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DELAWARE

Delaware State Innovation Model (SIM) Final Report (2015-2019)

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DELAWARE HEALTH CARE COMMISSION

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Additional materials, tool kits, webinars, white papers, and reports developed throughout the SIM Grant can be found on the Choose Health Delaware webpage – https://www.choosehealthde.com/Road-to-Value/SIM-Grant-Resources

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Introduction

On January 31, 2019, the state of Delaware concluded its Federal grant under the State Innovation Model (SIM) program. SIM tests state governments' ability to use their policy and regulatory levers to accelerate health transformation. Delaware worked towards this goal by pursuing the Triple Aim Plus One – with the Plus One focused on provider satisfaction and engagement. Our SIM efforts will continue into strategic areas of sustainability that stemmed from testing and learning in key areas, including key opportunities to use data transparency and investments in primary care. Delaware's Health and Social Services "Road to Value" include seven strategic initiatives to help improve the quality of care and reduce the cost of health care in Delaware. These initiatives include: 1) accelerate payment-reform readiness; 2) establish cost and quality benchmarks; 3) strengthen primary care; 4) advance behavioral health integration; 5) establish a health care claims database; 6) advance and shift Healthy Neighborhoods work to a new entity; and 7) engage patients and consumers. These goals set the blueprint for change that health care institutions and providers will be working to implement as we move forward.

As Delaware continued to innovate in 2017 and 2018, we began the process of investing in provider readiness and preparedness for new payment models. This process has included stakeholder engagement, resource identification, policy and payment reforms that incentivize adoption, and other activities to ensure that we maintain and make further progress. We have explored state levers that will be useful to move towards total cost of care payment models, transformation under Medicaid, and new conversations with the health care spending and quality benchmarks. We feel strongly that the partnerships built, the progress made, and the lessons – good and bad – learned will help us be effective in continuing to move forward.

Our "End State" vision for Delaware is a health system that is transformed, endures beyond the SIM funding period, and is grounded in a commitment to the Triple Aim Plus One. We envision a system that has strong infrastructure supported by an effective governance structure and stakeholder engagement process, strong working partnerships across public and private entities, communities, businesses, employers, and payers, and a realistic, and reliable financing mechanism. Under this transformed system, the health care system and the community are experiencing the benefits of change. The state and its people move along a "healthier" trajectory in response to a health system that is better able to address the range of demographic, medical and social needs facing consumers that currently, drive high costs and poor health outcomes. These beneficial effects will be felt for generations to come. Specific elements of the future state include:

- **Payment reforms deployed**: Delaware payers – including the state's Medicaid, state employee health programs, and large commercial payer, Highmark – are aligning definitions and goals around quality and value. Providers are increasingly engaged in value-based payment models. The healthcare spending and quality benchmark activities and value-based purchasing in managed care contracting will continue post-SIM. Specifically, we will continue to build on the foundational work to pursue global hospital budgeting models, population-level payments, Medicaid ACO-arrangements, and transformational systems of care for our most vulnerable. The provider incentive structure has shifted from volume to value and facilitates a focus on population health management and innovative care delivery that offers Delawareans the right care in the right place at the right time.

- **Practice transformation has taken hold, with a continuing emphasis on behavioral health integration.** Providers continue to improve and to learn under a transformed system, and are supported through viable financial models, technical assistance activities, coaching, and learning collaboratives.

- **Population health management is a shared action agenda in Delaware's communities.** The Healthy Neighborhoods Initiative is thriving, and a backbone organization and Community Investment Council will play a critical role in driving the implementation of evidence-based programs to improve population health. The state also has reporting mechanisms for population health metrics to identify areas that require improvement and track positive outcomes when achieved.

- **A robust and transparent Health Information Technology (HIT) platform has been established.** Data, systems and expertise established and launched during SIM will support improvement through the data analysis and transparency.

In brief, our future vision is for a stronger Delaware with a well-earned reputation for tackling the challenges of transformation to achieve the Triple Aim Plus One. Our focused, collaborative efforts alongside Delawareans is crucial to ensuring future health care delivery transformations and making Delaware a beacon for success for other states to emulate.

This final SIM report provides a summary of Delaware's SIM activities by primary driver (payment reform, practice transformation, population health, and health information technology). These focus areas included and built on activities in workforce supports and reforms, stakeholder engagement and input, and infrastructure to ensure accountability. This report highlights major accomplishments and milestones that occurred during the entire cooperative agreement term. In addition, this report includes a discussion of project activities, analysis of the effectiveness/success of the project, lessons learned to date, and a description of project activities that will be continued and sustained.

Payment Reform

The long-term sustainability of Delaware's transformation goals and the Triple Aim Plus One is inextricably linked to the degree of payment reform and types of payment models that the health care industry of payers, providers and providers are willing to implement. The Delaware Department of Health and Social Services (DHSS) has made payment reform an on-going priority across award years, with a heightened focus on engaging providers to participate in payment reform efforts.

Accomplishments and Progress Made Through SIM

Award Year 1

As the Delaware Center for Health Innovation (DCHI) began to establish a footing in the SIM Grant, DCHI established the Payment Model Monitoring Committee comprised of payers, providers, and state leaders, to identify areas where the State can pursue value-based payment models. Successes of the committee throughout AY1 included:

- Secured commitments from major Commercial and Medicaid payers to adapt alternative payment models for primary care to align more than 75% with v2.0 Common Scorecard measures.
- Defined core design principles for outcomes-based payment and worked with major Commercial and Medicaid payers to gain adoption, with new models designed for rollout in Year 2.
- Began drafting a consensus paper that outlines 1) a vision for outcomes-based payment for population health management; 2) principles for payment model design and implementation; and 3) strategies to promote availability and adoption of outcomes-based payment models in accordance with these principles. The paper explains outcomes-based payment as one of three forms of support for primary care providers or larger systems or networks to achieve better integration and coordination of care and assume accountability for the health and health care of a population.
- Monitored provider adoption of the Medicare Shared Savings Program (MSSP), with Delaware now having five Medicare Accountable Care Organizations (ACOs) and being the first state with full participation in MSSP by all Medicare-participating hospitals in the state.

In addition, Delaware Medicaid and State Employee Benefits programs worked to incorporate the core elements of Delaware's approach to outcomes-based payment into their payment models being adopted by the Medicaid MCOs and State Employee Benefits third party administrators. Although no tangible steps towards payment reform models were accomplished in the first year of the SIM Grant, DCHI established a foundation to advance payment reform into the next three years.

Award Year 2

Award Year 2 of the SIM Grant, DCHI published the "Outcomes-Based Payment for Population Health Management" consensus paper[1] which discussed payment model opportunities in total cost of care and pay-for-performance. The consensus paper included core beliefs of their Payment Model Monitoring Committee and their strategies for promoting payment model adoption.

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[1] Outcomes-Based Payment for Population Health Management, Delaware Center for Health Innovation (DCHI). February 2016. Available at: https://pages.dehealthinnovation.org/outcome-based-payment-for-population-health-management

Delaware's payer community also enhanced its role in accelerating the adoption of value-based payment models. Highmark launched its pay-for-value model, True Performance, to a small number of Medicaid providers (14 throughout the state) on July 1, 2016. This pilot included approximately 10,000 beneficiaries and gave SIM leadership and these providers an opportunity to preview how the model would function once made available to practices statewide. Highmark began initial outreach to primary care providers regarding its True Performance Model in Q2 and began contracting in Q3. United Healthcare began enrolling primary care providers in its Basic Quality Model and Accountable Care Shared Savings (ACSS) model during AY2.

Award Year 3

To spur the advancement of value-based payment models in the state, the Medicaid MCO procurement process in AY3 required more aggressive approaches to risk sharing at the provider level from the two MCOs selected. Moreover, in AY3, under the new administration led by Governor John Carney, DHSS Secretary Dr. Kara Odom Walker published the "Road to Value" outlining the interconnected strategies designed to transform health care and improve health in Delaware. The Road to Value includes seven strategic initiatives to help improve the quality of care and reduce the cost of health care in Delaware. These initiatives include: 1) accelerate payment-reform readiness; 2) establish cost and quality benchmarks; 3) strengthen primary care; 4) advance behavioral health integration; 5) establish a health care claims database; 6) advance and shift Healthy Neighborhoods work to a new entity; and 7) engage patients and consumers. These goals set the blueprint for change that health care institutions and providers will be working to implement as we move forward.

These strategies fully aligned with the goals of SIM, yet also marked a change in leadership and the refocusing of efforts on the creation of statewide cost and quality benchmarks and movement away from the provider-based Common Scorecard. At the halfway mark when the Carney Administration came on board, an examination of SIM progress to date highlighted the large gap between the goal of value-based health care payment models and the capacity of Delaware providers to bear risk and manage to the total cost of care. At the direct guidance from the Centers for Medicare and Medicaid Innovation, Delaware was encouraged to make greater progress in value-based payment reform efforts. Delaware took a close look at readiness for payment reform and reoriented towards opportunities to accelerate practice transformation.

Award Year 4

Health Care Spending and Quality Benchmark

A major achievement during SIM AY 4 was the development and launch of the health care spending and quality benchmarks. This tool will help the state get a handle on the cost and quality of Delaware's health care system and serve as a beacon in our efforts to understand and manage the total costs of care across populations, communities, and payers.

The SIM investments in Benchmark activity will create a transparent lever across all payers and large providers to engage in payment reform activities to keep the growth of spending at a sustainable level and improve quality. As we have seen in Massachusetts, their benchmark activity has driven quality improvement and cost containment. As described in Executive Order 25, signed into effect in November of 2018, the Delaware Health Care Commission (HCC) will have primary responsibility for measuring the performance of the state's providers and payers against cost and quality benchmarks. Cost and quality benchmarks have been set for 2019, and an Implementation Manual has been developed that clarifies the methodology for measuring performance and setting benchmarks in the future. The manual lays out

the technical steps to implement the benchmarks and provides a road map for the important activities that will be occurring in the future.[2] DHSS is excited to help champion the implementation of the benchmarks, along with state partner, the Delaware Economic and Financial Advisory Council. While the manual represents a significant achievement, much work is yet to come to operationalize fully the benchmark data collection and public reporting process. Working together, we can support the goal of making sure Delawareans can access and afford quality health care. The benchmarks are the start to a conversation about how to improve cost and quality for the individuals we serve as patients and members in our communities.

Medicaid Managed Care Contracts

In AY 4, Delaware had four Medicare Accountable Care Organizations (ACOs) in various phases of deployment. The state also deployed a Medicaid managed care contract that will drive value-based payment reforms. Within that context, Medicaid is working to determine the most successful means to propagate ACOs in Medicaid. The state's Medicaid managed care organization (MCO) contracts launched new contracting levers that started in January 2018. The initiative stemmed from a lack of stakeholder consensus on contracting strategies that now allows for multiple pathways to engage in value-based conversations. The MCO contract approach has two key parts: quality performance measures and value-based purchasing strategies. Through quality performance measures, Medicaid will select measures that relate to the following: quality, access, utilization, long-term services and supports, provider participation, spending and/or member/provider satisfaction. Key measures build on the Common Scorecard created in collaboration with the SIM Award and through the Delaware Center for Health Innovation's work. In the three years of this contract, seven key measures will be monitored including management of diabetes cases, asthma management, cervical cancer screening, breast cancer screening, obesity management, timeliness of prenatal care and 30- day hospital readmission rates.

These measures also will be tied to desired performance levels, with potential penalties being imposed if performance levels are not achieved. Through the value-based purchasing strategies, the managed care organizations will be required to implement provider payment and contracting strategies that promote value over volume and reach minimum payment threshold levels. If minimum threshold levels are not met, potential penalties could be imposed.

The Division of Medicaid and Medical Assistance (DMMA) released a Request for Information (RFI) to explore the viability and approach to Accountable Care Organizations (ACOs) that best fits Delaware Medicaid. Delaware is currently reviewing those responses in the second quarter of 2019 to evaluate how the state may pursue a formal request for proposals for Medicaid ACOs. The state may pursue a formal request for proposals.

Centers of Excellence Model

Additionally, in AY4 based on the direction of the State Employee Benefits Committee (SEBC), the State Employee Benefits Office completed a RFP and launched a new bundled payment model referred to as the Centers of Excellence model for the upcoming 2020 benefits year. The Centers of Excellence allows the state to help patients navigate high quality and significantly lower cost sites of care for a range of elective procedures. Additionally, through steerage and co-pay design, the SEBC is exploring other

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[2] Delaware Health Care Spending and Quality Benchmarks Implementation Manual Version 1.1
https://dhss.delaware.gov/dhss/files/benchmarkmanual041619.pdf

activities that will lower costs for covered procedures and services. Another example of the ongoing collaboration between DHSS and the State Benefits Office has also led to an ongoing exploration around joint drug purchasing and contract opportunities with some external support from the National Academy of State Health Policy. This arc of reform for our public payers will continue in 2019 and beyond.

Value-Based Payment Reform Mini-Grants

In AY4, DHSS launched 11 total pilot projects across ten provider organizations, with over $1 million SIM funding to test out and implement rapid, focused reforms. There were 48 entities from across the state that applied for these grants. The 11 pilot programs launched will serve as learning labs for other providers. We selected these grantees not just for the quality of their proposals, but also to have them serve as guides for other providers and payers about what works and what can be obtained with investment in provider-led innovations. Many of the grantees were able to report successful workflows and progress that should lead to sustainable outcomes. Grantees were enthusiastic about implementing long-standing ideas and they are excited to monitor outcomes going forward beyond the grant period. Of note, some of the readiness to engage in a Medicaid ACO, global hospital budgeting or population level-alternative payment models were built into the foundation of these successfully executed mini-grants.

The eleven projects that were granted through these SIM Grant investments are listed below (details related to these initiatives can be found in the Payment Reform Mini Grant Final Report[3]).
- Data Integration (Brandywine Counseling and Community Services)
- CareLink Behavioral Health Medical Home Pilot (Christiana Care Health Services, Inc.)
- Behavioral Network Evaluation (Connections)
- Cost of Care Analytics Tool (Delaware Health Net, Inc.)
- Alternative Payment Model (Mid-Atlantic Behavioral Health)
- EMR Vendor Fees for Speedy Data Integration (MedNet of Delaware)
- Global Budgeting Study (Nanticoke Memorial Hospital)
- Preparing for Value and Risk (Nemours Children's Health System)
- Admissions Reductions ER – Hospital (Stoney Batter Family Medicine)
- AllScripts EHR System (Stoney Batter Family Medicine)
- Population Health Software Platform (Westside Family Healthcare)

Lessons Learned

As the state was successful on many endeavors throughout the duration of SIM, Delaware also gained a multitude of knowledge throughout the grant period. Providers are willing to adopt new methods of practice, leading to improved integration and therefore quality, but only if payment models are adapted to help stand up, reward, and sustain these changes. To accomplish this requires:
- Proactive efforts to explore and implement new payment models
- Dialogue between payers and providers to align incentives with expected outcomes
- Cooperation among payers (i.e., MCOs) to align models with provider capacities.

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[3] Appendix 2: Payment Reform Readiness Grants Final Report, Health Management Associates (HMA), January 2019

During SIM, we encountered multiple challenges in alignment between payers (public programs and private sector-based efforts) and will continue to ensure that providers and payers move forward together.

Post-SIM

Governor Carney and his executive team have recognized the need for and consistently pressed forward on a payment reform agenda. Working with the legislature and with many stakeholders, state agencies must continue to drive reforms and focus on reducing the costs of care while sustaining and improving the quality of outcomes and overall health. Without new models of payment, other goals of practice transformation and population health will not thrive. Efforts to forward new payment models will lead to the continued spread of value-based payment and collaboration among private and public entities. Furthermore, reform efforts must include more and better analytics and reporting to mark our progress and hold ourselves accountable.

Sustainability Report (Appendix 1)

Please refer to the Delaware SIM Sustainability Plan for additional information regarding Post-SIM activities surrounding Payment Reform.

Practice Transformation

Throughout the duration of the SIM Model Test Grant, the engagement of healthcare providers has been critical to the success of achieving the goals of SIM. Transformation of healthcare providers and their teams at their individual practices is a building block for sustainment of healthcare delivery system transformation

Accomplishments and Progress Made Through SIM

Award Year 1

In the first year of Delaware's SIM Grant, the primary focus of the DCHI Clinical Committee was to accelerate adoption of value-based delivery models and to support providers to transform the way care is delivered for their patients. AY1 work focused on designing and launching various initiatives to enable that transformation.

The HCC issued a Request for Information (RFI) on practice transformation to inform the development of a consensus paper on Primary Care Practice Transformation, through which the DCHI Clinical Committee defined priorities for value-based delivery models. The HCC then released a Request for Proposal (RFP) to procure practice transformation vendors. The HCC selected and contracted with four vendors to conduct assessments, develop a curriculum for each practice based on needs, and complete semi-annual assessments against milestones for each practice site engaged in the initiative.

To support the vendors and encourage enrollment by practices across the state, the HCC, with input from the DCHI Clinical Committee, launched a communications campaign and hosted several informational meetings with ACOs, CINs, professional societies, and primary care practices.

Common Scorecard 2.0

Throughout AY1, the DCHI Clinical Committee led a consensus-based process for selecting the initial set of measures for Delaware's Common Provider Scorecard. In addition to selecting the measures, the committee conducted outreach to a diverse set of practices in order to test and gather feedback on the scorecard, which was critical for finalizing the requirement for version 2.0 of the Common Scorecard. The DCHI Clinical Committee also published consensus papers on care coordination4 and the integration of behavioral health and primary care5, which helped to prepare Delaware for implementation in AY2.

Award Year 2

Practice Transformation Support Services

Support of practice transformation activities continued and expanded in AY2, with 104 practices (351 providers) enrolling in practice transformation support services. The HCC redesigned the practice transformation vendor data reporting tools and developed a system by which to evaluate practice progress toward achieving the milestones identified by the DCHI Clinical Committee in Year 1. The Monthly Progress Reporting Tool (MPRT), allowed the HCC to monitor progress toward milestones

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[4] Care Coordination as an Extension of Primary Care, Delaware Center for Health Innovation (DCHI). January 2016. Available at: http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-Care-Coordination.pdf

[5] Integration of Behavioral Health and Primary Care, Delaware Center for Health Innovation (DCHI). January 2016. Available at: http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Consensus-Paper-Behavioral-Health-Primary-Care-Integration.pdf

through monthly average practice scores (APSs) and identify priority areas where expanded training was needed. Enrolled practices demonstrated measurable progress toward each of the nine milestones from September 2016, when the MPRT was launched, through January 2017.

Behavioral Health Integration Implementation Plan

During AY2, the DCHI Clinical Committee authored the Behavioral Health Integration (BHI) Implementation Plan, which identified the following elements for the BHI program: self-directed resources, data and reporting support, advisory group, training, infrastructure and technical assistance, outcomes (clinical) payment, and vendor performance management (process).

Common Scorecard 2.0

Following testing with 21 providers in AY1, version 2.0 of the Common Scorecard was released to primary care practices statewide in Q3 of AY2.

Behavioral Health Electronic Medical Records (EMR) Assistance Program

The HCC also released two rounds of an RFP for the Behavioral Health Electronic Medical Records (EMR) Assistance Program, which provided funding for BH providers who needed to implement or upgrade their EMR system. Since these RFPs were released in the second half of the year, activities carried over into Year 3.

Award Year 3

Practice Transformation Initiative

Throughout AY3, the number of practices and providers enrolled in Practice Transformation remained stable and represented over one-third of Delaware's primary care physicians. Participating practices made significant progress against practice transformation milestones, as measured by monthly APSs. Enrolled practices collectively scored highest on the following milestones: provide same-day appointments and/or extended access to care; document plan to reduce emergency room utilization); implement a process of following-up after patient hospital discharge. Practices made significant progress from the start to the end of the year, as measured by the percentage change in scores from February 2017 to January 2018.[6]

At the conclusion of the formal practice transformation technical assistance, two roundtable discussions (consumer and provider) were conducted. These discussions served to highlight the need for further focused efforts in primary care reform, ultimately tying in to the legislatively established Primary Care Collaborative in AY4.

Behavioral Health Integration

In AY3, the HCC took steps to create the Behavioral Health Integration (BHI) initiative, which officially launched a pilot program in November of 2017. In order to prepare for the launch to providers, the team met with and presented to state leaders, delivery systems leaders for primary care, behavioral health, and HIT to create a good will about the BHI and to encourage providers to fully participate in the BHI pilot program. The program was intended to test three integration models, which reflect practice options along the continuum of behavioral health and primary care integration, to inform further statewide implementation. At the end of AY3, the BHI pilot program was established and the HCC

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[6] Appendix 3: Practice Transformation Summary

brought in a team of expert consultants to work directly with the practices in the final months of AY3 into AY4.

Award Year 4

Behavioral Health Integration

In AY4, the BHI pilot program was divided into two cohorts of practices, each receiving technical assistance over a six-month period. The first cohort ran from January to June 2018 and the second from July 2018 to December 2018, with the first cohort of practices continuing in the second six-month period for a complete year of coaching. In total, 22 primary care and behavioral health practices participated across the two cohort periods.

Implementation of the BHI pilot program involved comprehensive, multi-faceted assessment, training, and coaching for participating practices, including face-to-face group training collaboratives and facilitated sharing sessions, virtual education and networking, and individualized practice coaching. Each practice received a dyad of coaches who had experience in working in primary care and/or behavioral health settings and knowledge relevant to the practice's selected integration model track. Practices also had access to subject matter experts related to components of integrated care who were available as needed.

In early 2018, HMA developed a patient registry for use as part of the BHI pilot program. The goal with this registry was to deploy a low-cost, effective tool that would align with the overall goals of the BHI pilot program to help primary care and behavioral health providers in Delaware record, track, and monitor care. HMA demonstrated the registry through several learning sessions during both cohort periods. In addition, HMA practice coaches encouraged individual practices to adopt use of the registry. Each practice received an adjusted registry to better suit their needs.

Additionally, Health Management Associates (HMA) engaged with payers and providers surrounding the adoption of payment models, CPT codes, and programs to adopt that would reimburse for behavioral health integration activities. These conversations have begun to peak payers interests in paying for such activities, but will need to continue beyond the SIM Grant.

A comprehensive evaluation[7] to objectively analyze the effectiveness of pilot implementation and BHI technical assistance showed that practices made substantial progress in every area assessed over the BHI pilot program period. Despite significant success, practices still have transformation needs to achieve the level of integration of their chosen track, and ongoing support is needed for sustainability of BHI.

Primary Care Collaborative

Late in the SIM cycle, the state legislature formed the Primary Care Collaborative to explore the current challenges facing Delaware's primary care workforce and to offer pathways for improvement to strengthen primary care in Delaware. This was an opportunity to build off earlier SIM experiences in practice transformation and workforce and further refine the road ahead. Using SIM resources and expertise, Delaware is supporting the work of a legislatively formed group to explore payment and practice reforms that will improve primary care across the state. The Collaborative will recommend

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[7] Appendix 4: Behavioral Health Integration Pilot Program Final Report, Health Management Associates (HMA), January 2019 (Appendix 4.1, 4.2, 4.3 additional references)

strategies the state can adopt to maintain and improve access to primary care, specifically addressing the sustainability of primary care practices to ensure that current providers remain in practice and new providers enter primary care. The strategies being researched and considered include increases in reimbursement, adoption of new value-based payment models, and direct investment in providers, practices, and technology.[8]

Telehealth Learning Lab

HCC hosted a seven-part Telehealth Learning Lab Webinar Series, with follow-up office hours provided upon request by participants. A team of telehealth experts from HMA led the content development and presented the series, with valuable contributions from Delaware-based providers and stakeholders. The HCC and HMA collaborated to promote the Learning Lab to all providers throughout the state, with an emphasis on those providers already involved with SIM practice transformation activities.[9]

Federally Qualified Health Centers (FQHCs) Alternative Payment Models

Leadership of three Delaware Federally Qualified Health Centers (FQHCs) – Westside Family Healthcare, Henrietta Johnson Medical Center, and La Red Health Center – expressed an interest in Alternative Payment Models. Two models of value-based payments were discussed; 1) a capitated approach to Prospective Payment System (PPS); and 2) Medicaid shared savings on total cost of care. The FQHCs engaged in these discussions pursued further discussions with DHSS leadership, Dr. Kara Odom-Walker (Secretary, DHSS), Stephen Groff (Director, DMMA), and Dr. Elizabeth Brown (Medical Director, DMMA), who will continue to research and consider various alternative payment models for provider groups, not limited to FQHCs. We look forward to the ongoing exploration and model development efforts in partnership with the FQHCs in our state.

Lessons Learned

As noted, there is a considerable gap between the capacity of providers to bear risk for costs of care and the need for getting a firm grip on Delaware's total cost of care. Providers are willing to adopt new methods of practice, leading to improved integration and therefore quality, however, if payment models are not adapted to reward these behaviors, there is no incentive for them to change. Additionally, for many providers securing up-front funding to make the necessary changes to accept value-based payments will be the difference between embarking on the Road to Value (RTV) or staying mired in fee-for-service. There needs to be ongoing engagement among providers, payers and the state to keep progressing toward RTV future state.

Post-SIM

Behavioral Health Integration

The evaluative components of the BHI project form a comprehensive assessment of challenges, successes, and lessons learned, and inform some key considerations for the state in providing the support needed to sustain ongoing BHI transformation and spread in Delaware. Partnership development, establishing measurement-based care, building organizational capacity, and supporting financial viability are critical components of BHI that would benefit from ongoing state-level support and prioritization. In addition, considerations in these critical areas, taken more broadly, also hold important

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[8] Primary Care Collaborative Report 2019, https://dhss.delaware.gov/dhss/dhcc/files/collabrpt_jan2019.pdf
[9] Appendix 5: Telehealth Learning Lab Webinar Series Summary, Health Management Associates (HMA), January 2019.

takeaways for other statewide integration efforts, and could be applied as relevant within those contexts (e.g., in efforts to integrate SUD treatment into primary care related to opioid use).
- Develop Partnerships to Support Integration
- Embrace Measurement-Based Care
- Build Organizational Capacity to Perform Integrated Care
- Develop Methods to Support Financial Viability

Primary Care Collaborative

As the Primary Care Collaborative was established through the Delaware General Assembly with the passage of SB 227, the work of the Collaborative will continue into the foreseeable future. The work will continue to inform policy formulation related to health care payment and practice advancement across the State of Delaware. With the enactment of SB 227, annual reporting to the HCC will include:
- Monitor spending on primary care
- Measure progress on transitioning from fee-for-service to value-based payment for health care services
- Provide oversight for health care workforce development in the state
- Evaluate how primary care supports state efforts on meeting its benchmark for controlling health care spending

Federally Qualified Health Centers (FQHCs) Alternative Payment Models

DHSS leadership was engaged in alternative payment model discussions with leadership from three FQHCs in Delaware (Westside Family Healthcare, Henrietta Johnson Medical Center, and La Red Health Canter). Two models of value-based payments were discussed: 1) a capitated approach to Prospective Payment System (PPS); and 2) Medicaid shared savings on total cost of care. DHSS will continue to research and consider various alternative payment models for provider groups, not limited to FQHCs.

Sustainability Report (Appendix 1)

Please refer to the Delaware SIM Sustainability Plan for additional information regarding post-SIM activities surrounding Practice Transformation.

Population Health

From almost day one, population health improvement through community engagement was an important part of SIM. Early on, stakeholders gathered to discuss possible ways to address these issues. This built strong engagement, it was not until action agendas and targeted grants were made available that significant progress was made. Communities created partnership agreements, and selected priority areas of need. Using evidence and technical assistance available through SIM, they applied to implement programs that would address specific challenges each community faced. These grants funded a wide-ranging set of activities, but all with the intent and capacity to improve select population health metrics. Simultaneous to these Healthy Neighborhood demonstration grants, the SIM team sought a more lasting solution—one that would continue to support community-level action and innovation beyond SIM. This effort to recruit possible funders, identify thought leaders and get stakeholder input on the future of this effort culminated in the launch of Healthy Communities Delaware. Potential funders, public health leaders, academia and local community coalitions will work together to perpetuate population health interventions.

The HCC worked with the Delaware Division of Public Health to generate a data repository that will help guide and evaluate population health initiatives. The Population Health Scorecard will provide communities with an understanding of their challenges and contributing factors. This will assist them in targeting initiatives that will reduce the cost of care and improve health outcomes. The Scorecard can also track progress over time and may align with the cost and quality Benchmark effort in future iterations.

Accomplishments and Progress Made Through SIM

Award Year 1

Population health improvement was a critical component of Delaware's SIM Grant initiatives from the beginning. Throughout AY1, DCHI planned the structure/operating model to implement the Healthy Neighborhoods initiative across the state.10 At the conclusion of AY1, the DCHI Healthy Neighborhoods Committee had established the boundaries for ten Healthy Neighborhoods across the three Delaware counties.

Award Year 2

In the second year of Delaware's SIM Grant, DCHI worked alongside community partners to initiate the work of two of ten Healthy Neighborhood Local Councils.

Award Year 3

In 2017, Governor John Carney took office, bringing changes to policy priorities midway through the SIM grant. Later in 2017 the HCC contracted with HMA to provide technical assistance related to population health improvement, among other activities. HMA began its contracted work by reviewing the work completed in AY1 and AY2, looking for efficiencies and areas where improvement could be made. Through the last quarter of AY3, HMA conducted a multitude of stakeholder engagement activities to gain a full understanding of the current environment. As the engagement progressed, HMA began to

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[10] Healthy Neighborhoods Operating Model, Delaware Center for Health Innovation (DCHI). September 2015. https://cdn2.hubspot.net/hubfs/2609556/Resources/Healthy%20Neighborhoods/DCHI-Healthy-Neighborhoods-Operating-Model.pdf

revise the Healthy Neighborhoods structure and model to ensure greater success and implementation of local initiatives.

By the conclusion of AY3, HMA had worked alongside community stakeholders and organizers, establishing three Healthy Neighborhood Local Councils (Wilmington/Claymont, Dover/Smyrna, Sussex County Health Coalition) and subsequent Healthy Neighborhood Task Forces.

Award Year 4

Healthy Neighborhoods

In the final year of Delaware's SIM grant, population health improvement activities on the local level continued to be funded and implemented through Healthy Neighborhoods grants. Over the course of AY4, ten Healthy Neighborhoods grants were awarded (below – details related to these initiatives can be found in the Healthy Neighborhoods Final Report[11]).

- Dover/Smyrna
  - o Dover Open Streets
  - o Homeless Engagement Initiative
  - o Community Health Worker for Domestic Violence Initiative
  - o Kent County Policy Connections Alliance
- Wilmington/Claymont
  - o Community Health Worker for Domestic Violence Initiative
  - o Peer Recovery Specialists
- Sussex County
  - o Botvin Lifeskills Training
  - o School-Based Mental Health Services

In addition to the implementation of the local initiatives, there was a strong focus towards sustaining such initiatives into the future. The University of Delaware (UD), the Delaware Division of Public Health (DPH), and the HCC, with assistance from HMA, developed the Healthy Communities Delaware model to enhance the successes of Healthy Neighborhoods throughout the SIM Grant. Additionally, more critically, UD and DPH have worked to engage even more stakeholders, opening more opportunities to fund and implement local population health improvement initiatives.

Population Health Scorecard

In AY4, DPH developed an innovative software platform *My Healthy Community* to deliver neighborhood-focused public health information to the public. The Population Health Scorecard will provide communities with an understanding of their challenges and contributing factors. This will assist them in targeting initiatives that will reduce the cost of care and improve health outcomes. The Scorecard data will be presented about local neighborhoods throughout Delaware, as well as aggregated to town, county and state geographic resolutions. Using this platform, metrics evaluating the success of the Healthy Neighborhoods initiative, and further the recent efforts to ensure evidence-based initiatives will be presented. The Scorecard can also track progress over time and may align with the cost and quality benchmark effort in future iterations.

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[11] Appendix 6: Healthy Neighborhoods Final Report, Health Management Associates (HMA), January 2019.

Lessons Learned

Local leaders are committed to implementing programs that will improve population health, but this commitment is not enough. It takes considerable effort to effectively implement evidence-based interventions. Furthermore, possible funders are not aligned well with these local coalitions or struggle to ensure their investments are effective. Linking passionate local leaders with consolidated funding opportunities and then supporting implementation, will ensure continued success of the grassroot initiatives and create a lasting impact on communities across Delaware. Healthy Communities Delaware is a formidable infrastructure to continue these discussions and engagements on all levels. Additionally, the infrastructure now in place will enhance the ability to identify funders whose priorities are aligned with those of the local coalitions to ensure their investments are effective.

Post-SIM

Although challenges were identified during Healthy Neighborhoods implementation, local stakeholders have an opportunity to learn from these identified issues moving into Healthy Communities Delaware, supporting the creation of a sustainable infrastructure that is supportive of community-driven initiatives focused on collectively improving population health. What is evident from Healthy Neighborhoods is the commitment, expertise, and passion Delawareans bring to this work, which, if aligned, will ultimately result in improved health outcomes and reduced health disparities across the state.

Sustainability Report (Appendix 1)

Please refer to the Delaware SIM Sustainability Plan for additional information regarding Post-SIM activities surrounding Population Health.

Health Information Technology (HIT)

Accomplishments and Progress Made Through SIM

Award Year 1

The SIM team met with various stakeholders to assess the current state of technology and understand stakeholder plans and priorities. This provided input into a comprehensive HIT roadmap, outlining the elements necessary to support statewide health transformation. Examples of roadmap elements include:

- Establishing a multi-payer claims database
- Increasing clinical data submissions
- Providing consumer access to their health records
- Expanding event notification

Work began in AY1 to develop a Provider Common Scorecard and piloted the scorecard to 21 practice sites representing roughly 120 providers.

Award Year 2

Health Care Claims Database

The DCHI Payment Model Monitoring Committee spent a significant amount of time early in AY2 focused on developing a perspective on increasing access to claims data to support health innovation. The Committee formed a Transparency Working Group (TWG), comprised of a diverse group of payers, providers, community members, and policy makers, to conduct extensive research utilizing resources from the APCD Council and perform an analysis of the Delaware landscape. This research was compiled into a white paper that was shared broadly with stakeholders for feedback. The white paper was used as input into the development of legislation for a multi-payer claims database in Delaware.

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

Common Scorecard Version 2.0

Version 2.0 of the Provider Common Scorecard, including data from Highmark Commercial and United Medical, as well as patient attribution at the panel level and individual measure level, was released for initial testing in Q2. There were multiple challenges encountered in preparation for operationalizing v2.0 including differences between payer reporting systems, establishment of data sharing agreements, improving data quality, and improving presentation of measure results.

Following release to the testing practices, the team prepared for the release of the Common Scorecard to primary care practices statewide in Q3. New functionality added included statewide aggregation of quality and utilization measures, comparison of measure performance against statewide goals and benchmarks developed with DCHI, and improved chart display for quality and utilization measures. Again, the technical team encountered many challenges in order to ensure payer data submissions adhered to high quality standards.

The DHIN technical team and HCC leadership explored adding display of Practice Transformation milestones into the Common Scorecard, but ultimately did not pursue due to technical complexity and costs. Work continued in preparation for Release 4 while DHIN, HCC, and the DCHI Clinical Committee began to assess the options for updating measures annually. The DCHI Board continued to discuss the path forward for the Common Scorecard as questions remain regarding its long-term use and sustainability.

Award Year 3

Provider Common Scorecard

In AY3, the HCC continued to support the Common Scorecard production of quarterly results that were made available to practices who logged in to a secure portal and saw their results on the measures relative to the results of other practices in the state. However, as the HCC consulted with DHIN and stakeholders, it became clear that there was insufficient engagement by practices with the measures to sustain. As a result, in AY4, the HCC changed the focus on public reporting to state-level results versus provider or practice-level results, and creating a more sustainable, less costly approach to producing the Scorecard with DHIN. Moreover, a formal benchmark introduced by Governor Carney and Secretary Walker planned to incorporate 2-5 quality metrics to be tracked along with the year over year increase in per-capita spending.

Health Care Claims Database (HCCD)

In AY3, DHIN promulgated two rules necessary for the reporting of and access to data that will be housed in the HCCD. In addition, DHIN and the HCC partnered to request Medicare data through the Research Data Assistance Center (ResDAC). Using SIM support, Freedman Healthcare assessed the level of resources needed to support ongoing operations of the HCCD. This assessment lays out the level of effort and resources required for DHIN across all tasks, without and with support from Freedman Healthcare.

Award Year 4

SIM made several investments in HIT throughout the grant period, working with DHIN on different projects, primarily focusing on the HCCD. Most recently, SIM supported the final steps toward the launch of the HCCD and technical assistance on data collection and alternative funding sources. The SIM grant also supported the development of HCCD data sharing agreements with state agencies which will allow broader access to the data stored within the database.

Lessons Learned

DHIN is an essential partner to the state in the sustainability and advancement of many payment reform and practice transformation initiatives. Establishing governance, concrete deliverables, and agreements between DHIN and state agencies are necessary for the state to ensure that progress continues, and expectations are met.

Throughout the SIM grant, it has become evident that there is a reluctance for providers to connect with DHIN. For providers to engage, there needs to be proven value to them and access to actionable data. In several legislative actions, the Delaware General Assembly has sought to stimulate the development and deployment of a multi-payer HCCD. These included encouraging public and private payers to send data to DHIN for this purpose.

Post-SIM

When fully functional, the HCCD could be an important resource to several transformation efforts, but also a potentially useful tool among plans, providers, and researchers as to the wellbeing of the Delaware health system and evidence of where focus is needed to drive improvement.

DHIN will continue to promote, establish interfaces, and onboard practices to its Health Information Exchange services, including the Community Health Record, Hospital and ED alerts, Clinical Gateway, and results delivery, as well as others.

Sustainability Report (Appendix 1)

Please refer to the Delaware SIM Sustainability Plan for additional information regarding Post-SIM activities surrounding HIT.

FINAL SIM EXPENDITURES

Category of Investment	Examples of state strategies	Total dollar amount	% of SIM budget
1. Delivery System Transformation	Practice Transformation Program	$8,824,093.11	25.21%
2. Payment Models	Value-Based Payment Reform Mini-Grants, Cost and Quality Benchmarks, Medicaid RFI, Medicaid MCOs Value-Based Contracts, Centers of Excellence Model	$7,409,150.99	21.17%
3. Health IT and Data Analytics	HCCD	$5,548,234.81	15.85%
4. Population Health	Healthy Neighborhoods Initiative, Population Health Scorecard	$3,644,879.08	10.41%
5. Project Management and/or Operations	Consulting firms (ex. Health Management Associates and Mercer), HCC personnel	$3,764,683.53	10.76%
6. Evaluation	SIM state evaluators (Concept Systems, Inc.)	$742,308.03	2.12%
7. Other (state defined): Patient/ Consumer and Workforce/Education	Engage and train the workforce around health care improvements and workforce supports into technical assistance activity	$2,162,884.90	6.18%
8. Unspent funds (if applicable)		$2,903,765.55	8.30%
Sum*		**$35,000,000.00**	**100%**