

Delaware State Innovation Model (DE SIM) State-Led Evaluation for AY4

Annual Report

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Evaluation Team

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1.0. Introduction

The State Innovation Model (SIM) Program is sponsored by the Centers for Medicare and Medicaid Services (CMS) and administered by CMS's Center for Medicare and Medicaid Innovation (CMMI). The SIM program is one of several initiatives developed and administered through CMMI to test and refine innovation around healthcare payment and delivery models with the goal of improving the health of state populations. Under this funding mechanism, CMMI is testing the ability of state governments to accelerate statewide health care system transformation from encounter-based service delivery to care coordination, and from volume-based to value-based payment. Underpinning health care system transformation in this context is the belief that more coordinated and accountable care is better care, leading to more efficient spending and healthier people. The initiative recognizes the unique role states play as facilitators of health care transformation. These roles may include regulators, legislators, conveners, and both suppliers and purchasers of health care services. Through the SIM initiative, CMMI supports states to use a wide array of policy levers, engage a broad range of stakeholders, and build on existing efforts to bring about or accelerate health care system transformation.

1.1. Delaware's State Innovation Model (DE SIM)

Delaware aspires to be one of the five healthiest states in the nation, as measured by its performance on core dimensions of Centers for Disease Control and Prevention's (CDC) Healthy People 2020 goals. Although Delaware has strong public health, community, and health care programs with a track record of success on specific initiatives, Delaware spends 25% more per capita on health care than the U.S. average and outcomes remain average or below in many areas.¹ Delaware's goal is to be in the top 10% of states on health care quality and patient experience within five years by focusing on more person-centered, team-based care. Delaware seeks to prioritize integrated care (including with behavioral health) for high-risk individuals (i.e., the top 5-15% that account for 50% of costs) and more effective diagnosis and treatment for all patients. Finally, Delaware seeks to leverage these changes as an avenue to improving provider experience.

As a CMMI funded initiative designed to support changes in healthcare delivery the Delaware State Innovation Model (DE SIM) is expected to create more than \$1 billion in value through 2020.² Under the auspices of the Delaware Health Care Commission (HCC), Delaware's robust, multi-sector plan (reflected in Figure 1 below) seeks to improve on each dimension of the **Triple Aim** (i.e., Improved population health, Improved quality, Lower health care costs), **plus one** (i.e., Provider experience). Setting

¹ <http://dhss.delaware.gov/dhss/dhcc/cmmi/files/choosehealthplan.pdf>

² Delaware's Department of Health & Social Services (2014). Delaware Receives \$35 Million for Plan to Improve Health Care Quality and Lower Costs. Retrieved 2/24/2017. <http://news.delaware.gov/2014/12/16/delaware-receives-35-million-for-plan-to-improve-health-care-quality-and-lower-costs/>

the stage for AY4, Governor Carney made a public, specific commitment to transformation, outlined in a Road to Value for the Delaware health care system that more specifically articulates the pathway for achieving this vision, as it seeks to transform health care delivery and improve health outcomes through the following strategies: (1) Improve health care quality and cost; (2) Pay for value; (3) Support patient-centered, coordinated care; (4) Prepare and support the health provider workforce and health care infrastructure needs; (5) Improve health for special populations; (6) Engage communities; and (7) Ensure data-driven performance.

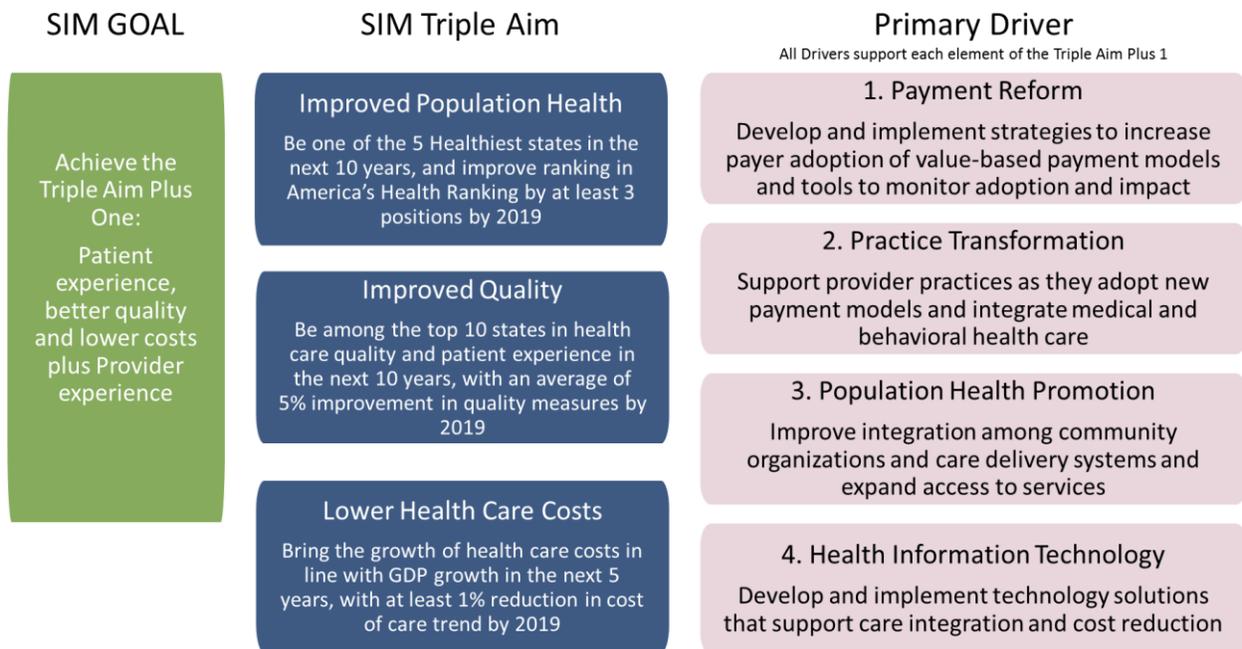


Figure 1. Delaware SIM Triple Aim, Plus One Strategy.

The previous year began with state leadership transition, resulting in several changes and new directions. The year ended with the launch of several new programs. In AY4, the State looked to leverage their collective experience and learnings to continue to cultivate the support of our stakeholders and to make substantial progress on a streamlined set of initiatives. The AY4 work plan was centered on Healthy Neighborhoods, payment reform, behavioral health integration, supported by Health IT, and continue the preceding efforts to transform health and health care for all Delawareans.

- Payment reform and related activities** were a major focus of the work in AY4. The Health Care Commission (HCC) sought to continue to support the Department of Health and Social Services in their efforts to construct and launch a health care benchmark. New models for payment were developed in collaboration with Delaware payers, providers, and consumers. The HCC and its vendors looked to continue to forward transparency and quality efforts through payment reforms on many fronts—linking with DHIN and the practice transformation efforts under SIM.

- **Behavioral health integration** was the mainstay of the AY4 practice transformation work. Based on the plan developed in AY3, HCC worked with practices across the state to improve their capacity to address behavioral health needs alongside primary care. The HCC continued to support other practice transformation activities and sought ways to support provider engagement in Delaware’s Health Information Network (DHIN).
- The **Healthy Neighborhoods (HN)** initiative was launched in the fall of AY3 and was established to propel population health efforts through three county-based HN councils. In AY4, the HCC formalized a mini-grant program that enabled these local councils to implement critical, evidence-based programs to improve population health. The HCC also supported population health through several other consumer-based efforts, including the state employees’ programs and elsewhere.
- **Health IT (HIT)** and health information exchange and transparency underpinned the success and sustainability of all the aforementioned strategies. Without data, payment reforms can be lopsided, practice transformation can be hindered, and local communities are unable to target high-need issues and populations. Therefore, the HCC continued to work with DHIN and invest in HIT efforts, concurrent with other initiatives.

Finally, the Health Care Commission anticipated final year of the SIM grant positioned the State to look forward and plan for the future. The payment, practice and community transformation efforts in AY4 was intended to stimulate action across the state, acknowledging the need to work collaboratively to retain momentum.

1.2. Transforming Healthcare in Delaware

DE SIM includes several interconnected components coordinated to improve health outcomes, facilitating change at multiple levels, and emphasizing transformation of the healthcare system. Healthcare is a complex industry with high societal and personal expectations from users, payers and practitioners. Transformative healthcare refers to a comprehensive system-wide ongoing approach to deliver excellent value with measurable improvements in quality and service and reduce costs through effective alignment of people, technologies, and processes.³ Transformative healthcare includes structural reconstructions and changes to the processes of providing clinical care and necessitates changes to the inherent culture and values of healthcare organizations, often seen through redefinitions of roles and relationships between agents.⁴

³ Institute of Medicine (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academies Press.

⁴ NHS Institute for Innovation and Improvement (2007). *NHS Institute for Innovation and Improvement annual report and accounts 2006 to 2007*, retrieved 3/17/2017.

These changes require human input and qualities such as energy, commitment and a sense of responsibility to organization-wide goals over an extended period.⁵ People need to have a full understanding of the process and a clear vision using appropriate technology to create value for the organization, and the people for whom it provides care. Recent research suggests an extended time horizon to fully realize systems change and successful transformation may take a decade or more to achieve.⁶ Evaluation of such efforts have become increasingly important and those that operationalize the structure, process, and outcome elements in the context of key elements such as essential services, quality of care, and determinants of health are critical to promoting sustainable healthcare services and their impact on community health outcomes.⁷

Delaware's overall SIM plan call for a highly collaborative, participatory, and consensus-based approach to facilitating healthcare transformation for the state. Broad representation across the healthcare community has been critical and providers from across Delaware - including physicians, behavioral-health providers, community-based and long-term care providers, every hospital and FQHC, provider professional organizations, other providers, and the state health systems leaders – have collaborated on the planning and implementation of this initiative. Through this engagement, DE SIM worked 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.

As Delaware moved forward in AY4 on the *Road to Value*, the State sought to drive, leverage, and work with stakeholders to collectively realize health care transformation evidenced by:

- Integrated systems of care competing on cost and quality
- Continuing to increase the proportion of payers and providers participating in value-oriented payment systems;
- An active use of purchasing and regulatory levers in public sector programs, through which momentum towards a value-based delivery system is sustained;
- Systems of care that are grounded in robust primary care and activated consumers, thereby improving provider engagement and reducing burden;

⁵ Best, A., Greenhalgh, T., Lewis, S., Saul, J. E., Carroll, S., & Bitz, J. (2012). Large-system transformation in health care: a realist review. *Milbank Quarterly*, 90(3), 421-456.

⁶ Lukas, C. (2009). Transformational change in health care systems: An organizational model. *Health Care Management Review*, 32(4), 309-320.

⁷ Reeve, C., Humphreys, J., & Wakeman, J. (2015). A comprehensive health service evaluation and monitoring framework. *Evaluation and Program Planning*, 53, 91-98.

- Organized systems and neighborhoods that are responsive to community-specific health priorities, tailor care to special populations, and adapt to changing needs; and
- Creating governance and stakeholder engagement mechanisms that ensure Delaware is strategic, systematic, results-driven and collaborative in creating solutions to our health challenges beyond the period of the SIM award.

A major priority of the DE SIM initiative in transforming healthcare in Delaware is the promulgation of value-based payment models. As of 2017, the State reached an important milestone: more than 30% of payments for primary care for Delawareans are now “value-based.”⁸ In AY4, Delaware looked further strengthen a foundation for a sustainable health transformation agenda. To that end the State sought to accelerate the adoption and broaden the scope of value-based payment in Delaware, and continue the program of practice transformation assistance, while also aligning with the evolving Medicare ACOs and other health plan-provider partnerships. A fundamental part of advancing this agenda was an effort to learn from payer and purchaser strategies outside of Delaware that support transparency and consumer decision-making and drive better outcomes at a lower cost trend.

1.3. Purpose and Approach

The purpose of this report is to summarize the activities and results of the state-led evaluation of the third-year implementation (AY4) for DE SIM. As an expectation of the overall DE SIM plan, the state-led evaluation is intended to engage stakeholders in a continuous improvement approach to examining the processes and outcomes of DE SIM. In collaboration with DE SIM stakeholders, the state-led evaluation provides input on, track, and inform stakeholders of progress towards unique, state-specific implementation milestones and model outcomes. This approach was intended to create a feedback loop for Delaware to track implementation, make mid-course corrections, and meet program goals. It was anticipated that the evaluation activities would 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.

This work represents the third year and final year of Delaware’s State-led evaluation of the implementation of its DE SIM strategy. The state-led evaluation is intended for the state to use for self-improvement and to share among in-state stakeholders and is focused on the goals established by the state. To meet the purpose of the evaluation, the CSI and UD/CCRS team employed an integrated, mixed-methods evaluation approach where qualitative and quantitative techniques for data collection and analyses were used. For each of the broad evaluation questions stated below, multiple qualitative and

⁸ Note: Delaware uses the CMS construct for “value-based” to mean payments that recognize quality rather than being only volume-based. Furthermore, we designate as value-based payment structures those that adhere to “Category 3 or 4” as defined by CMS’ Learning and Action Network

quantitative data points are expected to provide answers. Integration involved subjective and objective sources of information and occurred at several levels, including data collection, analysis, and reporting. The evaluation approach emphasized quality and strives to meet evaluative standards set forth by the evaluation field related to accuracy, propriety, feasibility, and utility.

1.4. Evaluation and Monitoring Focus

For the AY4 state-led evaluation, we carried out an approach responsive to needs of both DE SIM stakeholders and leadership. In this regard, we focused on two related purposes. First, we continued to evaluate the role of DE SIM in accelerating transformation in relation to the ever-changing nature of the context within which it is embedded, and the inherent challenges consummate with this approach. Our team sought to understand how major systems changes were unfolding, where it may be delayed or expedited, or how the innovation may need to be changed and adapted as it is scaled. In our approach to document the perceived effect of implementation of DE SIM upon the emerging system, the methods and questions were sensitive to understanding the initial conditions and how the initiative evolved as it took shape. Consistent with the purpose of the state-led evaluation, the results provided feedback about what is emerging, and enabled us to follow the incremental actions and decisions that affect the paths taken and not taken.

Second, we instituted a performance monitoring process to examine how DE SIM met or did not meet its objective and milestones as per the AY4 Operational Plan. Our approach emphasized process monitoring to generate information to expedite feedback on progress and performance through a more rapid turnaround of evaluation findings. This results-based feedback on performance on a quarterly basis accommodated the need for rapid-cycle utilization of findings to enable course correction recommendations for the system as a function of continuous quality improvement and accountability.

Three interrelated perspectives provided 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, our design and approach for this evaluation embraced a systems perspective 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, our design and approach for this evaluation emphasized a participant-oriented model of engagement. Third, our approach focused on utilization and was concerned with how real people in the real world apply evaluation findings and experience the evaluation process.

1.4.1. Evaluation Questions

We crafted a set of broad questions to frame our evaluative inquiry and produce findings to enable the DE SIM stakeholders to consider the application of new information relative to the ongoing assessment of transformation in the health care system. Through these questions, we examine processes,

boundaries, values, relationships, and perspectives that yield system information that enables reflection and assists in the identification of future change. The evaluation questions were as follows:

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

1.4.2. Monitoring Questions

We also crafted a set of broad questions to frame our monitoring process and produce findings with the aim of providing the DE SIM leadership and stakeholders with detailed information on the progress or delay of the ongoing activities, thereby enabling them to determine if the initiative was on track to achieve its desired goals and objectives. Through these questions, we sought to determine if the planned outputs, deliveries and schedules were reached so that action can be taken to correct the deficiencies as quickly as possible. The monitoring questions were as follows:

1. How is DE SIM implementation proceeding relative to the drivers and milestones outlined in the AY4 Operational Plan?
2. What are the conditions or situations that inhibit or expedite meeting the milestones? How are these acted upon?
3. What differences, if any, between the plan and the implementation were identified? What were the causes for these differences?
4. How does the progress toward meeting the objectives in the AY4 Operational Plan comport with the stakeholder perceived system changes?
5. What are the key processes for achieving the intended results of the DE SIM initiative? What are the effects (intended and unintended) on the achievement of results if those processes do not take place as foreseen?

2.0. Evaluation and Monitoring Methods

To meet the expectations outlined by CMMI for the state-led evaluation, we utilized an analytical framework that seeks to answer the global question of, "What difference did the initiative make"? Attribution in this context requires the understanding of the complexity of the situation, the presence of

other factors at play, and identification of the most likely explanation for the observed outcomes. Thus, we used a contribution analysis framework to construct a credible explanation of what occurred in the program has led to the intended outcomes. As we integrated the monitoring and evaluation purposes of our approach, we sought explanations for why DE SIM led to general systems changes, as well as the specific results observed at the driver level. The approach also allows us to glean as much insight as possible from performance measures about how well the operations of the initiative are working to inform stakeholders of progress towards unique, state-specific, implementation milestones and model outcomes.

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 system 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.

2.1. Stakeholder Survey

A structured, multi-item survey was designed and administered in the latter part of AY4. The survey contained both qualitative and quantitative elements. It was designed specifically to gather information from stakeholders about who they are, what they value, and how they see the healthcare system being transformed. In this survey, Delaware's efforts were referred to as the ongoing public-private collaborative work to transform the healthcare system to one that produces better outcomes at lower costs. DE SIM was described as the grant program that was awarded to Delaware help accelerate these transformative changes. A copy of the stakeholder survey is provided in Appendix A of this report.

The survey was provided to 1,154 healthcare transformation stakeholders contained in the HCC database through a link to access a web-based form. This web-based version was open on the SurveyMonkey platform from December 11, 2018 to January 18, 2019. A reminder to participate was sent out to all invitees on January 8, 2019. Of the 1,154 invitees, 127 (11.0%) responded. Data from the stakeholder surveys was summarized and reported in aggregate, based on both descriptive and inferential analyses where appropriate.

2.2. Meeting Observation

We observed interactions and processes at stakeholder meetings and recorded our observations using a formal protocol. These observations included updates and discussion of progress occurring at stakeholder meetings, as well as the dynamics of decision-making, communication patterns, presence and

influence of stakeholders, and interactions among stakeholders regarding DE SIM and healthcare transformation more broadly. A copy of the participant observation guide used to capture observational information from meetings is provided in Appendix B of this report.

Over the course of AY4, our team attended and observed 40 meetings. These meetings included DCHI facilitated committee meetings (e.g., Clinical, Healthy Neighborhoods, Payment, DCHI board, etc.), Health Care Commission public meetings, as well as the multiple public forums where information on the state strategy for healthcare transformation was shared (e.g., Benchmark Summit Series).

2.3. Document Review

Documents were an important source of information about what happened during AY4. We reviewed existing documents generated at public meetings and publicly available reports which included meeting materials, progress reports, and minutes. Coding and analysis of existing documents produced by the initiative to assess documented progress, changes in strategy, success, limitations, and barriers.

2.4. Progress Check Interviews

Throughout AY4, we held a set of brief interviews quarterly with key content leads focused on progress toward objectives and milestone achievement, including challenges and facilitators related to secondary drivers. These 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 a key informant interview. The progress check interviews were designed to address information gaps on the progress related to DE SIM areas of which respondents would have specific knowledge and insights. These could include perceptions and insights on progress, changes in strategy, success, limitations, barriers, awareness of activities, and sufficiency of approach.

We conducted a total 19 progress check interviews over the course of the four quarters. These interviews lasted between 20-30 minutes each and were driven by the specific questions to be addressed for the quarter in which they occurred. Results of the interviews were folded into the quarterly performance monitoring reporting process.

3.0. Results

3.1. AY4 Monitoring

The performance monitoring approach employed in AY4 was specifically focused on monitoring the activities outlined in the “Detailed Work Plans by Driver”, found in the *AY4 Operational Plan* drafted by HCC. This summary of performance for AY4, details progress by driver and provides contextual information by examining the activities and tasks that accompany them with a focus on secondary driver milestones, referred to as “process markers,” for all four quarters of AY4. The DE SIM Driver Diagrams outlines these drivers and metrics that stakeholders have determined to be important for monitoring

purposes. In this summary, we have used those metrics as process markers to determine the extent to which progress is on track and/or if changes were made to the plan (see Table 1 below). Additionally, updates on the progress of drivers that do not have any specific process markers assigned to a specific quarter are presented.

3.2. Overall DE SIM Progress and Performance

3.2.1. Quarter 1 (2/1/18-4/30/18)

At the end of Q1, through state leadership and stakeholder involvement, DE SIM made progress in advancing the goals of the initiative and progressed towards achieving the milestones and objectives laid out in the AY4 operational plan. Overall, action steps for 14 of the 17 secondary drivers were on track or proceeded as planned. Three of the progress markers assigned to Q1 (1.1a, 1.3a, 4.4a) were achieved.

Solid progress was made on each of the four target drivers for AY4. Nevertheless, some systemic issues surfaced during Q1. These appeared to stem from the shift in the approach being taken by HCC in AY4. That approach might be loosely described as directive, in contrast to collaborative. Although description is not judgmental, rather observational, such an approach had implications for stakeholder engagement, transparency, and the valuing of broad perspectives in decision making as DE SIM moves forward. These have implications for the sustainability of this work beyond this year, as well as for the credibility of decision making and the work being done.

3.2.2. Quarter 2 (05/01/18-07/31/18)

The Delaware SIM initiative made considerable progress in Q2 on all health care transformation drivers and was well-positioned to make progress on behavioral health and primary care integration. Overall, action steps for 13 of the 17 secondary drivers were on track or proceeded as planned. Nine of the progress markers assigned to Q2 (1.2a, 2.1a, 2.1b, 2.2a, 2.3b, 2.3c, 4.1a, 4.1b, and 4.3a) were achieved.

The work of DE SIM was effectively carried out this quarter with regards to the activities and drivers that are the focus of AY4. Both Mercer and HMA met their objectives for Q2. Nevertheless, we noted a philosophical difference around how to engage stakeholders in this work appeared to be driving much of the tension in the system. Key stakeholders reported that progress has been made on the part of the State in moving away from a “command and control approach” in directing DE SIM work prominent in Q1, towards a more collaborative approach that fosters authentic bi-directional engagement. How knowledge is acquired and used to inform decisions about what is working continued to be variable and inconsistent. Stakeholders emphasized the need for sustainability to be more widely considered across all aspects of the DE SIM work, to avoid the risk of losing commitment from key actors, particularly the private sector. Finally, stakeholders acknowledge that practice transformation, workforce development, and population health are all important interrelated components for moving towards payment reform as an overarching goal and coordination between public and private entities will be required for the future.

Table 1. Overall Summary of Progress Across Drivers

Primary Drivers	Secondary Drivers	Quarterly Progress and Process Markers			
		Q1	Q2	Q3	Q4
1 Payment Reform	1.1 Models developed and adopted by providers	1.1a Assessment of current value-based alternative payment model activity		1.1c Collaborate to align payment strategies*	1.1.d Stakeholder engagement
	1.2 Reliable data for Quality and Payment methods		1.2a Recommendations for Common Scorecard improvements*		1.2b Data strategy and deployment plan
	1.3 Regulatory and policy drivers	1.3a Review and recommend changes to statutes and regulations			
	1.4 Infrastructure for transparency, accountability, & continuous improvement				1.4a Cost and Quality benchmark
	1.5 Payment reform readiness investment fund				1.5a Minigrants distributed 1.5b Open Beds adopted 1.5c Telehealth technology webinars
2 Practice Transformation	2.1 Technical support and coaching for implementation of models		2.1a Practices recruited, engage with coaches 2.1b Site visits and readiness assessments		2.1c TA and practice coaching
	2.2 Forum for learning and exchange ideas and benchmarking		2.2a AY3 PT vendors provide additional TA; support integration, learning and sustainability		2.2b Learning collaboratives and regional forums 2.2c End of year learning congress 2.2d Virtual learning community
	2.3 Provider engagement in delivery system reform		2.3b Evaluate pilot implementation 2.3c PT vendors close out		2.3a Engage provider community on system reform
	2.4 Decision-making support through data sharing				2.4a BHI Scorecard and reports on progress for improvement
	2.5 Carryover activities-Practice Transformation Sustainability				2.5a Primary Care Workgroup 2.5b Pediatric behavioral health 2.5c Enhanced behavioral health integration
3 Improved Population Health	3.1 Community convening, goal-setting, and action planning				3.1a Infrastructure established to evaluate and fund initiatives 3.1b Mini-grants distributed
	3.2 Community-specific data sources to drive decision-making and planning			3.2a Population data collected and made available	3.2b TA provided to Local Councils on data use and prioritization
	3.3 Governance and consensus bodies to promote engagement, accountability, and sustainability				3.3a Model for post-grant sustainability 3.3b Transition plan 3.3.c Stakeholder inclusiveness and participation at the local council and task force level
	3.4 Consumer level engagement to support community-based health promotion activities				
4 Health Information Technology	4.1 Consistent and reliable data submission by payers and providers		4.1.a HCCD built; policies for data access and use 4.1b Incentives for ambulatory practices to submit clinical data		4.1c HCC and Mercer collaborate to recruit self-insured purchasers to submit claims
	4.2 Technology platform, analytic tools and reporting infrastructure to meet requirements			4.2a Population Health reporting tools developed 4.2b Cost, utilization, and quality analytics tools	
	4.3 Governance/data steward to ensure the integrity of the data structures, reporting methodologies and access to data and reports		4.3a Stakeholders engaged, and standardization achieved		4.3b Tools for practice transformation 4.3c Linkages between primary care and behavioral health organizations
	4.4 Sustainability plan for funding to maintain and continually improve system and processes	4.4a Collaborate with DHIN on sustainability plans			

Key: ■ On schedule/Adequate progress ■ Behind schedule/Limited progress ■ Behind schedule/No progress ■ Indefinitely postponed/Discontinued ■ No information

3.2.3. Quarter 3 (08/01/18-10/31/18)

The Delaware SIM initiative made moderate progress in Q3 on all health care transformation drivers. Overall, action steps for 13 of the 18 secondary drivers were on track or proceeded as planned. Three of the progress markers assigned to Q3 (3.2a, 4.2a, and 4.2b) were achieved. Two of the progress markers were not met (1.1c and 1.1b) and subsequently moved to the next quarter

The work of DE SIM is moving along well with regards to the activities and drivers that are the focus of AY4. There have been some barriers to progress with regards to payment reform that have pushed some of the work originally scheduled for Q3 and Q4 of AY4 beyond the grant period. Substantial progress around the development of the Healthy Communities Delaware model was made. It seems many more details around that model were worked out in Q3, and there is a fair amount of optimism about the structure and its potential for addressing health issues in communities across Delaware. Some key issues were yet to be clearly addressed including how to balance the voice of communities with the wants of investors, how this work will effectively be evaluated both at the local level and at the structural level, and how to ensure there is not a geographic bias in the investments. Several town halls were organized through a public-private collaboration with consumers involved, signaling interest in engaging consumers in learning about efforts to improve the healthcare system. Nevertheless, some consumers felt that information was not effectively being conveyed to the general public, and that their voices are crucial since this work ultimately effects people and their health. Formative discussions between public and private partners about strategies for meaningful engagement of consumer voice appeared to be needed, especially as other significant initiatives (payment reform, population health, etc.) advance. The slow progress of working to un-restrict and release funds through CMMI highlighted the importance of developing funding structures that can be responsive to local, regional, or statewide needs.

3.2.4. Quarter 4 (11/01/17-1/31/18)

The Delaware SIM initiative made significant progress in Q4 on all health care transformation drivers, as the grant period ended. Overall, action steps for 13 of the 16 secondary drivers were on track or proceeded as planned. Several of the progress and process markers identified for Q4 in the AY4 operational plan were not met, and have either been postponed, or in some cases put on hold indefinitely. Eighteen of the progress markers assigned to Q4 (1.2b, 1.4a, 1.5a, 1.5b, 1.5c, 2.1c, 2.2b, 2.2c, 2.2d, 3.1a, 3.1b, 3.2b, 3.3a, 3.3b, 3.3c, 4.1c, 4.3b, 4.3c) were achieved. Four of the progress markers were not met (1.1d, 2.5a, 2.5c, and 2.5c) and subsequently moved to the next quarter. One of the progress markers (2.4a) was not met and work on this action step discontinued indefinitely.

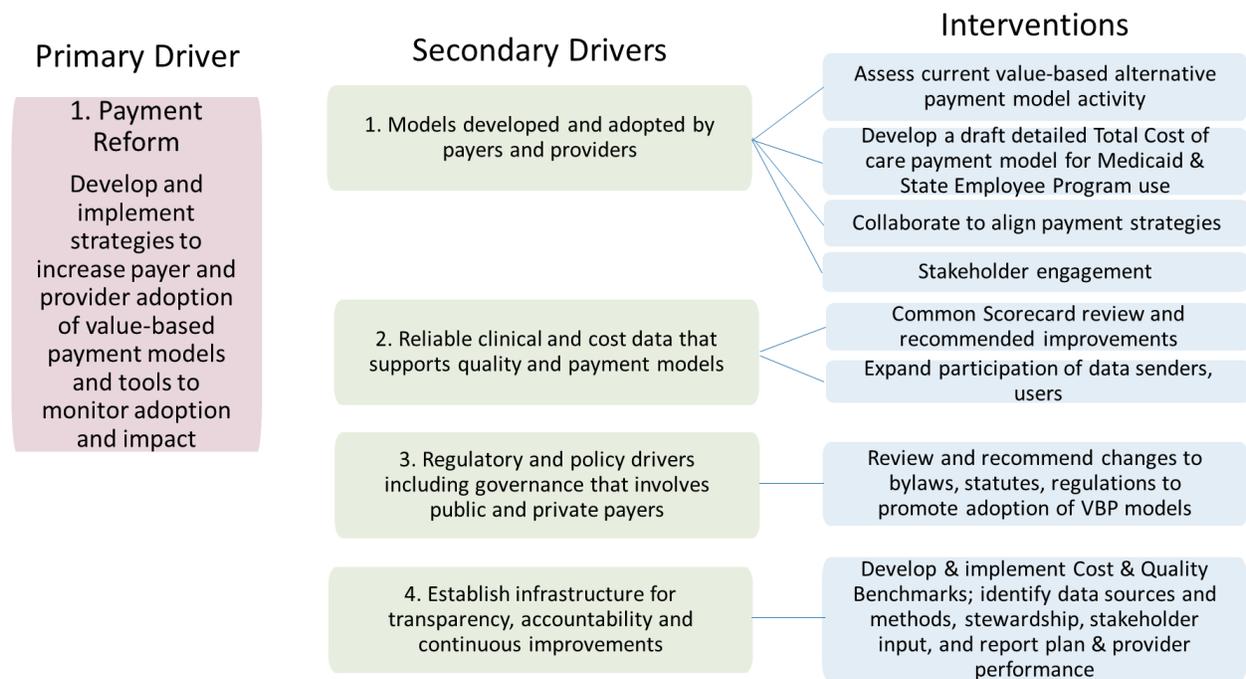
The work of DE SIM finished strong with regards to the activities and drivers that are the focus of AY4. Substantial progress around the development and launch of the Healthy Communities Delaware model has been made. As the official launch occurred in Q4, there appears to be a fair amount of energy

and optimism about the structure and its potential for addressing health issues in communities across Delaware. Perceptions of stakeholder engagement efforts seems to be mixed at the end of Q4. There are some respondents who suggest it has improved, but there are still voices that continue to speak about a lack of stakeholder engagement on the part of the state, and unwillingness on the part of payers to engage in authentic conversations about transformation.

3.3 Driver Specific Progress

3.3.1. Primary Driver 1: Payment Reform

Summary from Plan: Involvement of payers and adoption of new models of paying for care are pivotal to Delaware’s transformation strategy. Adoption was expected to come from stakeholders who believe that their voices have been heard and that the models are reflective of, and tailored to, local organizational structures and market dynamics. SIM work to develop models and assess the impact of these new models was to be conducted in a transparent fashion, with regular engagement with the HCC, state decision makers, and private sector leaders essential to the strategies. Payment reforms were expected to be integrated into other transformation efforts. As such, stakeholder dialogue around practice transformation, Healthy Neighborhoods and Health IT were to include and incorporate the payment reform connections as needed. The tandem development of payment models required close coordination and a clear communications pathway so that all stakeholders were kept informed and committed to this branch of the SIM work.



Progress for AY4 was steady and work related to this driver has resulted in completion of anticipated steps. A quarter by quarter summary of Key Accomplishments for the **Payment Reform** driver is listed below.

Primary Driver 1: Payment Reform	
	Key Accomplishments
Q1	<ul style="list-style-type: none"> • 14 Interviews with providers regarding adoption of value-based payment models and total cost of care models for Medicaid and state employee benefit recipients were completed. • Convened the Healthcare Spending Benchmark Advisory Group. The group has met two times and minutes as well as slides from those meetings have been posted to the DHCC website (http://dhss.delaware.gov/dhcc/global.html) • Two subcommittees of the Healthcare Spending Benchmark Advisory Group have been formed; the quality subcommittee, and the cost subcommittee.
Q2	<ul style="list-style-type: none"> • The Healthcare Spending Benchmark Cost and Quality Advisory Group have continued to meet with minutes as well as slides from those meetings available at the DHCC website (http://dhss.delaware.gov/dhcc/global.html) • Two subcommittees of the Healthcare Spending Benchmark Advisory Group have continued their meetings; the quality subcommittee, and the cost subcommittee. • Regular meetings between Medicaid, State Employee Benefits and HCC are taking place to formulate an ongoing strategy for sustainable and actionable Joint Purchasing and Primary Care improvements. • The Joint State Purchasing Strategy/Primary Care meeting took place. In this meeting Medicaid and HCC stakeholders identified state and/or federal barriers and strategies to invest in primary care, including support and a strategy for the Unrestriction of Funds Coordination and Work Plan. • A Data Needs Assessment has been ongoing throughout the quarter, including internal work and coordination with State to assess the availability of resources and system support to implement spending and quality measurement and reporting. • Collaboration with NCQA to discuss Common Scorecard, quality measurement and benchmarks in relation to transparency and public reporting. The release of the Common Scorecard is anticipated at a future Health Care Commission meeting.
Q3	<ul style="list-style-type: none"> • The minigrant process is moving along with award announcements expected soon after this report is completed. • Additional work to develop an Open Beds platform and Telehealth options is being done. • Benchmarks have been completed and recommendations have been made, except for one related to opioids/benzodiazepine. A meeting outlining these for major payers occurred. An implementation manual is being developed.
Q4	<ul style="list-style-type: none"> • Work on establishing 2019 benchmarks continues to progress and is on track. Feedback from the Governor was incorporated, and meetings with payers was held. • Common scorecard for Medicaid was prepared, refined, and will be released with the support of Mercer. • Rollout of the implementation manual for quality benchmarks began, and Mercer hosted a webinar with the State for commercial payers and Medicaid MCOs. The final version is expected to be delivered at the end of Q4. • The minigrant funds were deployed, and technical assistance was provided to grantees. • Work related to data deployment has been moved to the benchmark process.

Several challenges to the progress on the **Payment Reform** driver over the course of AY4 were noted. First, opposition to the benchmarking work was expressed in both written comments to the DHCC and in person at the Spending and Quality subcommittee meetings by members of those committees. In addition, stakeholders continued to voice concerns about the Common Scorecard. Concerns raised in discussion and public meetings included making the data useful to various audiences, the utility of some of the proposed measures, and ensuring clarity when the Common Scorecard is released about what the exact parameters the scorecard represents. Second, given the political nature of this work and the systems it includes decision making can sometimes take an extended period of time. The proposal review for mini-grants, unrestricting of funds, and contracting process took several months. As a result, the timeline for awardees to start their work plan was shortened. Finally, the discussions surrounding the identification of potential implementation barriers and mitigation strategies of value-based payment models was dependent on the development of TCOC model. The development of recommendations concerning a total cost of care (TCOC) risk-based model for implementation took longer than anticipated. There were challenges in obtaining data from ACOs for use in model impact analysis which delayed the work until after grant period ends. This also meant that stakeholder engagement on the topic would not happen in AY4.

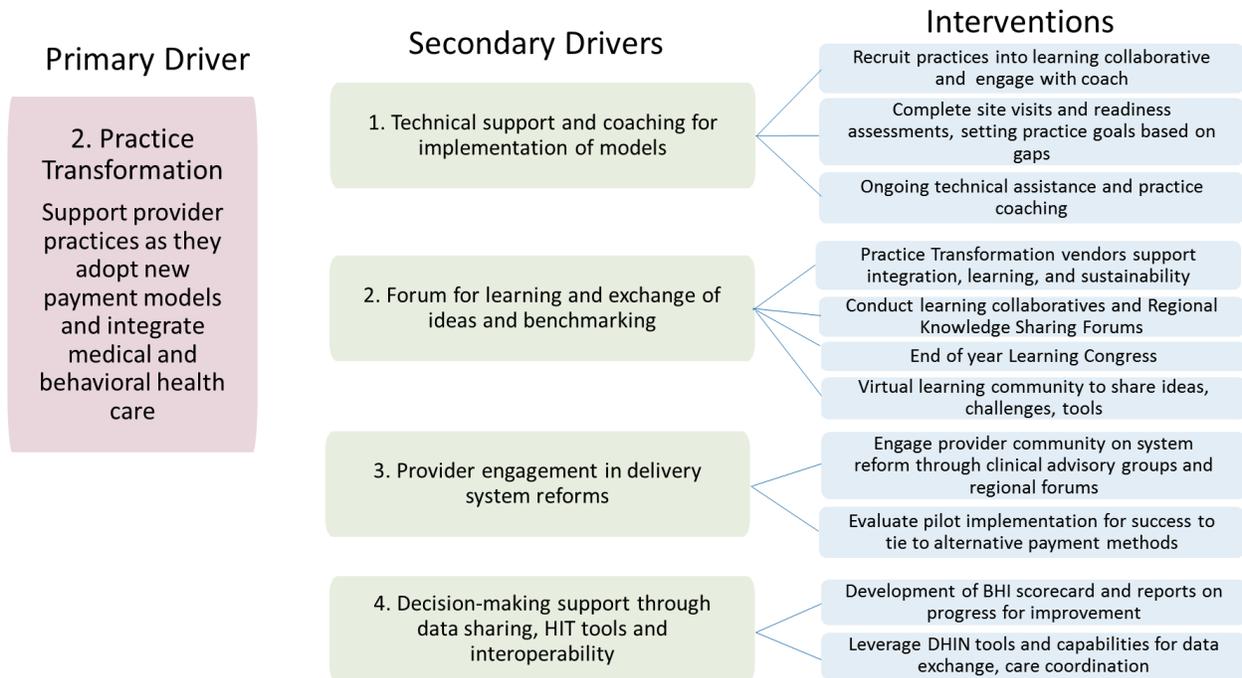
3.3.2. Primary Driver 2: Practice Transformation

Summary from Plan: There were many initiatives and much focus on practice transformation across the state of Delaware, and even more specifically within behavioral health integration and practice transformation in AY4. Delaware planned for a multi-faceted engagement approach expected to play an important role in aligning the initiatives in order to make significant progress in better health care quality and experience while being good stewards of resources and efforts across the provider practices and across the state.

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

In addition, the BHI team was to continue to meet with the existing DCHI clinical committee, re-establishing it as a BHI clinical advisory group. All practice transformation vendors were to work closely

with DHIN to develop standardized metrics and tools to help sustain these models long-term, and conduct other efforts to drive practice recruitment, including attending and updating state and local meetings that are connected to the practice transformation and BH integration work. This work was also expected to be closely aligned with the value-based payment approach/model in order to truly sustain an evidence-based standard model of care and gains made through the pilot phase. Finally, a patient council was to be developed to support the BHI efforts.



Progress for AY4 was steady and work related to this driver has resulted in completion of anticipated steps. Strong gains were observed in the uptake of behavioral health integration practices in Q3, although challenges were experienced with regards to the integration of technology into efforts for behavioral health integration. A quarter by quarter summary of Key Accomplishments for the **Practice Transformation** driver is listed below.

Primary Driver 2: Practice Transformation	
	Key Accomplishments
Q1	<ul style="list-style-type: none"> Baseline Practice Readiness Assessments for all 14 Cohort 1 participants have been completed. Work with Cohort 1 continues with practices participating in a virtual learning program, webinars and coaches assigned to practices. Work has begun on the development of the behavioral health registry, scorecard metrics and supporting tools. Recruitment of Cohort 2 is underway.
Q2	<ul style="list-style-type: none"> Recruitment of Cohort 2 was completed with 28 practices enrolled in Cohort 2 (including 14 new practices not currently enrolled in Cohort 1).

	<ul style="list-style-type: none"> Practice coaches are completing the Cohort 1 Post Assessments and coaching goals progress summary. These will serve in lieu of the Pre-Assessment for those practices continuing on from Cohort 1. Practice coaches have been scheduling and attending their Pre-Assessment appointments with the 14 new practices. building working relationships, and establishing the level of integration Step by step manual and tool kits for Collaborative Care Model and for Enhanced Referral Relationships have been added to the Virtual Learning Community and practices have been sent a reminder for how to access the tool kits.
Q3	<ul style="list-style-type: none"> Ongoing technical assistance and coaching is being provided to practices from cohort 2 with approximately 22 practices attending the last session. There has been steady progress around behavioral health integration with more primary care providers and behavioral health practitioners using measurement-based care. The Primary Care Collaborative continues to meet and is viewed as an effective place for providers to discuss practice models and future options in the state. It has also proved a high-quality stakeholder engagement exercise.
Q4	<ul style="list-style-type: none"> A DE BHI Learning Network meeting was held on 1/30/2019 bringing providers together to discuss PT. Webinars were held on 11/14/18, 12/12/18 and 1/9/19. Coaching calls with providers continued. A virtual learning community was established for both PT cohorts. The Primary Care Collaborative continues to meet and seen as an effective place for providers to discuss practice models and future options in the state. It released a report on 1/10/19 with recommendations and receiving public comment.

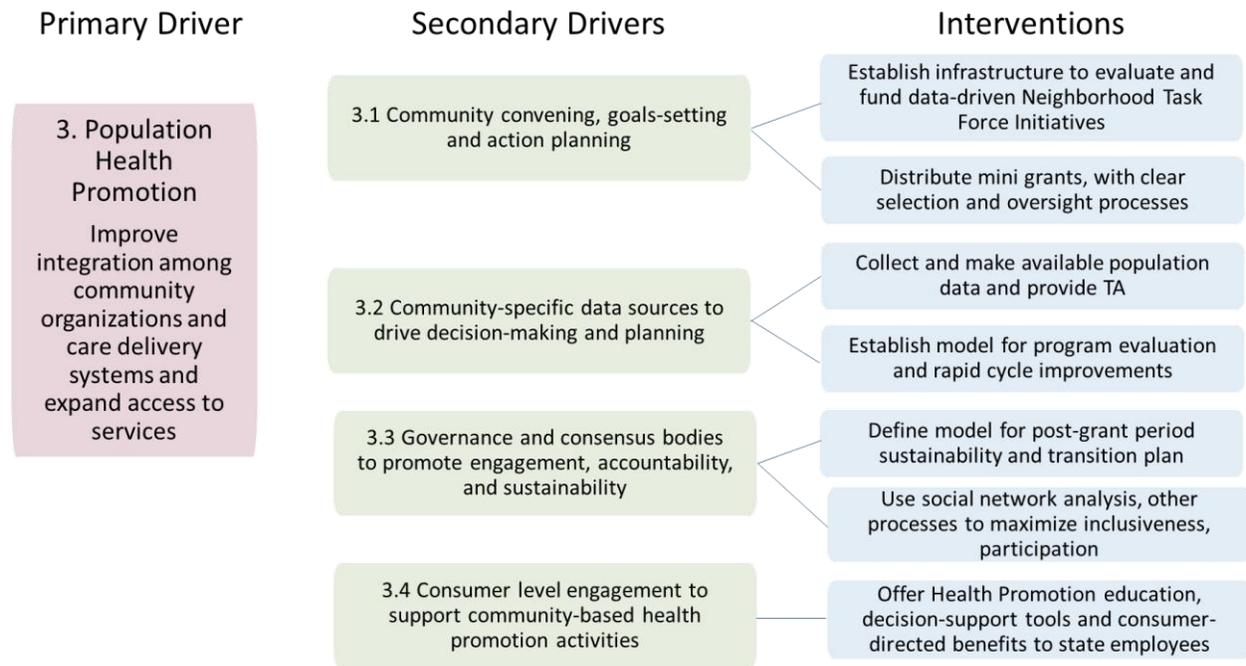
Two major challenges to the progress on the **Practice Transformation** driver over the course of AY4 were noted. First, practices expressed concern about the sustainability of practice transformation gains achieved through work with practice transformation coaches in AY3. Further, practices wondered how to support the BHI work going forward without some new payment mechanism during the time of implementation. In response, HMA and Mercer worked with HCC to create a summary of payment options to support this work. Further discussion around the State mini-grants and how that would help to build and sustain the BHI models were undertaken. Second, stakeholders reported a need for greater clarity around the requirements and expected outcomes of the HIT supported tools so that development may continue as it relates to practice transformation and behavioral health integration.

3.3.3. Primary Driver 3: Healthy Neighborhoods

Summary from Plan: Stakeholder engagement is critical in the Healthy Neighborhoods initiative. Through active recruitment in year four, neighborhood task forces, local councils and the statewide Healthy Neighborhoods Consortium are expected to have representation of cross-sector organizations, including community-based organizations, community health centers, hospital/health systems, payers, and consumers. As a bottoms-up approach, the plan anticipated ensuring community entities would work

to address the social determinants of health have a voice and become valued members of the delivery system.

Over the course of AY4, the Healthy Neighborhoods team planned to be in regular contact with all relevant stakeholder groups—sharing information and data, eliciting feedback and supporting cross-driver coordination and transparency.



Progress for AY4 was steady and work related to this driver has resulted in completion of anticipated steps. The Healthy Communities Delaware (HCD) model was developed and adopted and sustainability planning moved steadily forward. Some of the local projects were funded following an extended review by CMMI. A quarter by quarter summary of Key Accomplishments for the **Healthy Neighborhoods** driver is listed below.

Primary Driver 3: Healthy Neighborhoods	
	Key Accomplishments
Q1	<ul style="list-style-type: none"> • HN Model was created and promulgated to the 3 Local Councils. • The HN Consortium has met twice with local councils presenting their ideas for potential initiatives to be funded. Disbursement of funds request for 1 initiative has been submitted and approved by CMMI and the process for a second initiative is underway. • Work on sustainability planning has been progressing in collaboration with multiple partners. A sustainability workshop is scheduled for June 12, 2018 to discuss this work and receive feedback from stakeholders. • Vendors have been working with various partners including DPH to identify sources of data for use by Local Councils. A webinar was held to discuss data sources and how to use them. Due to the popularity of the webinar and positive feedback received by stakeholders another is being planned to share additional data sources and how to access them.

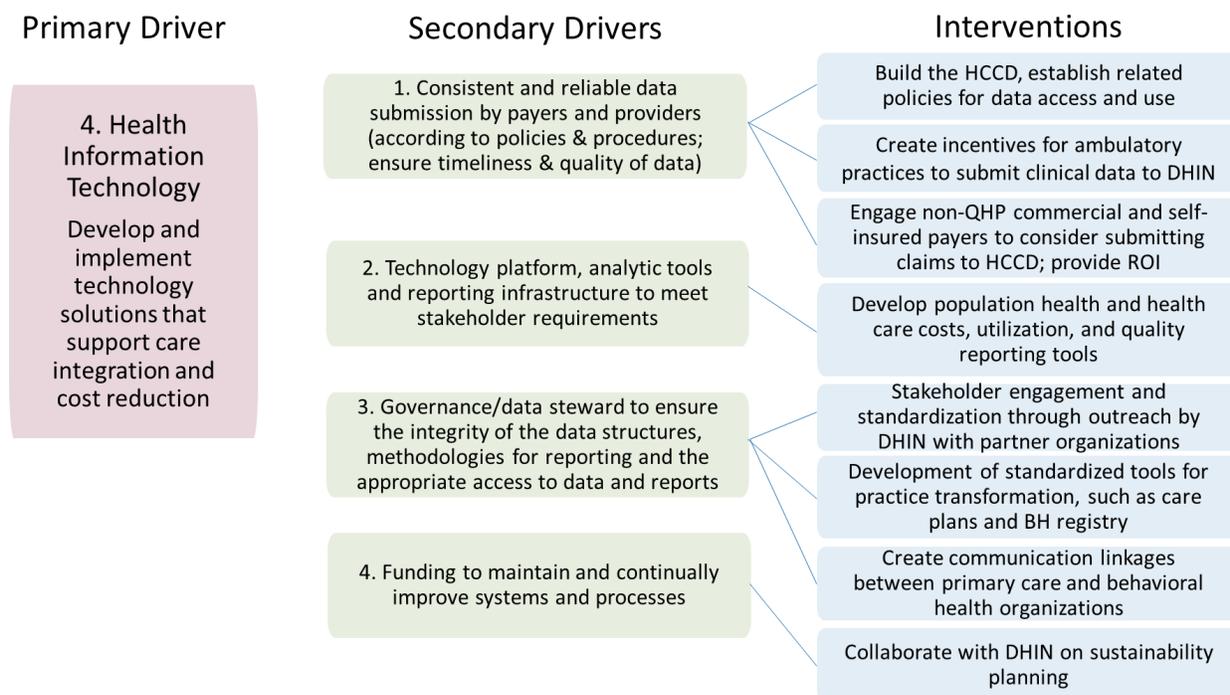
<p>Q2</p>	<ul style="list-style-type: none"> • Two initiatives from Dover Smyrna Local Council have received funding for the full requested amount (From Healthy Lifestyles and Chronic Diseases Task Force - Open Streets Dover with NCALL Research, Inc. as implementation partner and from Behavioral Health Task Force - Homeless Engagement with Dover Interfaith Mission for Housing, Inc. (DIMH) men’s shelter). In July 2018, three more initiatives were unrestricted by CMMI pertaining to Domestic Violence Community Health Workers (CHW) – two more from Dover Smyrna Local Council’s Behavioral Health Task force with Connections CSP, Inc. in conjunction with Kent Police Connections Association to serve as partnering implementation partners and DE Consortium Against Domestic Violence (DCADV). The final initiative approved was from Wilmington Claymont Local Council’s Behavioral Health Task Force also with DCADV. An MOU has been executed for the Kent County Police Connections Alliance and the Community Health Worker for Domestic Violence. • The sustainability model being developed by the Delaware Health Care Commission was presented to stakeholders at a sustainability conference on June 12th with State of Delaware’s Division of Public Health Director Dr. Rattay and former Executive Director Steve Peuquet of University of Delaware’s Center for Community Research & Service at the University of Delaware serving as official ambassadors. At this conference stakeholders were given the opportunity to ask questions and provide input on the sustainability model. There is ongoing work to identify the components and/or matrix of entities that are necessary to permanently sustain this work across the state.
<p>Q3</p>	<ul style="list-style-type: none"> • Progress continues on the development and implementation of the Healthy Communities Delaware model and filling out the proposed model with a leadership council, investment council, backbone team, and executive team. • Optimism and enthusiasm exist among many key stakeholders regarding the potential of this model to meaningfully support DE communities. • Those involved with the development of Healthy Communities Delaware are bought into the collective impact model and view this as a strong infrastructure for continuing the work on the ground level. • A townhall was held in October to again present the model and engage in public discussion.
<p>Q4</p>	<ul style="list-style-type: none"> • Eight Healthy Neighborhoods (HN) initiatives have been approved by CMMI and funding has been released. • The backbone organization entities have been selected and are beginning to meet. • Healthy Communities Delaware (HCD) entities are meeting. • The HCD kickoff was held on 1/14/19. • Efforts to identify funding mechanisms for the backbone organization are ongoing. • The HCD initiative continues to be integrated as a sustainability mechanism for the HN initiatives.

Several challenges to the progress on the **Healthy Neighborhood** driver over the course of AY4 were noted. First, the final decision to release funding came from CMMI. This meant a long delay between a local council submitting its proposal, HCC approving that proposal, and funds being released. Thus, some of the local projects were limited in their implementation. Second, stakeholders expressed concern about the transparency of sustainability planning and uncertainty among stakeholders about how the sustainability model will be operationalized. In particular, the absence of a formal decision about the structure and management of the backbone organization inhibited universal buy-in. Multiple stakeholders expressed the need for the backbone organization to be an independent neutral party who can facilitate broad stakeholder buy-in and support to ensure long term sustainability efforts. Substantial attention to

resolving these issues occurred over the course of AY4, including how those who were heavily engaged with the original healthy neighborhoods work of DE SIM fit in the new model. Third, it was unclear whether knowledge and learning from community projects was being captured effectively. Although evaluation of the initiative will occur as expected by the backbone organization, it has yet to be determined specifically how Healthy Communities Delaware will evaluate its own work, or how it will facilitate effective evaluation of funded initiatives. Compounding this issue was the suspension of technical assistance due to budget restraints for local councils in using data to identify local needs, monitor progress, and evaluate responses.

3.3.4. Primary Driver 4: Health Information Technology

Summary from Plan: To better integrate SIM interventions and activities, Delaware’s Year 4 plan placed new emphasis on building engagement of practices and other data users in the HIT work plan. Specifically, the Practice Transformation partners were asked to help convene practices to learn about the benefits of becoming DHIN data senders, to help inform the next phase of quality metrics activities, and to provide feedback on other current DHIN supported tools. The plan called for exploration of partnerships with provider organizations to co-sponsor CME sessions on HIT tools. Working with the Greater Philadelphia Business Coalition on Health, Delaware expected to engage with self-insured payers on becoming claims senders to the HCCD, as well as with the DHIN Board of Directors on longer term sustainability challenges.



Progress for AY4 was steady and work related to develop a health information technology solution that provides value to Delaware stakeholders has resulted in completion of anticipated steps. A quarter by quarter summary of Key Accomplishments for the **Health Information Technology** driver is listed below.

Primary Driver 4: Health Information Technology	
	Key Accomplishments
Q1	<ul style="list-style-type: none"> • Discussions on a new contract between DHIN and administration that includes the Health Care Claims Database implementation have taken place. • DHIN held a webinar on the common scorecard on April 12, 2018. • Guidance and technical assistance was received from ONC/CMMI conference. • Alternative fee structures to support and improve ongoing HIT initiatives have been identified and are being discussed.
Q2	<ul style="list-style-type: none"> • The Delaware State Legislature appropriated funds for development of the Health Care Claims Database (HCCD). • There has been ongoing training for behavioral health providers with regards to the behavioral health registry including what data drives that system. • Conducted 6th (and final) behavioral health data taskforce meeting. • Contracts have been put in place with MedicaSoft for services related to the HCCD.
Q3	<ul style="list-style-type: none"> • The process of loading and enhancing the claims data into the data system has commenced, including historical and Medicare claims. • Work continues regarding the standardization of data structures through stakeholder outreach and engagement by DHIN. • Work on the development of linkages between primary care and behavioral health organizations continues as planned
Q4	<ul style="list-style-type: none"> • Legislation was passed to require self-insured payers to participate in the HCCD. • Medicare claim loads are ongoing. • Decision to not use electronic consent solutions for sharing behavioral health data was made.

Several challenges to the progress on the **Health Information Technology** driver over the course of AY4 were noted. First, stakeholders reported a lack of direction as to how leadership in DE SIM envisions the use of health information technology to support the work in the final year of the grant. Further, concerns about the source of continued funding for HIT related projects were expressed. The lack of certainty was cited as a potential barrier in moving forward with projects. In the DE SIM plan, technology seemed to be viewed as a solution in and of itself. However, stakeholders maintained that technology might be better seen as a tool to support other activities and thus carefully linked with how it will support the work of DE SIM. Finally, electronic consent solutions for sharing behavioral health data with the community health record were determined to not be a focus of SIM funding and explored once it has been addressed more globally through FHIR protocols.

3.4. Systems Analysis

3.4.1. Attention to Knowledge Management

Knowledge management is focused on the systematic process of producing, using, and refining explicit and tacit knowledge in and across organizations. Within the ecosystem of healthcare, three main components interact to translate knowledge into relevant actions: audience (who), motivations (what), and mechanisms (how). Information and feedback are central to maintaining effectiveness, transparency, and accountability during implementation. It is also vital to any system processes that involves many different types of stakeholders. An optimal knowledge management framework should facilitate a movement from an information-sharing approach to engaging stakeholders to an approach that their collective knowledge to support health care transformation now and in the future.

Throughout DE SIM implementation most of the information flow emanated from initiative leadership to the broader stakeholder community. Knowledge management was identified in AY3 as a key consideration for AY4, critical to ensuring that the learning that has taken place among stakeholders is not lost when the funded phase of this work comes to an end. As recommended in AY3 evaluation process, a knowledge management strategy should include elements that facilitate the maintenance of this learning across the system. We found there to be a connection between how knowledge is managed and how stakeholders feel engaged the DE SIM work. Indeed, among some stakeholders who were interviewed over the course of AY4 there was a perceived lack of transparency as to how HCC moved forward. Stakeholders reported appreciating the opportunities to provide feedback on plans set forth from HCC but, some also felt that the feedback was not always valued. Overtime this led to some fatigue on the part of some stakeholders to continue to engage, given they felt their engagement was not always authentically valued. Subsequently, there was a lack of understanding about how activities were planned, what strategies were taken, and how sustainability was considered.

Key stakeholders reflected on their experiences around DE SIM, the lessons learned, and adjustments made. As reported by stakeholders, much was learned since the initial implementation of SIM about the healthcare landscape, about how to interact and engage in collaborative relationships to drive change, and about the challenges this approach brings. They expressed a disconnect between the work of DE SIM in AY4 and the progress and learning made in the first two years. Stakeholders reported that it was not readily known among key system actors how much of what was learned and/or developed over the course of the first 3 years of DE SIM was incorporated or built upon in AY4. This emerged in interviews in a couple of ways. First, stakeholders felt that some key activities such as workforce development ended with little explanation, and little attempt to apply knowledge that had been generated and build upon it. Before more details emerged around Healthy Communities Delaware there was some frustration with the model. These frustrations stemmed from the belief that stakeholders viewed the new model as very similar to the structure that had been in place prior. Some accepted this

and felt it is most important to continue moving forward to get the funds deployed on the ground. Others lacked faith that contributing to such an effort will lead to effective execution of projects and programs.

Over the course of AY4, key stakeholders emphasized the important relationship between knowledge management and the engagement of consumers and stakeholders. The relationship between the two revolves around how information about SIM is captured and disseminated with the purpose of keeping these groups informed. Stakeholders also clarified that the types of information and knowledge consumers need to understand the issues being addressed by SIM and other healthcare transformation efforts differ from that of professionals engaged in this work every day. Key stakeholders emphasized that supporting the information and knowledge needs of consumers in meaningful ways will affect their interest and voice in transformation efforts.

Knowledge management and dissemination also requires a clear authority or entity that consumers and other stakeholders know to look to for important information. According to interviews conducted over the course of the year that was lacking. Stakeholder perceptions were that the communication around DE SIM was sometimes disjointed and fragmented. Multiple websites contained information about various aspects of DE SIM work, and information outlets sometimes put out competing information (i.e. reporting different times and locations for the same event or the dissemination of inaccurate information). Nevertheless, according to some stakeholders, messaging regarding progress on DE SIM did improve over the course of AY 4.

Early in the planning for HCD some stakeholders expressed concerns that there was insufficient knowledge management planning being done with regards to the pilot projects. While it was clear that evaluation was an expectation, there was not always confidence that proper investments were being made to ensure that the capacity existed within the HCD projects to effectively capture the lessons learned generated by the pilot projects. In the absence of evaluation and learning processes incorporated into this work to ensure lessons are learned, and progress can be built upon in the post-DE SIM environment.

As the end of the DE SIM project formally comes to an end it is crucial to reflect on the progress made over the course of the 4 years and reflect on lessons learned, mistakes made, and use those to help improve future health care transformation efforts. Some of that is captured in this report, but this report is limited in what it can capture.

3.4.2. Opportunities to Strengthen Stakeholder Network

The overarching theme that frames the story of stakeholder engagement over the course of AY4 involves a tension between two philosophies. The first few years of DE SIM took a what could be described as a consensus-driven approach. This approach made space for many voices and allowed for plenty of debate before action. That said, this approach also demanded time. With the major shift in leadership in

the DE SIM infrastructure the approach shifted to a more top-down structure. The scope of DE SIM was narrowed, and the decision-making structure was consolidated. This led to less opportunity for stakeholder input but allowed for quicker decision making and action.

Through the first two quarters of this year, based on our interviews with stakeholders, the shift was towards a top down approach went too far. There were efforts to inform stakeholders about ongoing efforts and decisions through town hall type events, Facebook Live events, webinars, and the posting of meeting minutes. Those were not viewed as authentic efforts to hear from stakeholders, or take their opinions into account, and constituted a one-way flow of information. This was reported in the Q1 and Q2 reports, but over the course of Q3 there seemed to be some return towards a more stakeholder driven approach to executing on DE SIM work. That was apparent in Q3 interviews when stakeholders indicated new actions taken by state leadership to engage in dialogue. For example, the release of the Q1 evaluation report was cited by one stakeholder as a commitment to renewed stakeholder engagement, as well as participation in the payment committee by state leadership.

What remained clear throughout AY4 is that there is appetite and commitment among stakeholders to engage in health care transformation work. There is a willingness to collaborate, to give time, and to do the work that is needed to help move these efforts forward in Delaware. Questions continued to arise about whether the right stakeholders were always at the table, and groups that perhaps required more targeted engagement included smaller, more rural providers, as well as consumers. The reconstitution of the patient-consumer committee was one step towards facilitating consumer voice. But, issues of how to engage and support smaller PCPs in health care transformation are ongoing.

The fundamental issue relates to how stakeholder engagement should be defined. Should the work be done through broad engagement across sectors and actors to foster collaboration or consensus or is it more legislative and regulatory dictated from the top down, but still communicated about regularly and with clarity to key actors across the state? While the former approach can foster deeper buy-in, and stronger commitment to the work, it takes more time. The latter can quicken the pace of the process but risks losing broad based buy-in from key system actors.

The AY 4 stakeholder survey provides some insight into stakeholder engagement from a broader group of individuals. When asked to describe either their optimism or pessimism about future transformation efforts in Delaware respondents often cited issues of stakeholder engagement as explanations for their response. As we reported in the AY3 evaluation report there is certainly a recognition that the path forward involves collaboration, alignment, and communication

“I believe that now more than ever all parties involve want to do something different. We just need to agree on what that will be.”

across sectors. There still seems to be some who believe that commitment to this way of work is not widespread.

Related to the point above, absent effective information and knowledge exchange, social networks do not function effectively, and as a result of inadequate or dysfunctional knowledge flow, systems that could be effective are compromised and even prevented from achieving their potential positive impact.⁹ Continued attention to the recruitment of key groups within Delaware, such as payers and consumers, will remain of significant importance moving forward, as their lack of inclusion may inhibit the progress of DE SIM.

3.4.3. DE SIM as a “Loosely Coupled System”

In a loosely coupled system, effective planning and execution requires multiple groups or organizations coming together and self-organizing to achieve their shared goals. Balancing the complexity of an intervention with the necessary capacity to implement that intervention has been recognized as a general constraint to successfully accomplishing implementation goals and needs to be managed.¹⁰ As a way to implement the DE SIM strategy, a loosely coupled system has many benefits including stability and persistence, adaptability, satisfaction, and efficacy.

Over the course of AY 4 as work on the four drivers progressed there came a time where funding had to be disbursed to partners to undertake driver related work. For example, the Healthy Neighborhoods initiative ultimately resulted in eight projects receiving approval for funding from CMMI. That approval process sometimes took time, and this impacted the system. It became clear that there was an outside force (i.e., CMMI) that had major power over aspects of the DE SIM system. How quickly or slowly they approved funding to be unrestricted for investment in these initiatives affected actor engagement and satisfaction. This serves as a reminder that while systems principles demand that boundaries be drawn, there is still porous borders that allow for the entry or exit of certain actors.

One other way these porous boundaries manifested in the DE SIM system was with payers. There are few major payers in Delaware, and locally they exist within the system. That being said, as part of national companies those localized actors sometimes hold little control over their ability to affect change. They are bound to some extent to the policy of their national parent company. This can make it difficult to determine how to move forward with initiatives like payment reform when payers have little control over their own ability to collaborate effectively.

⁹ Leischow, S. J., Best, A., Trochim, W. M., Clark, P. I., Gallagher, R. S., Marcus, S. E., & Matthews, E. (2008). Systems thinking to improve the public's health. *American Journal of Preventive Medicine*, 35(2), S196-S203.

¹⁰ Gericke, C. A., Kurowski, C., Ranson, M. K., & Mills, A. (2005). Intervention complexity: A conceptual framework to inform priority-setting in health. *Bulletin of the World Health Organization*, 83(4), 285-293.

That being said, it was still apparent that stakeholders in the state believed that the relationships between the state, payers, and providers was critical to moving health care transformation forward. This will likely continue to be the case after DE SIM ends, and attention should be paid to developing those relationships over time.

Under the framework of a loosely coupled system, and absent a centralized source that offers directives and instructions for each entity within the system boundaries, it is important to understand what motivates actors to act. In AY 4 as progress was made on the four primary drivers there began to be recognition that a principal motivator was a desire to improve efficiency, while improving care. For example, providers within the system still might resist significant transformation efforts even if payments increase. The financial motive was found to be not as motivating as may have been assumed. But, finding ways to improve their efficiency in treating and serving patients, and demonstrating that efficiency was motivational for providers in considering practice transformation efforts. This highlights the importance of recognizing the root motives of key actors and identifying how to speak to those to move the system forward.

A recurring theme related to the organization of the system was the interaction between the four main drivers work was done to fulfill the implementation plan for the year. Implementation of the drivers was perceived by stakeholders to be somewhat independent, and that the interactions between drivers was limited. From their vantage point, there may have been missed opportunities for synergies to advancing the work. Beyond that though there were questions about whether comprehensive practice transformation was feasible without payment reform, and the ways that practices and providers were reimbursed.

One area where there was clear overlap was in the work of the State on benchmarking and the DE SIM payment reform driver. This appeared to be purposeful, but it was not always clear to stakeholders that the decision had been made, or it had not been made transparently. While the synergy between those two initiatives is clear, it could also be perceived as a co-opting of the payment reform driver by the state, and by an actor in the system with power. How that ripples across the system, and what it does to relationships between actors is unclear, but when a major actor like the state makes decisions like this the ripple cannot be underestimated.

As alluded to in the previous section the approach to DE SIM work shifted early in AY 4 coinciding with the changes in administration. Stakeholders reported the approach to be more directive, and less collaborative than what they had experienced previously. Such a shift created turbulence in the system, and initially resulted in tensions among key stakeholder groups, although some of the tension ultimately was resolved. Resolution of these tensions depended on actors recognizing the new dynamic that had emerged between actors and taking action to shift that dynamic. Increased engagement with a broad

range of stakeholders, two-way conversations about driver related issues, and authentic response to stakeholder feedback was one of the ways that this dynamic. This was a meaningful course correction, because if allowed to linger and key stakeholders had not been not re-engaged, resistance to future efforts may have increased, with implications for sustainability and credibility. That demonstrates the importance of cultivating system-based relationships, to ensure willingness of key actors to take action for the benefit of the broader system.

In AY 4 Health Management Associates (HMA) was engaged to drive manage the implementation of the work plan. HMA held a place in the system that served a linking purpose and seemed to do so effectively. A linking organization is one that connects parts of the system that hold separate, but equally important capacities. For example, the state (e.g., DHSS, HCC) have important technical knowledge and skills. However, community-based organizations and even DCHI have credibility that can bring actors together. HMA was able to act as a link between these types of systems actors and played a role of holding both technical skills and developing credibility with other actors in the system. They seemed to do this effectively based on the data collected and reviewed for this evaluation. They made steady progress on their AY 4 work plan, and also seemed to establish trust with other system actors. These relationships took time and work, but ultimately it seems the initial discomfort with HMA's presence subsided.

3.4.4. Stakeholders “See the Big Picture”

At the start of AY4, messages about how the re-prioritized DE SIM components fit together to drive and support healthcare transformation was critical to the development of a collective vision among stakeholders. A collective vision is one that is shared throughout the organization. It is not the exclusive purview of the “leaders” or hierarchy in an organization; it is “held” in common by each of the agents in the network. The more agents in a network that share the same vision—that “see” the same possibilities—the more a system can be said to have a collective vision.

We found that there appears to be agreement across the system about what should be achieved, reflecting consistency among stakeholders about the ends. Nevertheless, it became increasingly clear there is a philosophical divide regarding the means that drives much of the conflict in the system. That divide pertained not to the ultimate outcomes of healthcare transformation, but rather what methods are best for achieving those goals. One perspective of stakeholders is that this work needs to be done using a more top-down and directive approach to facilitate movement and action. On the other side, is a belief of a more horizontal, multi-actor approach. The perception of these stakeholders' is that work could be moved forward successfully only when actors across sectors are brought to the table so that there is broad representation and buy-in. Those who adhere to this point of view believe it fosters collaboration, and trust, but is only successful if self-interest is set aside.

On the AY 4 stakeholder survey respondents were asked to pick from a list the most effective strategy for pushing health care transformation forward in Delaware. The two most common themes that emerged from these responses related to issues of access, and payment reform. Stakeholders seem to understand the big picture, that more people need access to affordable, high quality care, and that providers need to be properly reimbursed and incentivized to provide that care.

3.4.5. Focus on Sustainability

The final year of the grant brought with it a renewed focus on the sustainability of the effort. We found there to be agreement on the idea that not all elements of the initiative were sustainable or even should be sustained. During AY4, DE SIM leadership worked to distinguish what parts of the SIM model should be prioritized and concentrated on the development of a sustainability strategy.

Healthy Communities Delaware (HCD) certainly offered the most prominent example of sustainable activity and much progress was made on this front. Key stakeholders reported excitement and energy around this work, and while some have raised critical concerns, there is a general sense that the model seems like a good one for supporting local population health initiatives. Key stakeholders suggested that an important component of sustainability is figuring out how to integrate ongoing work into the missions of existing organizations and entities.

There were some suggestions from stakeholders that arose over the course of the year and as data was gathered for quarterly reports related directly to HCD. While there was appreciation for the ambassador structure, there were suggestions that an ambassador from the private sector be added. Stakeholders believed that without this there would ultimately be insufficient buy-in from the private sector actors that are so important to the model.

Going forward, key stakeholders emphasized the importance of how the organizational structure of HCD can effectively balance and manage the wants of investors with the needs of communities and the voices of the people who live there. Despite this recognition, concerns on the part of key stakeholders persisted about how non-HCD components of this work will be sustained post-SIM. For example, as momentum increased around behavioral health integration efforts, providers remained concerned about if or how this important work will be sustained once SIM resources are gone.

“This is a tedious process that should not be abandoned with the closing of the SIM grant. Our state should pick up some of the burden of investing the resources necessary to do so and make it a priority on behalf of all Delawareans.”

During AY4 it appeared that sustainability across the other major drivers was less of a focus as compared to the focus placed on Healthy Neighborhoods through the development of HCD. There is commitment to the work started under DE SIM among key stakeholder groups in the state, and there is a

recognition that the way forward involves people, organizations, and sectors coming together as opposed to working isolation. This should be built upon, and the energy should be supported to continue efforts forwards as future support is sought out.

DE SIM stakeholders had much to offer in terms of how they system leadership might think about sustainability. According to stakeholders, sustainability can be conceptualized by thinking about three issues:

- **Political will:** change is difficult particularly when it involves complex systems like healthcare. But it is important for political leaders to maintain their commitment once a decision to change has been made because there will be resistance to that change.
- **Human capital:** related to stakeholder engagement, it is important to recognize that after this fiscal year the current consultants will no longer be in place. It is important that there be stakeholders who are informed, willing, and able to take up the work once those consultants are gone.
- **Financial capital:** there needs to be a way to pay for the work, and for the initiatives being proposed to change the system. This highlights the importance of payment reform as a link to much of the other work that DE SIM is trying to accomplish (e.g., behavioral health integration). Without developing systems that can support the work financially it will be difficult for it to continue.

What emerges at the end of AY 4 is that there is commitment to ongoing transformation efforts, but sustainability planning has not been particularly robust for initiatives beyond the HCD initiative. Ongoing efforts to identify resources to support transformation work are important. But, the foundational principle of collaboration and shared understanding of the end goal exists which is perhaps more important.

3.5. Stakeholders and Their Perceptions

In Delaware, efforts have been taken to accelerate the transformation of Delaware's healthcare system to one that delivers high-quality care at lower costs, improves provider experience, and leads to healthier citizens. The engagement of stakeholders in Delaware's healthcare transformation efforts is critical to its success and sustainability. To that end, understanding how stakeholder knowledge, experience, and perspective facilitates engagement efforts is a contributing success factor. The stakeholder survey was an effort on the part of the state-led evaluation team to ascertain stakeholder perceptions related to their role, success of the initiative, their engagement, and general assumptions about healthcare transformation.

3.5.1. Roles of DE Health Care Transformation Stakeholders

Transforming healthcare involves many different individuals from a variety of sectors working together. We asked stakeholder to select a response that **best described their primary role** related to healthcare transformation. Sometimes those working on health care transformation issues wear multiple hats. Thus, we further asked stakeholders to a response that **best described their secondary role** related to healthcare transformation. Figure 2 below displays the stakeholder responses for both primary and secondary roles, describing the role diversity across the healthcare transformation stakeholder base.

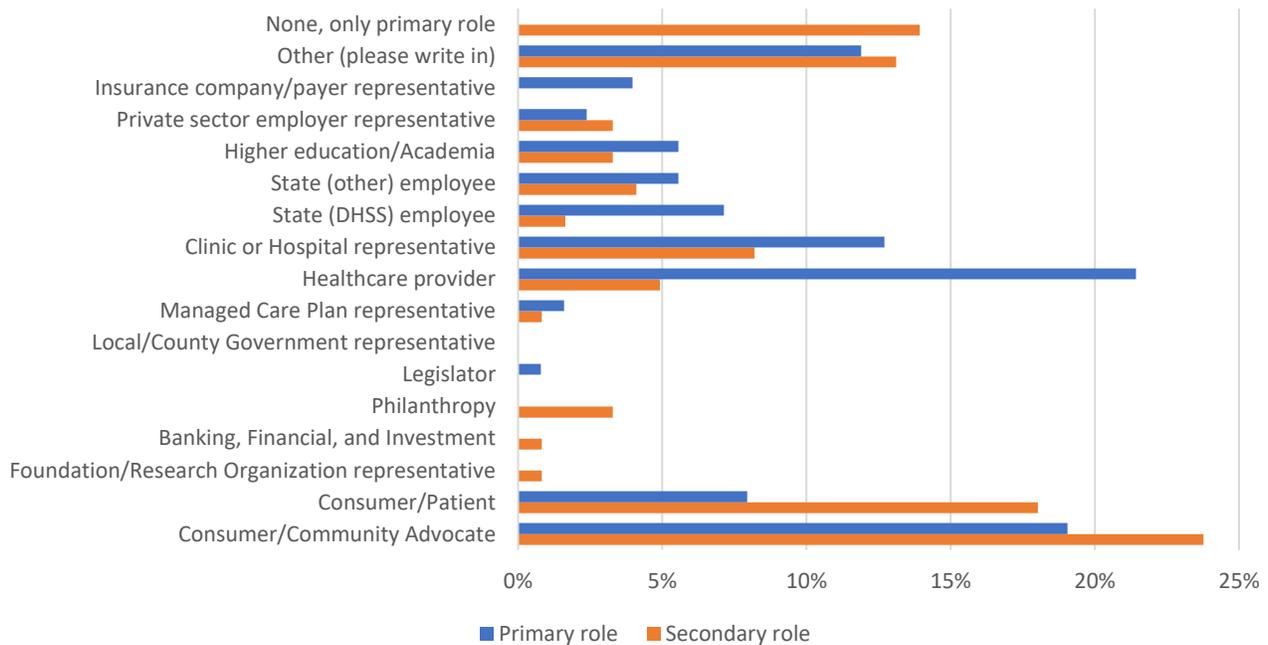


Figure 2. Stakeholder reported roles related to healthcare transformation.

In terms of primary roles *Healthcare providers*, *Consumer/Community Advocates*, and *Clinic or Hospital representatives* were the most frequently selected roles. In terms of secondary roles *Consumer/Community Advocate* and *Consumer/Patient* were the most frequently selected roles. This was not surprising as at some level, no matter what professional roles one occupies they are also healthcare consumers or patients. Overall, every role in the list except for *Local/County Government representative* was selected by at least on stakeholder. Furthermore, 12% indicated *Other* roles, of which included government relations for hospital providers, pharmaceutical suppliers, patient advocate, practice transformation vendor, information technology services provider, nurse health advocate and educator, and ordained clergy with mental health ministry to name a few.

3.5.2. Stakeholder Perceived Impact of Healthcare Transformation Strategies in Delaware

In order to accelerate the transformation of Delaware’s healthcare system to one that delivers high-quality care at lower costs, improves provider experience, and leads to healthier citizens, several strategies have been suggested and incorporated into the DE SIM plans. We listed some of these strategies for stakeholders to consider. We asked stakeholders to rate the level of impact you believe each element will have on transforming healthcare in Delaware. Figure 3 below displays the responses of stakeholders across the various strategies.

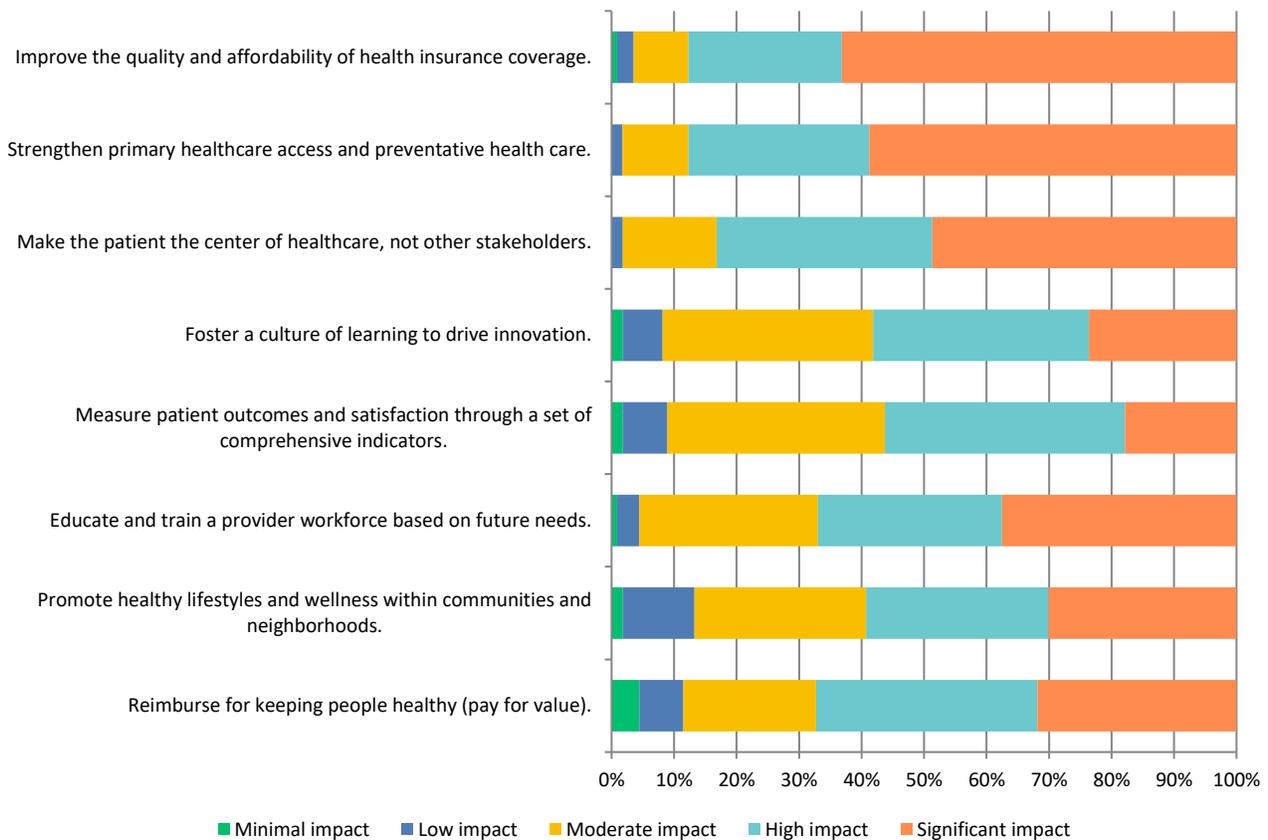


Figure 3. Stakeholder reported impact of various healthcare transformation strategies

For the most part, stakeholders saw the healthcare transformation strategies that have made up DE SIM work for the past four years as leading to high or significant impact. Two strategies: *Improve the quality and affordability of health insurance coverage* and *Strengthen primary health care access and preventative health care* were viewed as having the greatest potential impact, with more than 85% of stakeholders indicating either high or significant impact. Overall, few of the strategies were seen to generate minimal or low impact, suggesting consistency in stakeholder perceived impact. Nevertheless, *Reimburse for keeping people healthy (pay for value)* had the most variation in terms of stakeholder response, with about 12 percent suggesting the strategy would result in minimal or low impact.

3.5.3. Stakeholder Explanations of Strategy Impact

Depending upon the role, position, or experience of the stakeholder different views on what would make an impact in transforming healthcare may be present. Based on the list of healthcare transformation strategies stakeholders rated, they were asked to identify which strategy or combination of strategies they believed will have the most significant impact on transforming healthcare in Delaware. They were then directed to provide an explanation or rationale for why they believed this strategy or combination will have the greatest impact. The table below lists several verbatim responses to illustrate how stakeholders explained why they thought specific strategies or combinations would affect healthcare transformation.

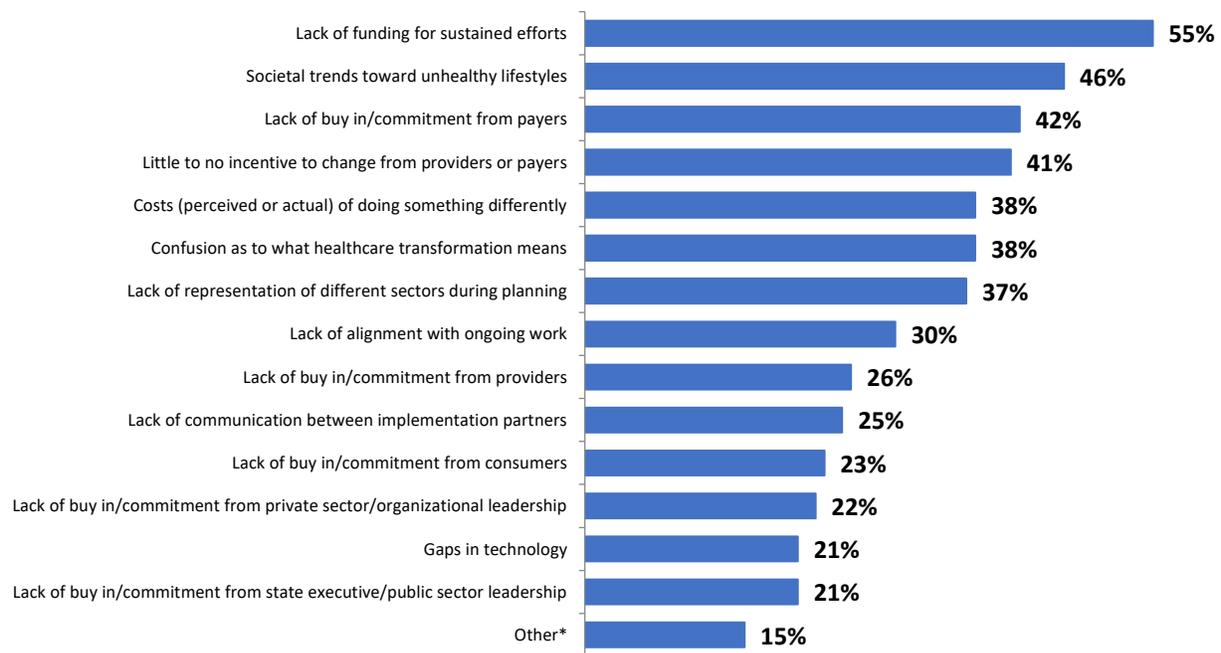
Table 2. Stakeholder reported strategies and rationale for impact.

Strategy(s) for Maximum Impact	Stakeholder rationale
Patient-centered healthcare, improvement of quality and affordability of healthcare and strengthen healthcare access	Patients need to be in the driver's seat and need access to good healthcare that does not break the bank.
Education and health promotion strategies	Move individuals toward awareness and need for change. Must be continued in a variety of communication levels in order to reach most vulnerable populations, repetitively.
Training based on future needs; affordability of health insurance coverage; value pay	Finding out societal trends early on will improve outcomes for prevention; value pay keeps providers accountable; Measure indicators which will give us a quantifiable idea of the direction we need to focus our attention.
Reimbursement for keeping people healthy, but needs to be done in a manner to keep private practices viable	Asking healthcare providers to do more for patients, but not paying them for their time will just push more primary care providers into a concierge model of care.
Strengthen primary healthcare access and preventative health care and improve the quality and affordability of health insurance coverage...for ALL individuals living in the state	Access continues to be a problem in the state of Delaware for those with and without insurance. Not all individuals have the same/equal access, but their health status affects our communities
Strengthen primary care and mental health care	Primary providers are decreasing in Delaware compared to specialists, and the geographical distribution of providers has, if anything, gotten worse. Need to value and compensate primary providers better.
Reimburse to keep people healthy and equal, affordable access to insurance coverage	Because payment drives health care policy and comprehensive affordable insurance coverage provides access to necessary primary and preventive care, management of chronic conditions and when necessary affordable access to specialty care and surgery
Improve the quality and affordability of health insurance coverage	If people have to make the choice between paying rent or health insurance, they will not make healthy choices. Affordable health insurance needs to be available to all.

Educating consumers, changing the insurance industry and properly reimbursing providers will provide the greatest impact.	Consumers need to be actively involved in their health care. Providers need to be properly reimbursed and this means that payers need to reduce profit margins by reducing premiums and increasing provider reimbursement.
Measuring patient outcomes w/ a variety of indicators	Moves healthcare into a more holistic approach rather than single issue/single disease focus - allows for inclusion of outcomes/indicators related to community context and/or trauma/disparity history

3.5.4. Stakeholder Perceived Barriers to Successful Strategy Adoption

In general, stakeholders routinely identify several barriers to the successful adoption of any strategy used to accelerate healthcare transformation. From a standard list, we asked stakeholders to select up to five potential barriers to the successful adoption of any strategy to accelerate healthcare transformation in Delaware. If a barrier was not in the list, they could select “other” and write in a response. Figure 4 below displays the percent of stakeholders who indicated the specific item was an obstacle in Delaware.



* Cost of change is substantial (financial, personnel, emotional) and "start-up" costs for change typically absent or inadequate (especially from insurers); Lack of consistency between payors (eg P4V programs) and lack of listening by payors makes this much harder than it should be; Control of care by insurance companies- money driven instead of care driven; Societal and environmental issues that impact health and drive up costs, including violence, hunger/poor access to healthy food, poor housing, unsafe neighborhoods, childhood trauma; Lack of pediatric medical home for ALL children ; many approaches seem to address adult needs and assume it will work for children, not enough focus on issues related to CSHCN and transition from child to adult health care; Consumers have little to no knowledge of Transformation efforts; Inner city & low income consumers lack time, energy, knowledge or confidence in personal or systemic change; Transparency by Leadership, Passionate Employees, Community Advocates needs national funding for Parkinson's Education for Medical Professionals, Academia Professionals, PD Community Advisors and More! Take Initiative so PD Clinic & CCHS INITIATIVES focused on PD continue!; Lack of knowledge of how to keep people healthy.; lack of knowledge about inequities; Hospital systems, which are dramatically overpaid in Delaware, have little interest in changing the status quo; Patient attitude about their health and how to change is terrible.; DE Board of Med Practice blocks PA transformation legislation; No health plans are affordable still for those not Medicaid eligible making only a small amount more than the cut-off.; The insurance marketplace plans are still too expensive and costly in other ways. There needs to be a program for these individuals.; Forcing too much change within a system that is fragile at the outset; lack of understanding that cost containment, value, and quality are three different objectives with different strategies necessary to achieve each.; Unethical concerns on horizon with population control, Assisted Suicide, damaging effects of LARCS; lack of mental health providers due to low pay, limited parity and licensing constraints

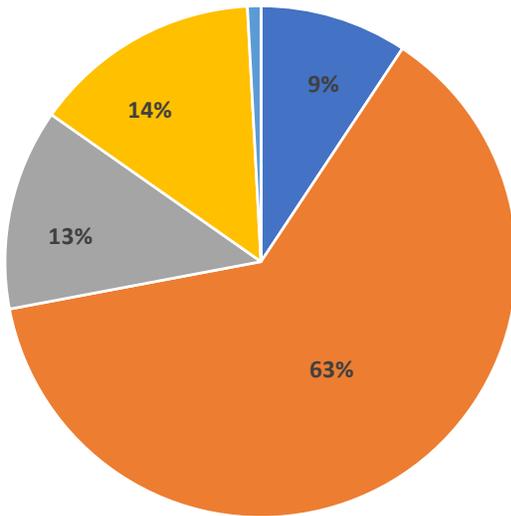
Figure 4. Stakeholder perceived obstacles.

3.5.5. Stakeholder Optimism About the Future

Stakeholders were asked about their optimism for the future of healthcare transformation in Delaware. Nearly two-thirds of stakeholders who responded to the survey reported that they were somewhat optimistic about the future of this work. Those responses were often qualified when prompted with a follow-up question as to why they responded in that way. These results are presented in Figure 5 below. The color boxes next to the figure include quotes to illustrate some of the responses from respondents when asked to describe why they answered how they did.

Those who were most optimistic about the future of healthcare transformation in Delaware (9%) seemed to be so because of the people who are engaged in the work, the recognition that exists about the urgency for transforming healthcare, and the collaborative environment that has been developed over the course of the initiative so far. These are arguably intertwined in that having committed stakeholders is to the collaborative nature of the work that has brought together various sectors to talk about, and begin working towards, transforming healthcare in the state.

The moderately optimistic responses varied. Some of these responses detailed issues that respondents believe need to happen for healthcare transformation in Delaware to continue making forward progress, while others are more related to the actual progress made to this point. According to these respondents there continues to be a need to increase the alignment among key sectors and actors in the state. There were also several respondents whose optimism seemed dampened because of the rate of change or simply how long change takes. Those stakeholders expressing uncertainty about the Delaware's efforts to transform healthcare (14%) or a lack of optimism about the Delaware's efforts to transform healthcare (13%) appear to have less confidence in the processes leading to change than the goals of change. They expressed concerns related to the makeup of the decision-makers involved in charting a course of action as well as those that might need to be engaged in the future for any approach to be successful. Some of the stakeholders expressed skepticism that change would ever take place, despite the efforts of individuals working collaboratively to address the issues in the health care system.



Very optimistic

- Because we have a strong core of people involved who are dedicated to see healthcare transformation.
- I believe the health care spending and quality benchmarks will lend more transparency to the system, which will help to facilitate change.
- I think there is a lot of energy and focus in the private sector to drive value in healthcare.
- The progress so far has been impressive.
- The attention from Governor/state is also important framing factor.

Somewhat optimistic

- I think there is a concentrated effort to reduce costs, but don't think the powers that be have the will to make the difficult choices.
- I'm encouraged by the SIM efforts to date, but know there are many significant challenges to overcome to achieve real change in Delaware.
- I am concerned that the health systems will be unable to successfully transition to new payment models.
- There is interest from community organizations and policy makers, as well as healthcare to try to make changes, but it is going to take time and patience that involves sustained partnerships and funding to make it happen.
- We need to have all partners working together not against one another

Not sure or uncertain

- I am not sure that the right people are at the table making decisions for healthcare in our state.
- We do a lot of talking but never really do anything substantive despite the general interest in improving healthcare.
- A lot more effort can be done for the consumer. Costs are too high overall.
- Not enough information from the provider/insurance industry as it relates to decision making and drafting any kind of legislation.

Not at all optimistic

- Providers/Community/State are not working as collaboratively as they need to get there.
- Without true payment reform, especially for primary care, transformation is impossible.
- Organizers stuck on a few large players for this and ignored the rest of the providers and the consumers
- there is too much emphasis on 'benchmarks' and not recognition that actual change is needed.

Figure 5. Reported optimism of stakeholders.

3.5.6. Stakeholders Reported Network

Complex system interventions require a network of stakeholders from multiple sectors working across several levels. Networks form the backbone of a system by harnessing the collective power of diverse individuals and groups.¹¹ Furthermore, networks allow for highly differentiated, but easily accessible pockets of specialized knowledge that enhance the speed and quality of learning across the system. Understanding the system's relational structure is key to maximizing system capacity to recognize complex problems, plan systemically to meet needs, and mobilize, leverage, and obtain scarce resources. Well-functioning networks include an inherent recognition that complex problems require adaptive relational structures that foster increased cooperation. Thus, optimizing network functioning relies on

¹¹ Leischow, SJ and Milstein, B. Systems thinking and modeling for public health practice. American Journal of Public Health, 2006; 96(3):403.

identifying organizational and disciplinary boundaries, specifying system relationships, and incorporating multiple perspectives.¹²

Because system networks encourage relationship-building among and between individuals and organizations to achieve mutually relevant goals and objectives, we deemed it critical to identify and assess the current DE SIM network. Examination of the network structure and function enabled exploration of patterns that enhance or inhibit successful system change.¹³ Moreover, since networks can be instrumental in: building the capacity to recognize complex problems; planning systemically to meet critical needs; and mobilizing, leveraging, and obtaining scarce resources, insight to network functioning and structure can determine the degree to which the network adjusts over time to support initiative goals and objectives. In this case, we looked at the structure and function of DE SIM network as a purveyor of health care system transformation.

The results of our network analysis characterized the network structure in terms of **nodes** (individual actors, people, or things within the network) and the **ties or edges** (relationships or interactions) that connect them. Line curves should be interpreted in a clockwise manner - outgoing lines from a node curve left, and incoming nodes come in curving right.

We elected to construct and analyze the Delaware healthcare transformation network in terms of roles, as they were identified by the survey respondents. Thus, the nodes represent the various roles people occupy (or are seen to occupy) and the ties are the connections they have to other roles in the system. Different roles serve different functions in the network as a system of interacting elements. The number of nodes in the network measured 30, based on the number of roles reported on the survey. We identified 206 links or ties between the nodes in the measured network. The average number of ties between network members was 6.9, indicating that each role on average had more than 5 connections. As a measure of how well connected or how “close knit” the network is, we found the density to be .24 or about 24 percent of nodes in the network connected with one another. Finally, as a measure of communication efficiency for an entire network, the average path length (the average number of steps it takes to get from one member of the network to another) was 1.5, indicating the network is relatively efficient for information flow.

Figure 6 represents the general shape of the DE SIM network. The roles indicated by survey respondents are marked by nodes (circles of various sizes) in different locations in the network. Node size represents the sum of incoming and outgoing connections to other actors in the network.

¹² Hargreaves, M B. (2010) Evaluating System Change: A Planning Guide. Princeton, NJ: Mathematica Policy Research. No. 6558. Mathematica Policy Research.

¹³ Wickizer, TM Von Korff, M, Cheadle, A, Maeser, J, Wagner, EH, Pearson D, et al. Activating communities for health promotion: A process evaluation method. American Journal of Public Health, 1993; 83(4); 561-567.

That is the larger the node, the more connections to and from that role were noted. *Health care providers*, *Clinic or Hospital representatives*, and *Consumer/Community Advocates* have the most connections across the network, with 33, 33, and 36 respectively. *Higher education/Academia* have 15 out-degree connections (i.e., connections to others) and 13 in-degree connections (i.e., connections from others). This pattern of linkages suggests that they function as a distributor of information or are initiating contact

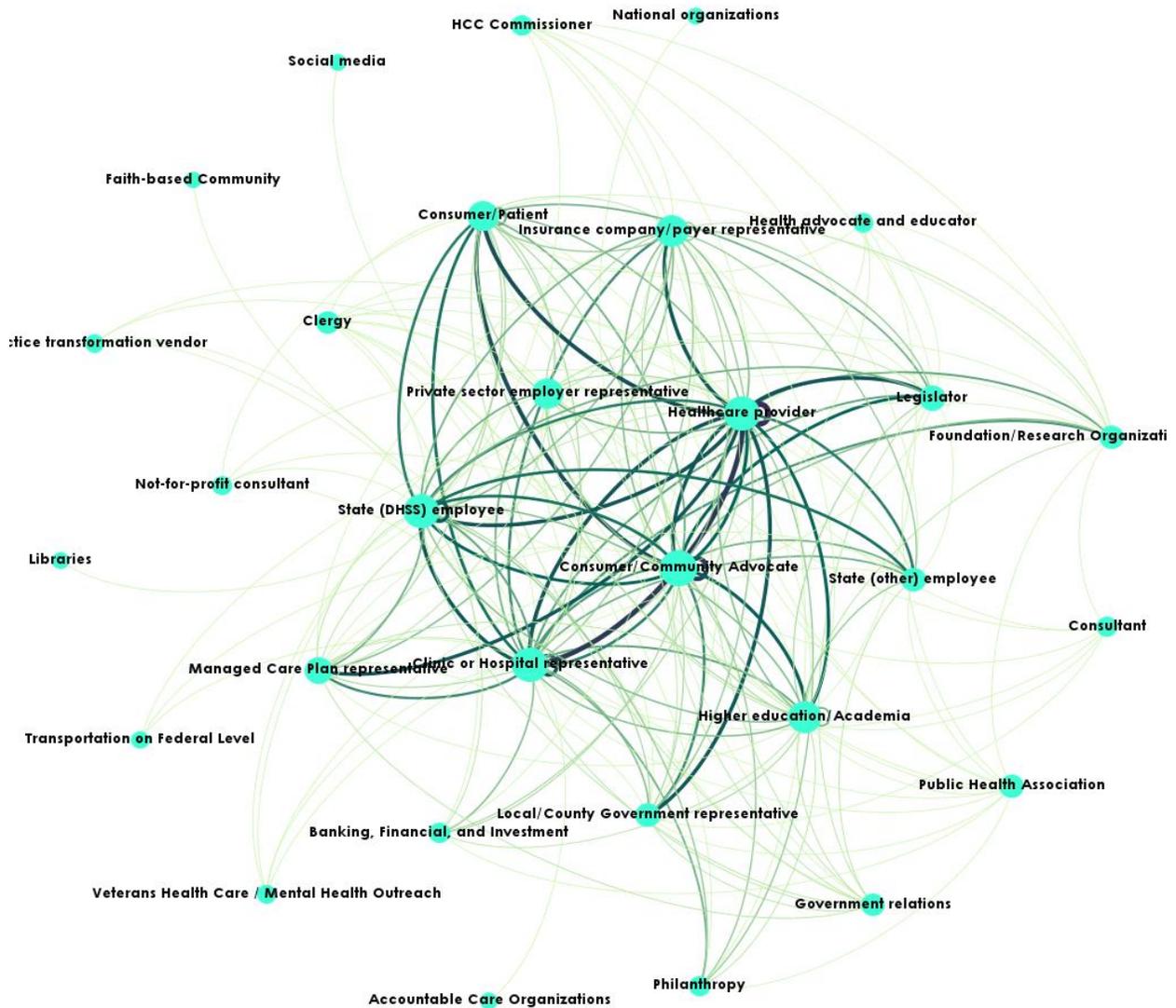
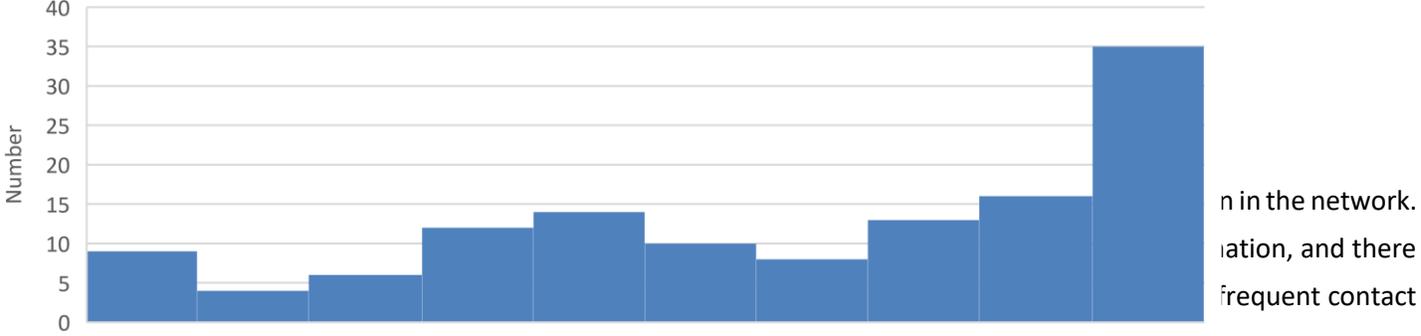


Figure 6. The general shape of the network

with others in the network. Conversely, *Healthcare providers* have 15 out-degree connections and 18 in-degree connections, and *Insurance company/Payer representatives* have 15 out-degree connections but



Overall, the results of the network analysis indicate the importance of the state-provider-payer relationship, by virtue of the centralized location in the network with multiple strong ties to each other as well as to other roles. Furthermore, the roles of *Higher education/Academia* and *Consumer/Community Advocates* feature prominently in this network, occupying a central location with many ties to other key actors. AY4 saw an increase in the number of stakeholders with these roles, as the University of Delaware and other advocacy organizations have come onboard around the Health Neighborhoods work.

3.5.7. Stakeholder Perceived Involvement, Interest, and Influence

We asked stakeholders to rate their overall involvement in healthcare transformation work in Delaware. The majority of survey respondents rated their involvement on the higher end of the scale (i.e., 8, 9, 10) suggesting they had been involved with healthcare transformation work for an extended time period.



Figure 7. Overall stakeholder involvement

In addition to the involvement question posed to stakeholders above, we asked them to rate how much interest they had in Delaware’s activities to accelerate healthcare transformation and how much influence they believed they have on Delaware’s activities to accelerate healthcare transformation. We then contrasted those two ratings, constructing 4 quadrants of interest-influence: More influential-Less interested; Less influential-More interested; More influential-More interested; and Less influential-Less interested. Each dot in the figure represents one stakeholder and where they fall according to their response on the two scales. Based on the responses from stakeholders, Figure 8 below presents two major

groups: one group that indicated high interest in activities to accelerate healthcare transformation in Delaware and yet also reported having a lower level of influence, and another group that indicated both high interest and considerable influence. It is clear that a substantial number of stakeholders responding to the items on the survey indicated they were more interested and less influential in terms of their connection to Delaware’s activities to accelerate healthcare transformation. This is evident as the bottom right hand quadrant has many more “dots” than the other quadrants. Nevertheless, there is a portion of the healthcare transformation stakeholders that are more interested, but consider themselves to be more influential (upper, right hand quadrant), possibly suggesting a set of stakeholders primed for engagement going forward.

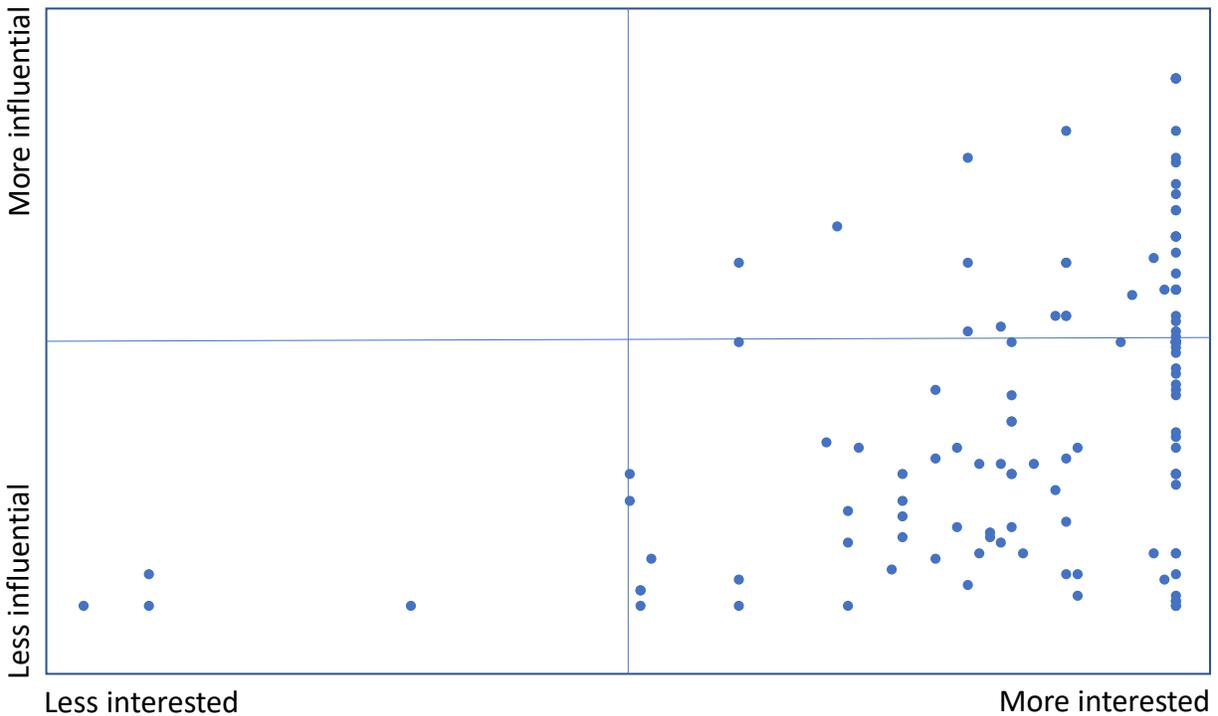


Figure 8. Interest and Influence of stakeholders.

A small number of stakeholders reported having little direct interest and a corresponding low level of influence in activities to accelerate healthcare transformation in Delaware. By definition, those individuals with little interest were unlikely to be part of our survey, so it is not surprising that there were few respondents in the “low interest” part of the matrix. However, for future efforts around healthcare transformation it may be useful to identify potential “context setters” (i.e., those actors with more influence) and engage them more fully as work continues. For instance, policymakers have been identified as a group with little specific interest but high influence and who may be important stakeholders to drive sustainable change.

3.5.8. Stakeholder Reported Engagement

Stakeholder engagement is a frequently used term when discussing the approaches to healthcare system transformation. Because engagement is an umbrella term which encompasses a variety of definitions and meaning, it is a difficult concept to measure. Drawing from specific ways engagement is described in the literature to help understand the variety of influence and interest of stakeholders with regards to activities to accelerate healthcare transformation in Delaware, a framework was developed and used as a part of our stakeholder survey to measure the perception of stakeholder interest and influence. Although engagement has not been explicitly defined and delineated, several words associated with the term are found in the DE SIM operational plans to illustrate what constitutes engagement, such as dialogue, commitment, involvement, cultivation, input, communication, and participation. In terms of further understanding what it means in the context of Delaware healthcare transformation efforts to be “engaged”, we sought to distinguish engagement from other factors that often serve as a proxy.

We also sought to measure engagement by understanding the degree to which people not only receive information, but also are able to participate in decision-making and are heard. Figure 9 below demonstrates the varying levels of engagement reported by stakeholders. As one moves clockwise around the figure following the directional arrow, the descriptors indicate a deeper level of engagement. Thus, being informed is considered the minimum level of being engaged and having the opportunity to decide on options the highest. Nearly all respondent stakeholders (89%) report that there are at least kept informed about healthcare transformation in Delaware.

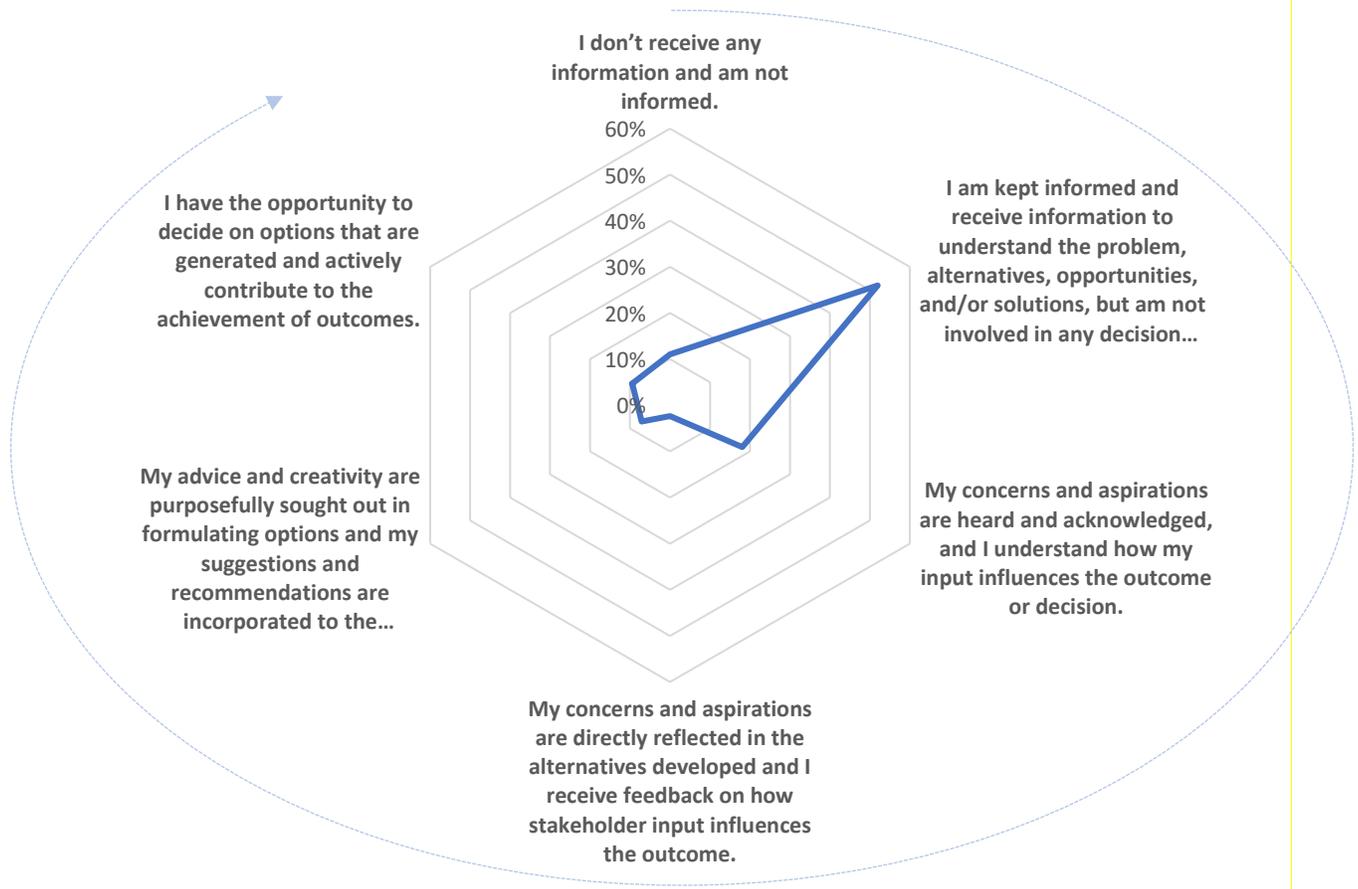


Figure 9. Levels of engagement

While most stakeholders indicated they were at the level of being kept informed about healthcare transformation in Delaware, substantially fewer indicated they were at the deeper levels of engagement, where ideas are sought, incorporated and used to shape the initiative. About 10% of stakeholders feel they have the opportunity to decide on items relating to healthcare transformation in Delaware and are equipped to actively contribute to reaching the outcomes of the initiative – the deepest level of engagement. However, several stakeholders (11%) indicated that they do not receive information about healthcare transformation in Delaware and they are not kept informed, which may hint lack of engagement within the system. It is possible stakeholders conceptualize engagement differently. Nonetheless, in terms of measurement, the findings detailed below help create a standard in terms of stakeholder engagement going forward, particularly as broad-based engagement of various kinds of stakeholders is viewed as an underlying critical component of healthcare transformation implementation and sustainability.

3.5.9. Ways Stakeholders Are Engaged

As DE SIM activities funded by CMMI ends, there exists strong stakeholder commitment to transformation work. Actors across the state and across sectors appear to be willing to sustain their participation in transformation efforts into the future. While stakeholder engagement is facilitated by outreach and communication on the part of SIM leadership, there is an inherent interest and willingness among many stakeholders to improve health and health care in Delaware that drives much of their engagement and ongoing commitment.

Both the state/HCC and DCHI continued in their efforts to engage new and maintain existing stakeholders in AY4. Some new groups formed, some existing groups continued to meet on a regular basis, and other groups transitioned in terms of the role they played within the evolving system. Similarly, both the state and DCHI continued to maintain a strong web presence and electronic communication channels. HCC continued to maintain and enhance the www.ChooseHealthDE.com website as the primary vehicle for sharing information about health care transformation activities (framed as the “Road to Value”). The website contained information and links to key documents, legislation, and references regarding the “Road to Value” initiative as it has continued to progress. DCHI continued to maintain its website (www.dehealthinnovation.org) to share SIM-related resources, links and information about public meetings of its board and committees. Both HCC and DCHI maintained large stakeholder databases, which were used for electronic newsletters, email blasts about upcoming events, and for data collection and evaluation purposes.

Following the series of stakeholder meetings related to the health care benchmark in AY3, Secretary Walker also continued in her efforts to gather feedback from a broad range of stakeholders on issues related to the establishment of a global health care spending benchmark. A Healthcare Spending Benchmark Advisory Group was established through executive order and convened throughout the first half of AY4. Two subcommittees of the Advisory Group were established, with constituent leaders from Delaware’s healthcare institutions, to provide recommendations to the Secretary and the Governor on both cost and quality. The Advisory Group met four times between March and June 2018 and submitted formal recommendations to the Governor in August. Secretary Walker provided regular public updates on the work of the Advisory Group at DCHI Board meetings and monthly meetings of the HCC.

Also in August, the Governor signed legislation to establish the Primary Care Collaborative (PCC), aimed at strengthening primary care in Delaware. Dr. Nancy Fan, chair of the HCC, was charged with convening the PCC along with Senator Townsend and Representative Bentz. The PCC met regularly during the second half of AY4 to gather input from stakeholders on primary care needs in the state and released a final report with a set of high-level recommendations related to payment reform on January 9th, 2019. While some concerns were raised as to the lack of diversity of stakeholders in attendance at the

information gathering meetings, and the lack of consensus in developing recommendations, the PCC was charged with moving rather quickly to generate a report and this precluded them from being as inclusive and collaborative as they would have liked. For instance, the PCC did not have time to integrate feedback from stakeholders in their final report; therefore, comments were included as an appendix. The PCC is scheduled to continue meeting into 2019 and it will be important for them to continue in their efforts to engage relevant stakeholders and integrate feedback when feasible in order to maintain such engagement.

DCHI also continued to work to strengthen and broaden stakeholder engagement in AY4 through communication and regular meetings of SIM-related committees and workgroups. While there was a perception among many stakeholders early in AY4, that the SIM initiative was evolving to be more of a top-down or state-directed effort, DCHI supported the state/HCC by continuing to facilitate regular, public meetings ensuring opportunities for stakeholder input and engagement. For instance, while the PCC was charged with gathering input and developing recommendations for strengthening primary care in DE, the DCHI Clinical Committee continued to meet and provided an additional forum for stakeholders to engage in a parallel process of discussing primary care needs in the state. The Committee has adapted to the establishment of the PCC and committee members see themselves as having an ongoing, important role to play in strengthening primary care. Despite the end of SIM funding, committee members are in the process of revising the committee charter, which will likely include reference to how they will interact with the PCC. Fortunately, Dr. Fan chairs this committee, providing another opportunity for alignment between DHIC and HCC. Despite these efforts there is still concern that providers, especially small or independent practices, are not as engaged as they may need to be for transformation of the system. It will be important for the state and the clinical committee to continue to work to engage providers to the extent possible.

DCHI also reconvened its Patient and Consumer Advisory Council in AY4 in response to concerns about engagement at this level. The committee has met regularly since July with support from both DCHI and in-kind support from the Partnership for Healthy Communities at the University of Delaware. There is energy surround this committee, which has reviewed and revised its charter, ensuring its purpose and work is evolving as the broader transformation effort evolves. However, there remain concerns that not enough consumers are engaged in discussions around health care transformation, and that among those consumers who are engaged, their perspectives are less important than other kinds of stakeholders (e.g. providers and payers). Going forward it will be important for leaders to find ways to engage broader consumer groups, ensure the voices of consumers are being heard and that consumer feedback is being integrated into transformation efforts.

AY4 also saw a major transition in the SIM strategy related to population health and healthy communities that relied on continued engagement of various stakeholders at the state and community

level. Early in AY4, stakeholders seemed concerned about this transition from “Healthy Neighborhoods” to “Healthy Communities Delaware” and were skeptical about how information was being shared and how decisions would be made. However, the state and various partners, including HCC, DCHI, the DE Division of Public Health, and the University of Delaware, worked together to develop and provide a consistent message about the model for Healthy Communities Delaware (HCD) that eventually seemed to resonate with stakeholders. Engagement efforts included large, open town hall meetings, as well as a number of one-on-one meetings with key stakeholders to share the model and gather input. With support from the vendor, HMA, Healthy Communities Delaware developed a consistent messaging strategy which included a collective impact framework, relying on collaboration and commitment across sectors. The planning work of HCD culminated with a public “launch” at a symposium on January 14th, 2019. Approximately 175 stakeholders attended the symposium, with most staying until the end of the day. Again, there appears to be positive energy surrounding this work with engagement of varied stakeholders. However, a number of concerns have been raised and it will be important for leaders to remain attentive to engagement as the initiative evolves. Specifically, stakeholders in Kent and Sussex county continue to raise concerns about whether resources will focus primarily on communities in New Castle County. Similarly, communication strategies will need to include varied media platforms, as for example, some in rural communities still rely on poor internet connections. Finally, stakeholders in attendance at the HCD symposium stressed the importance of community voice in problem-solving and decision-making; such input will depend on ongoing outreach and engagement, as well as a purposeful feedback loop.

The stakeholder driven and consensus-oriented approach that characterized DE SIM early on has evolved over the past four years to include more of a top-down or directive approach from the state. While our evaluation does not speak to the relative value of either approach, it is important to understand the ways in which stakeholder engagement is affected by this transition. Further, it is important to recognize that a system transformation such as that which is being undertaken in DE requires strong and sustained engagement of stakeholders regardless of the approach to transformation undertaken by the state. While the role of stakeholder engagement may have been more obvious at the outset of DE SIM, the engagement of various kinds of stakeholders—providers, payers, consumers, etc.—remains crucial to system transformation and the sustainability of efforts to achieve the stated goals of DE SIM. Fortunately, there remains much energy and commitment to the work of transformation. Many stakeholders have remained steadfast since the DE SIM planning phase, while some have taken a lesser role or appear to be “watching and waiting”. At the same time, new and important stakeholder groups have become engaged or have become more engaged over time (i.e. payers). With a system transformation as large and complex as health care, leaders will need to remain attentive to maintaining buy-in and commitment of a large and diverse group of stakeholders. As discussed earlier, DE is fortunate to have so many individuals with an inherent interest in seeing positive changes in the health care system to improve the health of the

population. Many are committed to this work and state leaders would do well to continue to recognize the value of such engagement and build upon this to sustain the work of health care transformation.

3.5.10. Stakeholder Opinions About Health Care and Transformation

In transforming the health care system to produce better outcomes at lower costs, several assumptions drive the need to change. To inform future collaboration around healthcare transformation efforts it is important to understand the perspectives and values of key stakeholders in the state in relation to these assumptions. We asked stakeholders to review a list of assumptions that are pertinent to healthcare transformation and rate their level of agreement with some of these assumptions. Figure 10 below displays the response of stakeholders across the list of assumptions associated with healthcare transformation.

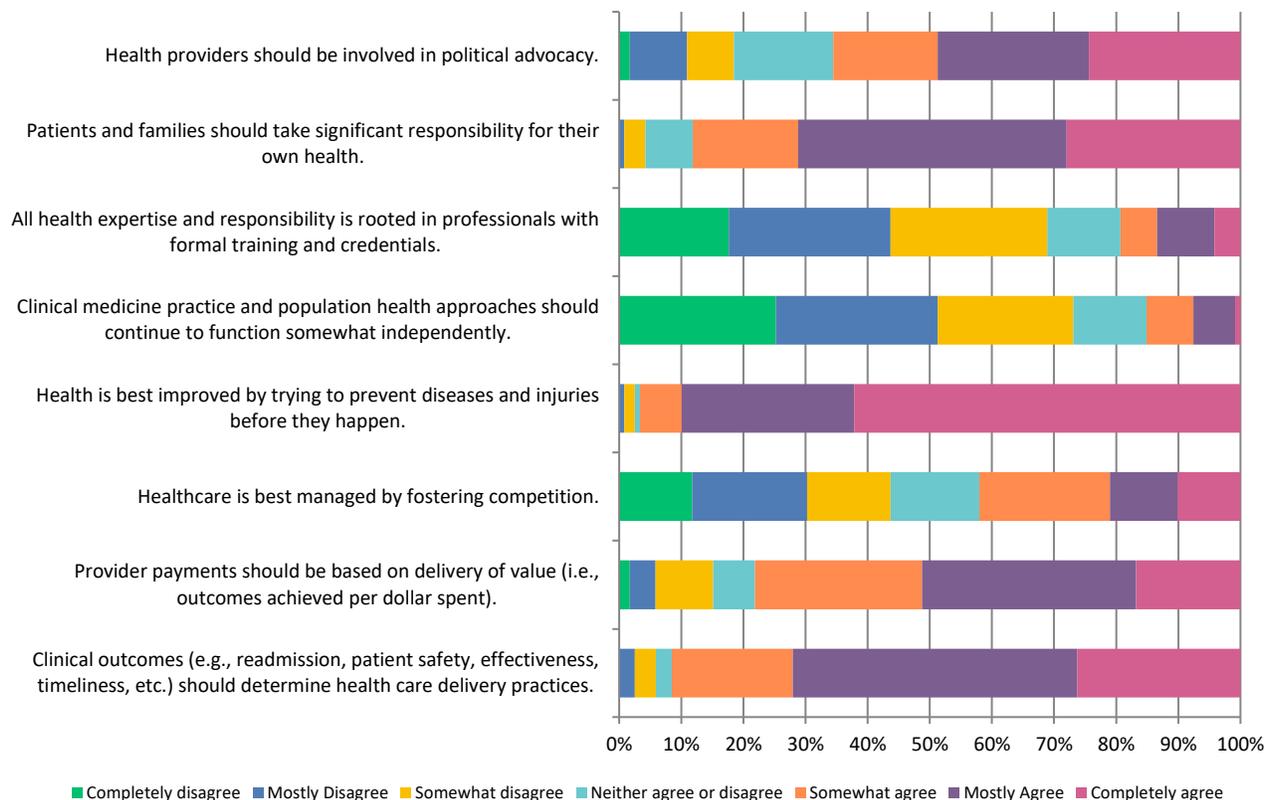


Figure 10. Stakeholder reported agreement on health care transformation assumptions.

Stakeholders indicated moderate to strong agreement across the assumptions listed above. For some assumptions, like *Health is best improved by trying to prevent diseases and injuries before they happen*, almost 90% of stakeholders either mostly or completely agreed with the assumption. Similarly, for the idea *Clinical outcomes (e.g., readmission, patient safety, effectiveness, timeliness, etc.) should determine health care delivery practices*, nearly 75% of stakeholders either mostly or completely agreed with the assumption. About half of the stakeholders either completely or mostly disagreed with the

assumption that *Clinical medicine practice and population health approaches should continue to function somewhat independently*. The widest variation in response from stakeholders was observed in response to the assumptions *Health care is best managed by fostering competition* and *Health providers should be involved in political advocacy*. As an indication of support to the work of DE SIM and its activities related to healthcare transformation, more than half of stakeholders either mostly or completely agreed with the assumption *Provider payments should be based on delivery of value (i.e., outcomes achieved per dollar spent)*.

Transforming Delaware’s healthcare system is a complex undertaking that involves addressing several challenging issues simultaneously. These issues are not unique to Delaware but may be applicable in the state. We asked stakeholders to review a list of these challenging issues and rate their level of agreement as they pertain to Delaware. Figure 11 below displays the response of stakeholders across the list of Delaware-specific issues affecting transformation.

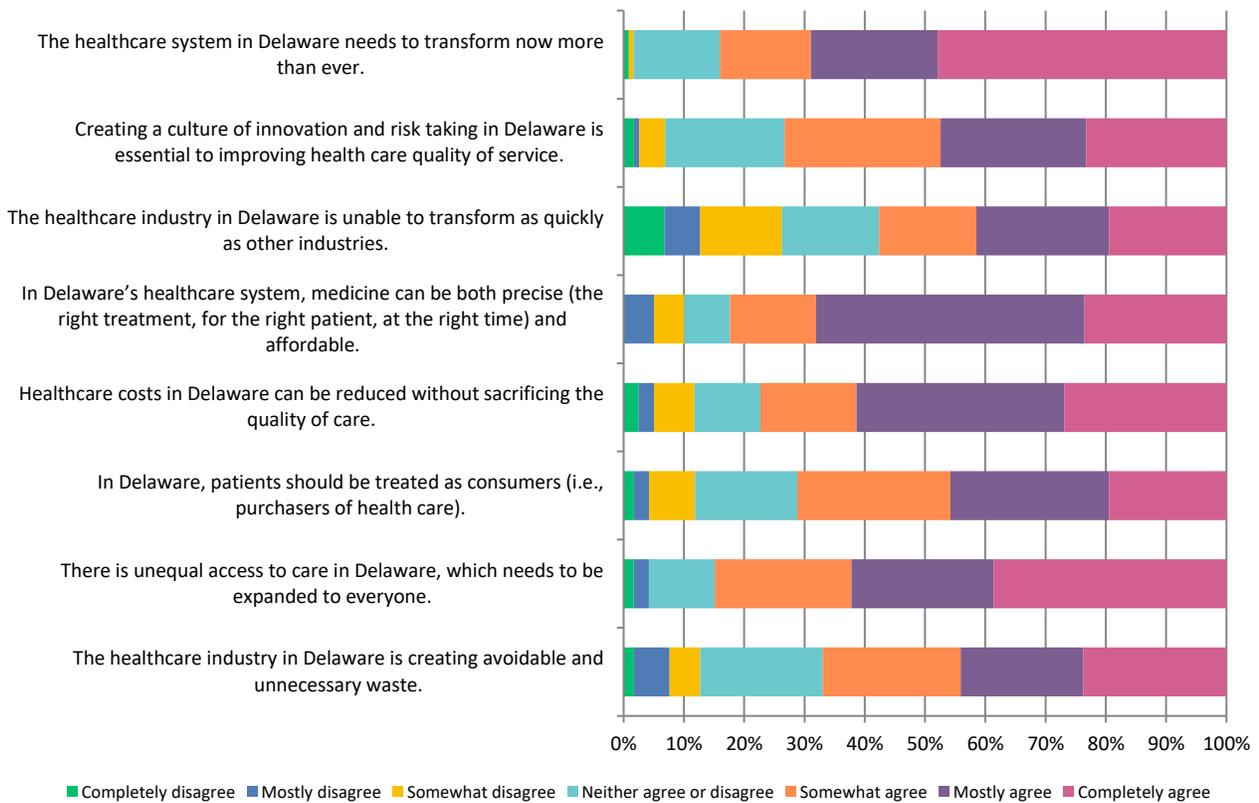


Figure 11. Stakeholder reported agreement on Delaware-specific issues affecting transformation.

Stakeholders indicated moderate agreement across the Delaware-specific issues affecting transformation listed above. For some issues, like *The healthcare system in Delaware needs to transform now more than ever* and *In Delaware’s healthcare system, medicine can be both precise (the right treatment, for the right patient, at the right time) and affordable*, almost 70% of stakeholders either

mostly or completely agreed with the issue. Similarly, for the issues *Health care costs in Delaware can be reduced without sacrificing the quality of care* and *There is unequal access to care in Delaware, which needs to be expanded to everyone*, more than 60% of stakeholders either mostly or completely agreed with the issue. The widest variation in response from stakeholders was observed in response to the issue *The healthcare industry in Delaware is unable to transform as quickly as other industries*. Interestingly, more than 40% of stakeholders either mostly or completely agreed with the issue that *The healthcare industry in Delaware is creating avoidable and unnecessary waste*, signaling a sense from stakeholders that transformative action should be taken to remedy this issue to rein in costs.

3.6. Medicaid Claims Data Analysis of Potential Outcome Measures

As the overriding goals of CMMI-funded state innovation model initiatives are to achieve better quality of care at lower costs and with improved outcomes, an inherent assumption within SIM is that with improved efficiency and quality of care, utilization rates for health care services will be impacted. RTI International, the contracted federal evaluator for the overall SIM initiative, specifically argues that we should expect to see decreases in hospital admission rates and emergency department visits as a result of improvements in the practice of primary care and in the coordination of care across provider types.

DE SIM focused specific attention and resources on these types of “practice transformation” activities among primary care providers in the state. Approximately 100 providers were connected with expert vendors who delivered training and technical assistance to improve the capacity and capabilities of the providers in adopting best practices in the delivery of primary care. These practices included things like identifying and coordinating care for high risk patients and offering same day appointments and extended hours to increase access to primary care and reduce emergency room visits. Although it is likely to take much more time to see impacts on health outcomes as a result of practice changes, one might expect to see changes in healthcare utilization more quickly.

In order to test this assumption of Delaware’s primary care system change intervention, we conducted an exploratory analysis which involved linking Medicaid claims data with a database of providers who participated in the practice transformation intervention. More specifically, we identified the primary care physician (PCP) for each Medicaid client within our claims database (Medicaid clients without a PCP listed were dropped from the analysis). The PCP variable was then linked to the list of providers who participated in practice transformation funded by DE SIM between December 2015 and July 2017. We then examined number of emergency department visits and inpatient hospital admissions within the Medicaid claims files. In order to account for changes in utilization that may have occurred for reasons other than participation in the practice transformation intervention, we examined trends over time and compared utilization rates among patients with providers who participated in SIM practice transformation with those who did not. Further, in order to test the assumption that providers who made

more progress on practice transformation milestones (e.g. those who maintained the practice changes for longer periods of time) would have greater impacts on their patients' utilization, we divided the provider groups into those with higher and lower levels of achievement within the practice transformation milestones. Demographic comparisons included age cohorts, geographic location, gender and race/ethnicity. Finally, comparison of means (t-tests) were performed for the average number of emergency department visits and inpatient admissions for each year between the practice transformation group and the non-practice transformation group.

This type of analysis has a number of limitations and findings must be contextualized and interpreted with caution. For example, although each Medicaid client is assigned a PCP by their managed care organization, it is not known whether the Medicaid client actually considers and utilizes that PCP as their primary place of care. Among other quality "checks", it is important to share preliminary findings of this type of analysis with experts and stakeholders (including colleagues at the DE Division of Medicaid and Medical Assistance) for their feedback and input. Our analysis demonstrates the feasibility of such an evaluation approach, and once a more careful review occurs, this type of analysis may provide valuable insights and be an important addition to any state effort to evaluate the impact of healthcare transformation activities. Future analysis could include examination of both provider behaviors and patient utilization rates over longer periods of time and with a focus on high risk patients or those with particular health conditions. Other characteristics of providers and patients could also be included in future analyses to determine whether the intervention impacts certain groups more than others and in what ways. Finally, such analysis may be used to compare impacts of healthcare transformation activities on Medicaid patients and those with private insurance in order to help inform state leaders on the impacts of their investments.

4.0. Conclusions

In carrying out the monitoring and evaluation approach for AY4, we sought to understand the critical process of how system change occurred based on implementation of DE SIM and its related healthcare transformation activities. We were interested in generating feedback about how major systems changes were unfolding, where it might be delayed or expedited, or how the innovation may need to be changed and adapted as it is scaled. Several characteristics of complex adaptive systems are relevant to implementation, including (a) the way in which change occurs, (b) differences and multiplicity of perspectives, (c) information generation and knowledge exchange, (d) the actors and action, and (e) the nature of interactions and variability. In our approach to document the process of implementation of DE SIM and the perceived effects on that implementation upon the emerging system, we sought to ensure our methods and questions were sensitive to understanding the initial conditions and how the initiative is evolving as it is taking shape. Consistent with the purpose of the state-led evaluation, the results

generated here provide insight about what is emerging and enable the state to follow the incremental actions and decisions that affect the paths taken and not taken.

DE SIM continued to make progress towards health care transformation in Delaware. In complex systems, the strategies that individual agents and organizations pursue simultaneously reflect both a sense of stability and change over time. As the healthcare system in Delaware moves from the transactional changes (i.e., doing things better) prescribed in the operational plan to more transformational changes (i.e., doing better things) around culture and the values associated with health care, it may be useful to take stock of stakeholders' perceptions of what changes are likely to make the most impact in light of the allocation of resources. The following are our summary observations of the system and changes at the end of the grant cycle.

The level of voluntary engagement/participation/commitment to the DE SIM efforts across a wide range of stakeholders has been impressive and this should be recognized and supported. There are a number of people who have given of their time for many years, meeting regularly, drafting documents, and doing research. It is important for leaders in the state to recognize and appreciate this. While a more directive approach may be needed to continue moving the work forward the leadership needs to acknowledge what has been accomplished to date with through the volunteer efforts of dozens of individuals. Furthermore, it is likely that these stakeholders remain engaged if they see things moving forward in a direction they agree with, or at least are both kept informed of future action, and given the opportunity to provide feedback. There needs to be transparent communication mechanisms to ensure that happens.

As AY 4 comes to a close there is clearly momentum in a number of areas (e.g., healthy communities Delaware and BHI). The state should continue to invest and make transformation an ongoing priority so that progress continues in these areas. Committing to ensure this progress is not stalled goes a long way in helping to ensure stakeholders who have worked hard to bring these initiatives along feel their work is valued. Political will is critical, and a commitment to moving transformation efforts forward, and building upon what has been accomplished is critical as DE SIM ends.

While there are still some who feel payers have not made good faith efforts to work with other actors in the state in transforming the health care system, it is important to recognize the challenges they face as branches of larger companies. There also have been examples of how the payers in Delaware have been making strides in trying to increase their collaboration with providers and the state, and this should be recognized.

Evaluation is a crucial component and should not be overlooked. The quarterly evaluation reports in AY 4 began to be disseminated more broadly, and stakeholders appreciated the opportunity to stay informed on what was being learned through the evaluation process. Evaluation should continue in some

form to ensure lessons are learned, and to help support future efforts and to understand their impact. Systems change is not to be taking lightly – DE SIM set out to undertake and galvanize major, complex changes that take time and may be hard to fully assess/appreciate in the short term. Delaware is somewhat unique in its comprehensive approach to HC transformation - that means progress may not be as apparent (and maybe progress was slower than if DE SIM had focused more narrowly on fewer drivers at the start) but based on what we understand about health and healthcare the approach seems to have been appropriate. At the same time, that reinforces the idea that investments and attention need to be sustained to realize the longer-term changes.

Engaging consumers/patients in this type of work given its complexity can be a major challenge. However, it is also important both for the perspectives they bring and because it demands connections with advocates who are important to the transformation coalition. Initiatives like HCD seem to be doing a good job of trying to engage communities in the decision making process. Future transformation work should be sure to make concerted efforts to engaging consumers/patients and their advocates in appropriate contexts. This also requires a communication strategy that allows this kind of work to be approachable for the public. This is something that was a challenge for DE SIM.

In loosely-coupled systems without a central actor that has direct control it is important for there to be an institution that can link together other actors in the system to leverage the capacities each brings. This helps to ensure that the system actors all understand their role and are supported to use the skills and expertise they bring to best support the system goals. This should be considered for future transformation efforts in Delaware. There are many individuals and organizations in the state that have the ability to help move health care transformation forward, but an organizer to help build bridges between these groups is crucial.

There was never clarity about who was the primary communicator about the work happening around DE SIM. This led to many not knowing enough about the initiative, that includes legislators, providers, and consumers. Communication is crucial, particularly when so much of the work of an initiative is built upon stakeholder engagement. If there is misinformation, or inconsistent information spreading through the system it makes it difficult for stakeholders to know they are on the same page with one another. Operationally it means that time is wasted during stakeholder interactions because time has to be spent sorting out what is real and what might not be. A clear communication strategy, with a clear authority for executing that strategy is critical.

5.0. Appendices

5.1. Appendix A: Stakeholder Survey

Delaware’s State Innovation Model (DE SIM)
Healthcare Transformation Stakeholder Survey

<PAGE 1>

Introduction

The **Delaware State Innovation Model (DE-SIM) Initiative** is a federally funded effort designed to accelerate statewide healthcare transformation. Delaware’s SIM plan represents a state strategy to use all available levers to transform the state healthcare delivery system.

In this final year of Delaware’s State Innovation Model (DE-SIM), we are seeking input from those aware of and involved with these efforts to transform the healthcare system in Delaware. This survey is part of larger evaluation effort in which we are collecting data from several different sources.

The purpose of this survey is to gather information from stakeholders about who they are, what they value, and how they see the healthcare system being transformed.

Given the size of Delaware and your role with DE SIM, you may be involved in other components of the evaluation and that’s okay. Information collected on this survey will be consolidated with other sources. We will not be reporting any individual level responses and your confidentiality will be maintained.

This survey should take approximately 10 minutes of your time. Your participation is voluntary – you can skip questions or stop at any time. Thank you for taking the time to complete this survey.

<PAGE 2>

Context: Large-scale transformation is happening in healthcare. In Delaware, efforts have been taken to accelerate the transformation of Delaware’s healthcare system to one that delivers high-quality care at lower costs, improves provider experience, and leads to healthier citizens. In this survey, we refer to Delaware’s efforts as the ongoing public-private collaborative work to transform the healthcare system to one that produces better outcomes at lower costs. DE SIM is the grant program that was awarded to Delaware help accelerate these transformative changes.

<PAGE 3>

1. Please place an **(X)** in the cell that corresponds to your overall involvement in healthcare transformation work here in Delaware.

Just recently became aware of this work ←————→ *Involved with this work for some time now*

()	()	()	()	()	()	()
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2. Transforming healthcare involves many different individuals from a variety of sectors working together. Please select the response that **best describes your PRIMARY role** related to healthcare transformation:

- Consumer/Community Advocate
- Consumer/Patient
- Foundation/Research Organization representative
- Banking, Financial, and Investment
- Philanthropy
- Legislator
- Local/County Government representative
- Managed Care Plan representative
- Healthcare provider
- Clinic or Hospital representative
- State (DHSS) employee
- State (other) employee
- Higher education/Academia
- Private sector employer representative
- Insurance company/payer representative
- Other (please write in): _____

3. Sometimes those working on health care transformation issues wear multiple hats. Please select the response that **best describes your SECONDARY role** related to healthcare transformation:

- Consumer/Community Advocate
- Consumer/Patient
- Foundation/Research Organization representative
- Banking, Financial, and Investment
- Philanthropy
- Legislator
- Local/County Government representative
- Managed Care Plan representative
- Healthcare provider

- Clinic or Hospital representative
- State (DHSS) employee
- State (other) employee
- Higher education/Academia
- Private sector employer representative
- Insurance company/payer representative
- Other (please write in): _____
- None, only primary role

4. Please place an **(X)** in the cell that corresponds with how much **interest** you have in Delaware’s activities to accelerate healthcare transformation:

<i>No Interest</i>	←—————→						<i>Significant Interest</i>
()	()	()	()	()	()	()	

5. Please place an **(X)** in the cell that corresponds with how much **influence** you believe you have on Delaware’s activities to accelerate healthcare transformation:

<i>No Influence</i>	←—————→						<i>Substantial Influence</i>
()	()	()	()	()	()	()	

6. In thinking about your primary role, please place an **(X)** in the cell above the description that best characterizes your level of engagement in Delaware’s healthcare transformation.

<i>With respect to Health Care Transformation in DE:</i>					
()	()	()	()	()	()
I don’t receive any information and am not informed.	I am kept informed and receive information to understand the problem, alternatives, opportunities, and/or solutions.	My concerns and aspirations are heard and acknowledged , and I understand how my input influences the outcome or decision.	My concerns and aspirations are directly reflected in the alternatives developed and I receive feedback on how stakeholder input influences the outcome.	My advice and creativity are purposefully sought out in formulating options and my suggestions and recommendations are incorporated to the greatest extent possible.	I have the opportunity to decide on options that are generated and actively contribute to the achievement of outcomes.

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7. In transforming the health care system to produce better outcomes at lower costs, several assumptions drive the need to change. To inform future collaboration around healthcare transformation efforts it is important to understand the perspectives and values of key

stakeholders in the state. From the list of statements below, please rate your level of agreement with some of these assumptions.

	<i>Completely Disagree</i>						<i>Completely Agree</i>
a. Clinical outcomes (e.g., readmission, patient safety, effectiveness, timeliness, etc.) should determine health care delivery practices.	1	2	3	4	5	6	7
b. Provider payments should be based on delivery of value (i.e., outcomes achieved per dollar spent).	1	2	3	4	5	6	7
c. Health care is best managed by fostering competition.	1	2	3	4	5	6	7
d. Health is best improved by trying to prevent diseases and injuries before they happen.	1	2	3	4	5	6	7
e. Clinical medicine practice and population health approaches should continue to function somewhat independently.	1	2	3	4	5	6	7
f. All health expertise and responsibility is rooted in professionals with formal training and credentials.	1	2	3	4	5	6	7
g. Patients and families should take significant responsibility for their own health.	1	2	3	4	5	6	7
h. Health providers should be involved in political advocacy.	1	2	3	4	5	6	7

8. Transforming Delaware’s healthcare system is a complex undertaking that involves addressing several challenging issues simultaneously. These issues are not unique to Delaware but may be applicable in our state.

In reviewing the list of statements below, please rate your level of agreement as they pertain to Delaware.

	<i>Completely Disagree</i>						<i>Completely Agree</i>
i. The healthcare industry in Delaware is creating avoidable and unnecessary waste	1	2	3	4	5	6	7
j. There is unequal access to care in Delaware, which needs to be expanded to everyone	1	2	3	4	5	6	7
k. In Delaware, patients should be treated as consumers (i.e., purchasers of health care).	1	2	3	4	5	6	7
l. Health care costs in Delaware can be reduced without sacrificing the quality of care.	1	2	3	4	5	6	7
m. In Delaware’s healthcare system, medicine can be both precise (the right treatment, for the right patient, at the right time) and affordable.	1	2	3	4	5	6	7
n. The healthcare industry in Delaware is unable to transform as quickly as other industries.	1	2	3	4	5	6	7
o. Creating a culture of innovation and risk taking in Delaware is essential to improving health care quality of service.	1	2	3	4	5	6	7
p. The healthcare system in Delaware needs to transform now more than ever.	1	2	3	4	5	6	7

9. From the following list of potential **barriers** to successful adoption of any strategy to accelerate healthcare transformation, please mark up **to 5 you believe apply in Delaware**:

- Lack of buy in/commitment from state executive/public sector leadership
- Lack of buy in/commitment from private sector/organizational leadership
- Lack of buy in/commitment from payers
- Lack of buy in/commitment from providers
- Lack of buy in/commitment from consumers
- Lack of representation of different sectors during planning
- Lack of funding for sustained efforts
- Gaps in technology
- Societal trends toward unhealthy lifestyles
- Confusion as to what healthcare transformation means
- Little to no incentive to change from providers or payers
- Costs (perceived or actual) of doing something differently
- Lack of communication between implementation partners
- Lack of alignment with ongoing work
- Other(s): _____

10. How optimistic are you in the likelihood of Delaware’s efforts to transform the healthcare system in the state? Please select one.

- I am **very optimistic** about Delaware’s efforts to transform healthcare
- I am **moderately optimistic** about Delaware’s efforts to transform healthcare
- I am **not at all optimistic** about Delaware’s efforts to transform healthcare
- I am **not sure or uncertain** about Delaware’s efforts to transform healthcare
- I am **not sure** that the health care system needs to be transformed

Please briefly explain why you selected your choice.



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11. In order to accelerate the transformation of Delaware’s healthcare system to one that delivers high-quality care at lower costs, improves provider experience, and leads to healthier citizens, several strategies have been suggested.

Below is a list of some of those strategies. Please rate the following using the scale provided as to the level of impact **you believe each element will have on transforming healthcare in Delaware**.

	<i>No Impact</i>						<i>High Impact</i>
a. Reimburse for keeping people healthy (pay for value).	1	2	3	4	5	6	7
b. Promote healthy lifestyles and wellness within communities and neighborhoods.	1	2	3	4	5	6	7
c. Educate and train a provider workforce based on future needs.	1	2	3	4	5	6	7
d. Measure patient outcomes and satisfaction through a set of comprehensive indicators.	1	2	3	4	5	6	7
e. Foster a culture of learning to drive innovation.	1	2	3	4	5	6	7
f. Make the patient the center of healthcare, not other stakeholders.	1	2	3	4	5	6	7
g. Strengthen primary health care access and preventative health care.	1	2	3	4	5	6	7
h. Improve the quality and affordability of health insurance coverage.	1	2	3	4	5	6	7

12. From the list above, which **strategy or combination of strategies** do you believe will have the **most significant impact** on transforming healthcare in Delaware:

Tell us why you believe this **strategy or combination** will have the greatest impact:

13. Many people are working on healthcare transformation across Delaware and you may interact with people working in different roles or positions within the healthcare system. From the list below, **select the role(s) of individuals with whom you discuss issues of health care transformation** (check all that apply).

- Consumer/Community Advocate
- Consumer/Patient
- Banking, Financial, and Investment
- Philanthropy
- Foundation/Research Organization representative
- Legislator
- Local/County Government representative

- Managed Care Plan representative
- Healthcare provider
- Clinic or Hospital representative
- State (DHSS) employee
- State (other) employee
- Higher education/Academia
- Private sector employer representative
- Insurance company/payer representative
- Other (please write in): _____

14. Finally, please share with us any additional information related to your experience with health care transformation in Delaware.

5.2. Appendix B: Participant Observation Guide

**Delaware State Innovation Model (SIM) Evaluation
Participant Observation Guide**

Name of Observer:		Date and Time:	
Meeting Location:		Meeting Purpose/Title:	

LOGISTICS		
# of Participants: _____	Names and designations of Committee Members	Notable names or individual profiles in the audience
Panel: _____		
Audience: _____		
<small>(This may include members of externally contracted organizations, community members, providers and health care administrators).</small>		
Meeting materials (e.g. agenda, PowerPoint presentation, reports, etc.) – attach if available:		
ENGAGEMENT		
Record observations related to level of participation and/or interest of committee members	<i>Prompts:</i> <ul style="list-style-type: none"> • Is the meeting interactive? Is everyone involved in discussion? • Role of the chair; relationship with committee members? Encouragement of full participation? • Role of staff? How is the audience involved? 	

	<ul style="list-style-type: none"> • Members appeared prepared for meeting? <p><i>Behaviors that may signify engagement or lack thereof:</i></p> <ul style="list-style-type: none"> • facial expressions, posture, gestures • statements about commitments, values • attitudes towards subject, others and self
DECISION-MAKING/PROBLEM-SOLVING	
<p>Record observations related to group dynamics, decision-making, conflict resolution, leadership and power relationships</p>	<p><i>Prompts:</i></p> <ul style="list-style-type: none"> • Interactions among committee members, with the chair, with the audience? • How are decisions made? • Are there areas of tension? • What is the general tone/climate of the discussion? • To what extent are different opinions expressed, valued, reconciled? <p><i>Types of interactions that may be observed:</i></p> <ul style="list-style-type: none"> • cooperation, mutual support, validation • flexibility, adaptability • discord, discomfort, lack of resolution • imbalances in power, influence
INFORMATION EXCHANGE	
<p>Record observations related to the ways in which information is delivered, received and utilized</p>	<p><i>Prompts:</i></p> <ul style="list-style-type: none"> • Is new information shared? How much redundancy? • Are committee members interested in information? Do they ask questions; appear to understand?

	<ul style="list-style-type: none"> • Types of information being shared? • Discussion of dissemination beyond meeting? • Evidence of feedback loop? Is new information integrated in planning and implementation? • Evidence of information exchange outside meetings? <p><i>Types of behaviors/interactions that may be observed:</i></p> <ul style="list-style-type: none"> • general climate of learning • skills and knowledge level • clarity of communication • use of aids and other teaching/learning techniques
ADDITIONAL NOTES	
	<p><i>Prompts:</i></p> <ul style="list-style-type: none"> • Did the discussion stay on track? Was facilitation effective? • Is implementation proceeding as expected? Were assigned tasks completed? • How is committee work/activities discussed in relation to overall SIM objectives? • Are discussions more strategic or operational? • To what extent are external conditions (barriers & opportunities) identified and addressed?

Methodological Comments – (After observation has concluded)

How did the process go? How useful was this guide?

Suggested Improvements:

Themes or connection with the evaluation questions

Any important dynamics of the program that the evaluation questions may not capture?

Any relevant information obtained during personal interaction with the participants?

Any specific individuals who may be approached for key informant interviews?

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