategy including identification of meetings/forums for outreach, cadence of communications, and presenters and implement by coordinating presentations/outreach with presenters/organizers	Identify meetings to present DCHI content; engage DCHI members to facilitate presentations/ outreach; coordinate with meeting organizers to schedule presentations; develop content to use for presentations/outreach	Q1 2017 (launch)	SIM Expenditures: \$100,000  Responsible: Contracted communications vendor, DCHI administration, with oversight from DCHI Clinical Committee
<b>Goal/Driver 6: Develop and implement a strategy to promote integration of primary care and behavioral health</b>				
Milestone/Measure of Success	Budget Activity	Action steps necessary to complete	Timeline	Expenditures and Responsible Party
Support behavioral health providers to implement electronic medical records	Increase the awareness and application to the BH EMR assistance program and assist practices through awarding of funds	Prepare communications highlighting EMR assistance program; communicate existence of program and encourage BH providers to apply broadly; review proposals and advise on considerations for upgrading/integrating EMRs	Q1 2017	SIM Expenditures: \$100,000  Responsible: HCC, with oversight from DCHI Clinical Committee
Test new models of integrating BH and Primary Care	Launch plan for behavioral health integration testing program to test operational feasibility of integration	Facilitate partnership between BH and primary care practices; launch application; screen/select program participants; convene advisory group of BHI experts	Q1 2017	SIM Expenditures: \$400,000  Responsible: HCC, with contracted support from DCHI BHI Program Manager, DCHI Clinical Lead, training vendor, oversight from DCHI Clinical Committee
	Develop best practices and share statewide	Gather data and report on learnings from program	Q2 2018	SIM Expenditures: N/A

				Responsible: DCHI BHI Program Manager, DCHI Clinical Lead, oversight from DCHI Clinical Committee
<b>Goal/Driver 7: Promote introduction of value-based payment models across payers and monitor implementation</b>				
Milestone/Measure of Success	Budget Activity	Action steps necessary to complete	Timeline	Expenditures and Responsible Party
All payers make available a pay for value and a total cost of care payment model for primary care providers, specialists, and/or health systems	Ensure payers make available, to providers broadly, value based payment programs tied to both cost and quality and consistent with state goals	Meet regularly with payers to understand/approve value based payment models with incentives and metrics consistent with state goals for cost and quality	Q1-Q4 2017	SIM Expenditures: \$200,000  Responsible: DCHI Payment Monitoring Committee with strategic support from HCC-contracted consultant
Enrollment by primary care and other providers in new payment models statewide	Monitor rollout of pay for value and/or total cost of care payment models	Host regular (bi-weekly or monthly) meetings to monitor rollout of plans and ensure payers are tracking against goals	Q1-Q4 2017	SIM Expenditure: \$100,000  Responsible: DCHI Payment Monitoring Committee with strategic support from HCC-contracted consultant
Embed requirements in expectations for Medicaid MCOs, State Employee TPAs, and QHP Standards	Work with DMMA and State Employees to develop approach for inclusion of VBP requirements	Develop desired requirements with DMMA and State Employees Benefits, embed in contracts, and roll out to payers	Q1-Q4 2017	SIM Expenditures: \$100,000  Responsible: HCC and DCHI leadership with strategic support from HCC-contracted consultant

<b>Goal/Driver 8: Introduce Common Scorecard and Health Care Claims Database as convenient tools for cost and quality transparency</b>				
Milestone/Measure of Success	Budget Activity	Action steps necessary to complete	Timeline	Expenditures and Responsible Party
Develop scorecard (data and analytic platform) to aggregate and report scorecard measures across payers	Promote increased adoption of the Common Scorecard among DE practices	Develop communications strategy to keep Scorecard users engaged	Q2 2017	SIM Expenditures: N/A  Responsible: DCHI Clinical Committee
	Incorporate Medicare data into the Common Scorecard	Apply to obtain Medicare data from CMS; Calculate quality measures based on raw Medicare claims data; develop plan to incorporate into Scorecard	Q4 2017	SIM Expenditures: \$200,000* <i>*(Targeted for Y2 Carryover Funds)</i>  Responsible: HCC, DHIN and Scorecard vendor (IMAT) with strategic support from HCC-contracted consultant
	Develop roadmap and conduct concept testing for integration of CCDs into the Common Scorecard	Test quality measure generation based on CCDs; develop tactical plan for integrating CCDs into the Common Scorecard; collaborate with payers to integrate CCD results in quality measure performance	Q3 2017	SIM Expenditures: N/A  Responsible: DHIN
	Execute against implementation plan for Common Scorecard, to include development of additional functionality and requested changes	Execute against implementation plan to be developed by EOY 2016	Q1-Q4 2017	SIM Expenditures: \$425,000  Responsible: DHIN and Scorecard vendor (IMAT) with strategic support from HCC-contracted consultant

Establish Health Care Claims Database	HCCD design	Identify HCCD design decisions; engage stakeholders on aspects of HCCD design; Transparency Working Group (TWG) to share input on use cases to inform priorities for the initial HCCD output	Q1-Q3 2017	SIM Expenditures: \$350,000  Responsible: DHIN with strategic support from HCC-contracted consultant and DCHI committees
	HCCD technical implementation	Determine and contract with appropriate HCCD vendor; develop plan for implementing technical infrastructure of the HCCD in preparation for payer data submissions in 2017	Q1-Q3 2017	SIM Expenditures: N/A  Responsible: DHIN with strategic support from HCC-contracted consultant and DCHI committees
	Receive initial data submissions for the HCCD	Liaise with payers and establish submission templates and guidelines; accept test files from payers and provide feedback on data validation; begin accepting HCCD claims submissions	Q4 2017	SIM Expenditures: N/A  Responsible: DHIN with strategic support from HCC-contracted consultant and DCHI committees

## **IV. Program Evaluation and Monitoring**

### **A. State-led Evaluation**

#### **Plans for Year 3**

In Year 3, the evaluation team intends to continue the implementation of the evaluation approach as detailed below. In terms of a general schedule of evaluation activities, the first quarter of Year 3 (Feb-Apr) will focus on the engagement of the Utilization Committee to review the following: (1) appropriateness of the evaluation questions, (2) data collection targets and tools, and (3) plans for application of course correction recommendations from Year 2 into the operational plans of the initiative for Year 3. In cases where the Utilization Committee in collaboration with the evaluation team determines that adjustments need to be made to the evaluation focus and approach, revision to the evaluation questions, data collection targets, and tools will occur. A review of the current stakeholders, their role, and level of engagement, as well as anticipated stakeholders and plans for their engagement will be considered. The second quarter (May-Jul) and third quarter (Aug-Oct) will focus on the evaluation team facilitating the recommended revisions and in some cases designing new data collection procedures and instruments to facilitate data collection and analysis. Scheduled engagement of the Utilization Committee will occur over this period with the purpose of soliciting feedback and approval of the data collection targets, procedures and tools. Data collection and analysis will occur primarily in quarter three with the intent of preparing results for review and planning on the part of the Utilization Committee. Quarter four (Nov-Jan) activities will focus on reviewing results from the data collection and analysis and working with the Utilization Committee to develop course correction recommendations for the system as a function of the continuous quality improvement approach.

#### **Updates**

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

## Evaluation approach

Early in Year 2, the evaluation contractor worked to develop an approach to evaluation based on three interrelated perspectives. These perspectives provide a foundation for both the design of the evaluation and its related activities, as well as the role of stakeholders in the evaluation process. First, the design and approach for this evaluation embraces a systems perspective. DE SIM is a complex systems change initiative designed to address health determinants that purposefully alter system-wide patterns by changing underlying system dynamics, structures, and conditions. The evaluation seeks to identify and examine underlying patterns and structures that influence system-wide behaviors, as well as the complex and dynamic patterns of component parts, adapting, and coevolving with each other and the environment. Second, the design and approach for this evaluation emphasizes a participant-oriented model of engagement. For the evaluation of DE SIM, direct and active participant involvement over time in evaluation planning and implementation is a priority. Third, the approach for this evaluation focuses on utilization. Utilization-focused evaluation is concerned with how real people in the real world apply evaluation findings and experience the evaluation process. To that end, the evaluation process seeks to engage DE SIM leadership and representatives from various work stream committees to plan for and inform system on use of evaluation findings. Frequent and ongoing engagement of system stakeholders in the utilization processes is focused on DE SIM specifically, with an emphasis on how the information generated can be used to adjust the initiative as needed and improve the chances of success.

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

Given the unique nature of the DE SIM and the challenges of finding a reasonable comparator, the evaluation team is employing an analytical framework that seeks to answer the global question of, "What difference did the initiative make"? To describe and assess the cumulative success of the DE SIM requires:

- A logical explanation for why the investment can be expected to have led to the observed outcomes.
- A plausible time sequence of the investment that occurred and the observed change relative to an appropriate starting point.
- Compelling evidence that the investment/actions are the partial or full cause of the change when competing explanations are considered.



The evaluation team is using contribution analysis framework to construct a credible explanation of what occurred in the program has actually lead to the intended outcomes.

### **Data Collection Tools and Analyses**

The instruments and methods for collecting the needed information to address the evaluation questions have included a combination of surveys, document review, observations and key informant interviews. The evaluation questions, data collection tools and analyses are focused on the overall DE SIM implementation, viewing DE SIM as a systems change initiative made up of multiple interacting components. In addition, variation in the implementation across the different components (i.e., driver activities) will be examined in an effort to provide information that allows for specific adjustments in needed areas. The focus of the evaluation is on the interaction and coordination among the driver activities and less so on any one specific activity. Exhibit 6 outlines the specific data collection methods and key measures to date. Of note, the evaluation team has spent considerable time developing a stakeholder database and verified the contact information of multiple stakeholders across the system. This database is expected to expand over time as the initiative is implemented more broadly to include future stakeholder targets. To date, all data collection has commenced and is proceeding as per the timetable presented below. Given the various stages of data collection and analyses, preliminary results have been prepared and shared with multiple groups of stakeholders.

Exhibit 6: Data Collection Methods

Method	Description	To measure	Who or What	Timing	Staff
<b>Participant observation</b>	Observations of stakeholder meetings are recorded using a formal protocol.	Dynamics and processes for decision-making; communication patterns; Presence and influent of stakeholders; Interactions among stakeholders	Meetings and public forums	DC: Jul. '16 – Jan. '17  A: Ongoing	Erin; Hira  P: Erin; Hira S: Scott
<b>Stakeholder survey</b>	A structured, multi-item survey that contains both qualitative and quantitative elements.	Perceptions of stakeholders related to progress, engagement, satisfaction, quality, sufficiency of approach, etc.	Various DE SIM stakeholders (target population ~80)	DC: Sep. '16 – Oct. '16 (8 weeks)  A: Nov. '16 – Jan. '17	Justin  P: Scott; Justin S: Mary Joan
<b>Key informant interviews</b>	In depth, semi-structured interviews (f2f & virtual), designed to be conducted with specific individuals occupying different roles in the system.	Perceptions and insights on progress, changes in strategy, success, limitations barriers, etc.	Purposeful sample of DE SIM stakeholders (target ~8-10 individuals)	DC: Aug. '16 – Oct. '16 (12 weeks)  A: Nov. '16 – Jan '17	Erin  P: Erin S: Scott
<b>Pulse-check interviews</b>	Brief interviews focused on a few prompts to gather quick responses from individuals with some knowledge of the system, but not the in-depth level as the key informants	Perceptions and insights on progress, changes in strategy, success, limitations, barriers, awareness of activities, sufficiency of approach etc.	Purposeful sample of DE SIM stakeholders (target ~15-18 individuals)	DC: Aug. '16 – Oct. '16 (12 weeks)  A: Nov. '16 – Jan '17	Jessica; Kelly  P: Erin; Jessica; Kelly S: Scott
<b>Document review</b>	Coding and analysis of existing documents produced by the initiative	Documented progress, changes in strategy, success, limitations barriers, etc.	Existing documents generated at public meetings and publicly available reports	DC: Jul. '16 – Jan. '17  A: Ongoing	Justin  P: Scott; Justin S: Erin; Hira
<b>Work Stream Self-Assessment</b>	A brief structured review document completed by the work stream committee; submitted as a consensus report of the committee	Agreement on progress toward meeting objectives; supports; integration	Work Stream Committee	DC: Nov. '16 – Dec. '16 (6 weeks)  A: Dec. '16 – Jan. '17	Justin  P: Scott S: Mary Joan; Kelly

NOTE: DC = Data Collection; A = Analysis; P = Primary; S = Secondary.

### **Utilization Process and Procedures**

A Utilization-Focused Evaluation begins with the premise that evaluations should be judged by their utility and actual use. In the case of the DE SIM State-Led evaluation, we determined it was critical that intended users of the evaluation are involved in ways they find meaningful, feel ownership of the evaluation, find the questions relevant, and care about the findings. In this context, primary intended users are people who have a direct, identifiable stake in the evaluation.

To help ensure the DE SIM State-Led evaluation met the intended uses, a Utilization Committee was established and intended to be supported over the life of the evaluation. In collaboration with the evaluation team, the Utilization Committee is charged with:

1. Considering how the evaluation could contribute to initiative improvement and efficiencies.
2. Considering how summative evaluation judgments could contribute to making major decisions about the merit or worth of the initiative.
3. Considering how evaluation could contribute by generating knowledge, lessons learned, and evidence-based practices.

The Utilization Committee has broad representation of the DE SIM system, including members from the different work streams and leadership groups. Currently, all 5 work stream committees, the DCHI, and HCC are represented. Utilization Committee members were selected on the basis that they:

- Have an interest in and commitment to using evaluation findings, either because they will be making decisions using the findings, or are closely connected to those likely to use the evaluation findings
- Bring a perspective that will contribute to the diversity of perspectives and views that surround the evaluation
- Are willing to effectively participate in the group process to deliberate and negotiate; seeking agreement related to evaluation uses

The principal role of individual committee members has been to engage in a collaborative process to plan the evaluation and negotiate key issues that will affect the evaluation's credibility and use. Members are instrumental in helping to prioritizing evaluation questions, making good design decisions, interpreting data, and following through in the application of the findings.

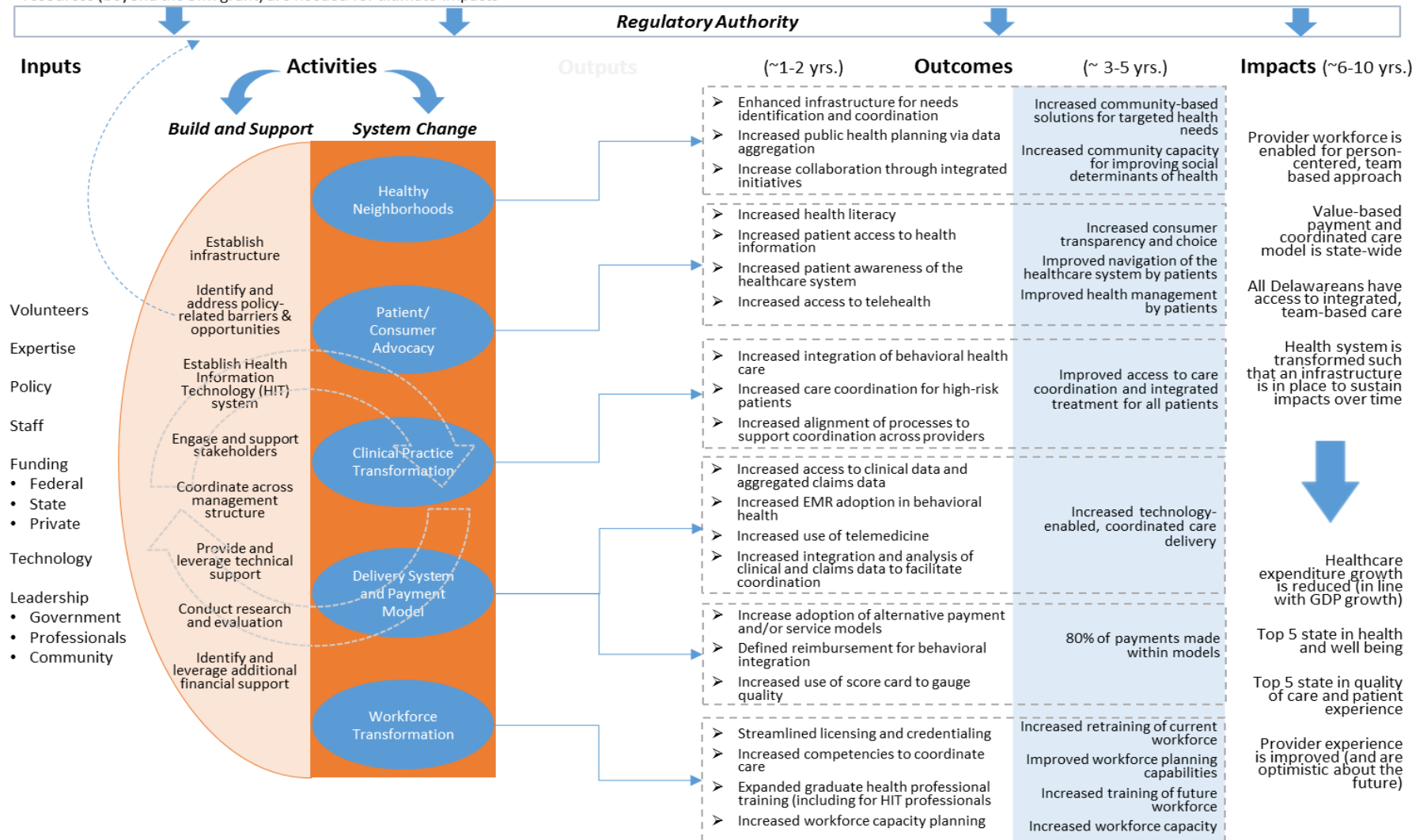
To date, the Utilization Committee has been convened in two virtual meetings to (1) review the purpose and design of the evaluation, and (2) review data collected as outlined above. The Utilization Committee is scheduled to meet in-person in January of 2017 to review all of the

results of the initial data collection effort and generate course correcting recommendations for the initiative leadership for application in Year 3.

#### **Current logic model and evaluation questions**

Early in the operationalization of the approach for the evaluation, the evaluation team engaged an initial group of key stakeholders in the development and refinement of a logic model to guide the evaluative inquiry. The DE SIM logic model is presented in Exhibit 7. In general, the logic model captured the stakeholders' assumptions about how the different resources and activities of DE SIM lead to the desired outcomes and ultimate impact. It describes the presumed theory of change and conveys the sequence of expected processes and outcomes. The logic model mapped out and represented the linear sequence that shows how the logic of the program leads from inputs, activities, and outputs to the short-term, intermediate and long-term outcomes. In this regard, the logic model enabled the evaluation team to articulate specific, detailed, measurable and objective program evaluation questions. The following page displays the current logic model being used to frame the evaluation.

**Assumptions:** Participatory, consensus-driven approach is most appropriate and effective; Healthcare systems change requires a multi-component, integrated approach simultaneously targeting multiple areas; Some technical solutions are currently available, others need developing or refined; Changes to health care system impact individual and population health; Financial resources (beyond the SIM grant) are needed for ultimate impacts

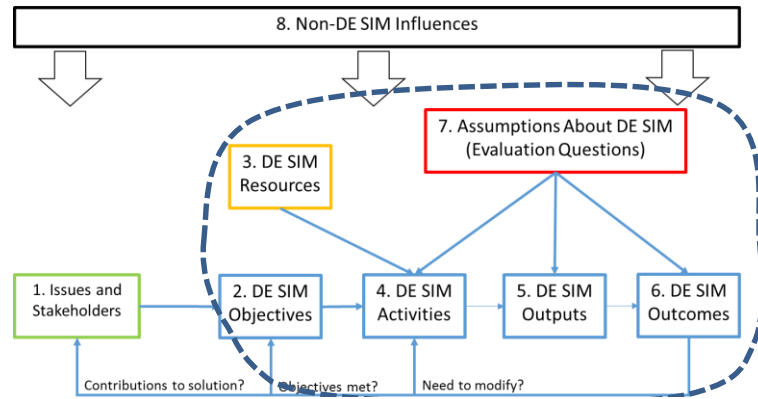


**External Factors:** Political will; Provider will; Policy changes; Changes in health and system trends; Economic variables and changes; Sustained funding; Consumer/patient expectations

Exhibit 7: Logic Model

## Evaluation Focus and Questions

In the initial phase of the evaluation, the primary objective was to design and facilitate a process evaluation that will comprehensively describe the DE SIM implementation and gather qualitative and quantitative data from providers, consumers, and health systems to assess perceptions, identify challenges and inform the development of strategies for success.



*Exhibit 8: Focus of the DE SIM Evaluation*

To meet the primary objective stated above, a set of evaluation questions were developed to frame the initial inquiry and produce findings that will enable the DE SIM stakeholders to consider the application of new information to the ongoing assessment of the quality of implementation. As shown in Exhibit 8, the initial focus of the evaluation is primarily on the connection between what the DE SIM is designed to do, and the extent to which this occurs. The evaluation questions focus on the activities, outputs and outcomes of DE SIM, and generating information to facilitate planning and implementation. This focus also enables stakeholders to raise questions as to the need to modify the activities or whether objectives of the model have been met. Evaluation data collection, analysis and utilization processes are focused on examining the assumptions of DE SIM about the relationship between the model activities, outputs, and outcomes to frame learning about what is working, or not, and what needs to be adjusted. The priority evaluation questions for Year 1 are listed below:

1. How has the infrastructure been developed to enable the stakeholder to plan and implement the DE SIM initiative?
  - a. In what ways are supports provided to the stakeholders committing time to the development of DE SIM?
  - b. To what extent do the supports provided to stakeholder groups meet their specified needs?
2. How have stakeholders been engaged in the design and development of DE SIM?
  - a. How do DE SIM stakeholders understand and apply learnings generated from monitoring and evaluation processes?
3. What the activities of DE SIM have been coordinated across the management structure?
  - a. How is information exchanged across the DE SIM management structure?
  - b. How do decisions related to activities comport with the desired impact of DE SIM?
4. To what extent are the resources allocated to DE SIM being used as planned?
  - a. How do the resources allocated to DE SIM reflect stakeholder priorities?
  - b. Are the resources allocated to DE SIM being used efficiently?

- c. Have the resources been allocated in a manner corresponding to the desired impact?
5. In what ways have additional resources and supports (beyond those funded through the SIM grant) been identified and leveraged?
6. How have policy (and other environmental?) related barriers and opportunities been identified and addressed?
7. Have the work streams made progress toward meeting the stated objectives for their respective areas? If not, why?
  - a. Are work stream purposes/objectives/activities aligned with the desired impact of DE SIM?
8. Do DE SIM stakeholders receive information on progress in meeting objectives, overall and by work stream? If not, why?
9. Has the sustainability (i.e., durability) of DE SIM infrastructure and activities been addressed? If not, why?

Collectively, it is expected that these questions enable the evaluation to examine several system concepts at work across the initiative. Embedded within the evaluation questions are sensitizing concepts related to communication, information exchange, engagement, decision-making, supports, alignment, leadership, direction, sustainability, leveraging, and transaction. Used as a heuristic, sensitizing concepts are terms, phrases, labels, and constructs that drive the evaluative inquiry, even as evaluation question change over time. These concepts provide insight as to the stakeholder's perspective prompting the evaluation team to inquire, "What does this concept mean in this context to these people?" and "What are the variations in meaning and the implications of those variations?" Focusing on these concepts provide an opportunity for the evaluation team and stakeholders to understand the dynamics of the system during implementation and how the inner workings are producing the results expected. These concepts serve as a framework for the coding and analysis of evaluation data and ensure consistency of the inquiry across different data collection methods.

## **B. Federal Evaluation, Data Collection, and Sharing**

During Year 2, Delaware actively and regularly participated with the selected CMMI SIM Evaluator, RTI, to support evaluation activities. This includes:

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

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

## **C. Program Monitoring and Reporting**

### **1. Project management structure**

The Health Care Commission, as the Governor's designated award recipient, has oversight and project management responsibility for the State Innovation Model Cooperative Agreement. The Principal Investigator for the agreement is HCC Executive Director Laura Howard, who oversees all aspects of the grant and all vendors associated with it, and monitors the project's overall progress. Other state staff at the HCC are assigned to assist with vendor management and monitoring as well as grant management functions. Contracted consultants have provided additional project management support through their support to DCHI committees and workstreams and their contributions to quarterly and annual reporting.

In addition to the quantitative metrics and the qualitative narrative reporting required by the SIM Cooperative Agreement, one of the tools that Delaware will use for regularly monitoring the impact of the work of the SIM initiative is the overall Program Dashboard. This will allow the DCHI board, committees, and stakeholders alike to view the goals associated with each Committee and have an updated view into each's progress toward stated goals.

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

### **2. New risks for upcoming year**

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

- **Changes in state government administration as a result of 2016 election:**  
With term-limits for governor in place in Delaware, the state will see a new individual in this role beginning in January 2017. Governor-Elect John Carney, who won the election in November, served as Delaware's at-large U.S. Representative for six years and before that was our Lieutenant Governor. Delaware also elected a new Lieutenant Governor to take office in January 2017



with State Sen. Bethany Hall-Long winning that election. Both the Gov. Elect and the Lt. Gov. Elect have strong health policy backgrounds with Gov. Elect Carney having served as Chair of the Health Care Commission during his tenure as Lt. Gov., and Lt. Gov. Elect Hall-Long, a nurse, having served as Chair of the Senate Health and Social Services Committee in the General Assembly. Another anticipated change in Delaware government leadership is within the Dept. of Health and Social Services. Current DHSS Secretary Rita Landgraf announced that she will resign as Secretary at the end of the Markell Administration, allowing the new Governor to fill that appointment. In order to ensure a smooth transition, HCC and DCHI will meet with the incoming Administration to provide information on the current status of the initiative and establish regular communication. In addition to leading the Department in which the HCC sits, the new Secretary will serve on the DCHI Board of Directors and thus have the opportunity to engage directly in the SIM work. HCC will ensure that the new Secretary is briefed on the SIM initiative as soon as possible and will work to establish regular communication.

- **Changes in federal government administration as a result of the 2016 election:** After the election of 2016, there is ambiguity about the future of the Affordable Care Act, as repeal of the law was a frequently debated topic of the campaign. Delaware will maintain close communication with our federal project officer at CMMI to understand the implications that any possible legislative or budgetary changes may have on our SIM work.
- **Financial sustainability of the HCCD:** The Health Care Claims Database was created through legislation in 2016 without specifying a financing mechanism. The final regulations, any fee structure, and ultimately the sustainability of the HCCD are to be determined by DHIN and its board of directors. The HCCD is a key element of the state's transparency strategy as providers will be able to access data from the HCCD to maximize their participation on VBP models. Data from the HCCD will also be used to support other SIM initiatives including Healthy Neighborhoods. To mitigate the risk posed by the sustainability of the HCCD, HCC and DCHI will work with DHIN to provide input, guidance and assist in identifying strategies and resources for long-term financial stability, including implementing user fees. In addition, DHIN will explore the possibility of leveraging existing technology and staffing assets to the greatest degree practicable.
- **Financial sustainability of the Common Scorecard:** The Scorecard is currently an integral part of Delaware's SIM plan helping to ensure alignment of quality and cost measures across value based payment models and providing a single aggregated view for practices across patient panels. However, risk exists for financing the ongoing functionality of the Scorecard after the SIM project period ends. To mitigate this risk, DCHI's leadership and in particular the

Clinical Committee will assess the current structure of the Scorecard to determine potential funding strategies and sources. Two strategies to explore will be enhancing the functionality of the Scorecard to add sufficient value to charge fees, or working with the payers to encourage them to use the Scorecard as the source of data for paying providers enrolled in VBP models.

The most recent Quarterly Progress Report outlines other project risks and mitigation strategies currently being employed and is available at “Q3 DE SIM QPR as Submitted 11-30-16.pdf”.

#### **D. Fraud and Abuse Prevention, Detection and Correction**

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

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

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

## V. Sustainability Plan

Beginning with our State Innovation Model Design award, Delaware recognized that health system transformation would be a long-term proposition. In 2013, the Health Care Commission convened a multi-stakeholder coalition of consumers, providers, payers, community organizations, academic institutions, and state agencies in order to develop a plan to achieve the Triple Aim plus One in our state. As a result of that collaboration, the State Health Care Innovation Plan was developed and established the idea of creating a non-profit organization – outside of the state government structure – to guide and lead the ongoing work of innovation, knowing that this work requires sustained involvement of public and private sectors over an extended period of time. This separate organization, the Delaware Center for Health Innovation (DCHI) which was incorporated in 2014, will provide continuity to and stability for the vision of a multitude of stakeholders regardless of the administration at the state, federal, or corporate levels. Recognizing the critical link between the public and private sectors in this work however, the DCHI Board of Directors includes seats for Delaware’s Director of the Office of Management and Budget, Secretary of the Department of Health and Social Services and the Chair of the Health Care Commission.

An additional area where sustainability planning occurred early on was in Delaware’s approach to Health Information Technology. Just as state agencies are represented on the DCHI board, so too is the Delaware Health Information Network (DHIN). In fact, the DCHI by-laws name DHIN as its sole member and the CEO of DHIN serves in an ex-officio capacity on the board. This gives DHIN, a statutorily created public instrumentality of the state, a leadership role in the development of policy and direction of the initiatives undertaken in the advancement of health innovation, ensuring that HIT activities are considered and coordinated.

DCHI was created to be financially independent, relying on in-kind and financial support from a variety of stakeholders. While some SIM funds may be used to enable DCHI to manage specific projects, the majority of the organization’s staffing, administration and general infrastructure is financed through the contributions it receives. DCHI undertook a strategic planning effort in 2016, recognizing that after two years of operation it was time to look ahead to what the organization’s goals and imperatives were especially in light of the changing landscape (i.e. changing state administration, tapering and eventual end of federal SIM support). This strategic plan was developed in Q3 and Q4 of AY2 with the input of the DCHI Board and dozens of stakeholders and approved by the DCHI board at the December 2016 meeting. It will provide a roadmap for the organization into the future and a guiding direction that will ensure sustainability past the SIM project period. In the process of the strategic plan development, DCHI’s mission and role were positively affirmed, as was the commitment of these stakeholders in their active support of DCHI.

One key theme that arose in DCHI’s strategic planning process was the need to maintain a broad portfolio of initiatives in order to achieve the Triple Aim plus One, but to be flexible and evolve in response to changes in the landscape. While many of the initiatives originally outlined during the Design process are still relevant and continue, there have been significant changes in the health care landscape in just the first two years of DCHI’s existence.

For instance, the passage of MACRA has created an additional incentive for providers to explore Practice Transformation and understand the payers' current value-based payment models. DCHI and Delaware will look to align its delivery system reform and payment model strategies with MACRA to position providers for MIPS in 2018 and eventually the availability of an All Payer option in 2021. In 2016, DCHI led an exploration of the CPC+ initiative. While Delaware's payers ultimately chose not to participate, DCHI played a critical role in assessing the opportunity for alignment with our state's goals. Since no providers in Delaware currently participate in any CMS Advanced Alternative Payment Model at this time, DCHI will continue to bring stakeholders together to understand the changing landscape and evaluate any opportunities to move providers toward APMs in the future.