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Centers for Medicare & Medicaid Services

State Innovation Model Progress Report

Award Detail

Award Title	Delaware:Test R2	**Round**	2
Organization Name	Delaware	**Grants Management Specialist**	Gabriel Nah
Type	Test	**Project Officer**	Katie Shannahan
Total Funding Amount	$35,000,000.00		
Description	Delaware will: (1) support ten community-based population health programs (Health Communities); (2) develop an IT infrastructure to support a cross-payer scorecard of core measures available to providers with related tools for patient engagement and price and quality transparency; and (3) engage payers in the development of a pay-for-value model and a total-cost-of-care model for providers (including independent PCPs), with the goal of attributing all Delawareans to a primary care provider during the performance period. In addition, the state will offer technical assistance to providers focusing on models of integrated, team-based care and transition to value-based payment models. Delaware will implement workforce development strategies to build competencies and address the current workforce and will also develop educational programs to address the needs of model participants.		

Progress Report

Progress Report	Q3 - 2016 Progress Report	**Award Title**	Delaware:Test R2
Report Quarter	Q3	**Date Submitted**	11/30/2016
Report Year	2016	**Approval Status**	Approved

Date Approved	1/11/2017	**Last Modified By**	Katie Shannahan

WBS Not Applicable ☐

Executive Summary

Success Story or Best Practice

Q3 brought an acceleration in the adoption of value-based payment models among providers in the state. With the introduction of new value based payment models catering to new types of providers (United's extension to pediatric and quality shared savings and Highmark's True Performance for Medicaid and commercial), Delaware currently has more than 30% adoption of value-based payment for primary care, meaning that more than 30% of Medicare, Medicaid, and Commercially insured populations in Delaware are attributed to primary care providers under value-based contracts. While these efforts have been directly led by individual payers and the providers with whom they contract, DCHI has played a meaningful role in accelerating the pace of adoption in Delaware through active and consistent engagement with the state's main payers. With active contracting underway from the state's MCOs and commercial payers, there is potential to surpass 50% penetration in the coming months.

DCHI has promoted value-based payment adoption by holding bi-weekly, monthly and quarterly meetings with payers (frequency/cadence varies by payer, attendees and agenda), during which payers provide current enrollment numbers for value-based payment models, as well as a qualitative update on partnerships in progress. DCHI uses these meetings to reiterate mutually defined enrollment goals and encourage continued progress towards more advanced value-based payment models. This reporting mechanism is in addition to quarterly enrollment reporting for CMMI. In addition, DCHI and DMMA regularly share information on program enrollment to facilitate a coordinated approach to monitoring.

Challenges Encountered & Plan to Address

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

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

Governance

In Q3, DCHI filled a vacant board position by adding Dr. Steven Kushner, D.O. who represents practicing physicians. Dr. Kushner is employed by Christiana Care Health System’s Department of Family and Community Medicine and serves as Preceptor to the Department of Family and Community Medicine at Christiana Care Health System. A graduate of Swarthmore College in Swarthmore, PA, Kushner completed his medical training at the Philadelphia College of Osteopathic Medicine in Philadelphia. Dr. Kushner completed his residency in Family Medicine at the former Medical Center of Delaware, now Christiana Care Health System in Newark, Delaware. Dr. Kushner has a particular interest in advancing the interests of family medicine. He is a Past President of the Medical Society of Delaware and has served as President of the Delaware Academy of Family Medicine and President of the New Castle County Medical Society.

Starting in Q2 and continuing in Q3, the DCHI board, with support from SIM-funded consultants, engaged in a process to define a short-term and longer-term strategic plan for the organization. During Q3, consultants conducted 30 interviews with stakeholders from across the state. These interviews were a key element in identifying areas of consensus as well as opportunities and challenges that the organization will face. The consultants also conducted two strategic workshops with board members that were designed to allow small group discussion and problem solving to define the path forward for the organization. The first draft of the strategic plan document was provided to Board members in October, with adoption/finalization planned for Q4.

Stakeholder Engagement

DCHI remains committed to providing support to primary care practices throughout Delaware and launched a provider engagement campaign in Q3 with the goal of increasing awareness of DCHI's initiatives and tools among as many practices as possible. The DCHI Clinical Committee developed a three-pronged approach to provider engagement including: 1) formal oral presentations at professional meetings in Delaware, 2) formal published notice through newsletters of professional organizations, and 3) informal notice through Committee members' provider networks. Committee members presented at 6 professional meetings, published content in 4 newsletters, and engaged several physicians, physician assistants, nurses, practice managers, etc. through these outreach efforts.

In Q3, DCHI completed its series of Community Forums designed to introduce the public and additional stakeholders to the work of SIM. Six forums were held throughout the state and included a total of approximately 200 attendees. Each forum consisted of a presentation by a panel of speakers from the DCHI Board and Committees followed by written and live Q&A with the attendees. DCHI also attended two church-planned Hispanic Community Conversations in the southern part of Delaware in order to reach Spanish-speaking audiences directly. Ab+c, the media/PR firm contracted to lead this scope of work, is preparing a summary of the events as well as synthesizing pre- and post-event surveys and recommendations that will be used to inform any future outreach.

Population Health

In Q3, the Healthy Neighborhood infrastructure continued to develop with the hiring of Council Leads for the Western Sussex and Wilmington/Claymont Neighborhoods. The Healthy Neighborhoods Committee also created a Sustainability Subcommittee with the purpose of identifying key funding partners and developing an outline for capacity development. The Committee met with State agencies and other stakeholders regarding funding. The subcommittee outlined three strategies for sustainable funding: Short Term (Alignment/Grants), Innovation Funding (Anchor Institutions), and Long Term (Reinvestment Model).

The Wilmington/Claymont Local Council structure was approved by the Committee and recruitment began for leadership. The Committee suggested the structure must be unifying, logical, sustainable, community engaged, and data driven. The Committee continues to meet with Wilmington area leaders and stakeholders to gain a better understanding of resources and the community landscape.

Interns from the UD Service Learning Scholars Program continued work on a resource inventory. They collected data from Wilmington, gathered local health metrics and resources, and established Health Care Data Metrics for Local Councils. The Committee identified strategic partners for a Data Subcommittee to provide structure and leadership, to continue the work on the data and resource inventory, and to create a mechanism to merge relevant data for targeted communities.

The Sussex County Health Coalition (SCHC) continues to provide strategic support to the Western Sussex Local Council. In addition, the Healthy Neighborhoods Committee is providing counsel to the SCHC Board expansion and strategic planning process.

Health Care Delivery Transformation

The Practice Transformation program continued through Q3, with 99 provider sites including 342 unique providers enrolled. Our goal is to have 50% of the ~1,000 primary care providers in the state enrolled by Q2 2017; we currently have 34%. Vendor reporting was revised to include standardized qualitative and quantitative elements which will increase accountability and improve reporting to stakeholders.
The DCHI Clinical Committee developed its BHI implementation plan in Q2 and refined and finalized the program in Q3. Based on input from the Committee, the program includes the following elements, which are detailed in the consensus paper "Behavioral Health Integration Testing Program Implementation Plan" that was approved by the DCHI Board in August: self-directed resources, data and reporting support, advisory group, training, infrastructure and technical assistance, outcomes (clinical) payment, and vendor performance management (process). We anticipate that the BHI testing program will launch in Q1 2017. The Clinical Committee has an “interest application” open to allow interested behavioral health and primary care providers to express interest and be contacted in advance of program launch.
In Q3, HCC released an RFP for the Behavioral Health Electronic Medical Records Assistance Program. The program provides funding for BH providers in two categories: Category 1 will provide funding to BH providers who do not have an EMR system with funding ranging from $15,000 to $20,000 depending on the size of the practice; Category 2 will provide funding to BH providers to upgrade or enhance their current EMR system with funding ranging from $10,000 to $15,000 depending on the size of the practice. HCC will coordinate the EMR assistance program with DCHI’s BHI testing program by allowing applicants to the assistance program to opt into the BHI testing program as part of their submission. HCC plans to release another round of funding through an RFP in Q4 2016.

Payment and Service Delivery Models

HCC and DCHI leadership continue to hold regular discussions with the state’s main payers in order to foster communication on the payers’ plans for rolling out new payment models and to ensure engagement and alignment with other areas of SIM work.
Highmark launched its P4V model, True Performance, to a small number of Medicaid providers (15 statewide) in Q2. In Q3, Highmark began to provide quality reports and care coordination payments to these practices. In Q3, Highmark also introduced True Performance for commercial populations and targeted 123 “high volume” providers that represent 60% of their membership. To date, approximately 55 providers have contracted for Highmark’s commercial True Performance program with an initiation date of Jan. 1, 2017.
UnitedHealthcare continued to enroll primary care providers in its Basic Quality Model (which provides care coordination and quality improvement payments) and Accountable Care Shared Savings model (which provides care coordination, quality improvement, and shared savings payments) in Q3. In Q3, United made two additional models available that provide payments linked to quality and cost of care in addition to care coordination (Quality Shared Savings Model and Pediatric Model). United has already begun transitioning practices contracted for BQM into the three value-based models linked to both cost and quality and plans to continue to contract with practices throughout the state.
In Q3 the DCHI Payment Model Monitoring Committee formed a Transparency Working Group (TWG). The TWG, comprised of a diverse group of payers, providers, community members, and policy makers, met several times to develop recommendations for the DHIN as they operationalize the Delaware’s Health Care Claims Database (HCCD).

Leveraging Regulatory Authority

As mentioned above, SB 238, passed in Q2, established a Delaware Health Care Claims Database (HCCD). As a result, the DCHI Payment Model Monitoring Committee formed a Transparency Working Group comprised of payers, providers, community members and policy makers to provide recommendations to the DHIN as they operationalize and craft the regulations that will govern the HCCD. In addition to the working group, DCHI and SIM leaders have been working closely with the Executive Committee of the DHIN and the Governor's office to provide guidance and input on the regulations.

In Q3, HCC, which oversees the Health Insurance Marketplace for the state, updated its QHP standards for plans sold on the Marketplace. The QHP standards, which in prior years were updated to ensure that all QHPs were making value-based payment models available to PCPs or ACOs, funding care coordination, and aligning at least 75% of quality and efficiency measures with the Common Scorecard, were further refined for 2018 to reflect the passage of SB 238, making explicit that QHPs are considered a mandatory reporting entity under the law and that claims data shall be submitted to the DHIN.

Also in Q3, Delaware's Health Resources Board, which reviews and approves new or expanded health care facilities in the state, approved a revised Health Resources Management Plan (HRMP). The HRMP serves as a guiding document to the Board as they review Certificate of Public Review applications. The HRMP was updated to ensure alignment of Delaware's existing health planning framework with statewide efforts aimed at promoting health system improvement. The revised HRMP also includes Guiding Principles which align with the state's health care reform efforts and succinctly capture the coordinated approach to achieving the vision outlined in the State Health Care Innovation Plan. The HRMP will be listed in the Registrar of Regulations and available for Public Comment in Q4 before final approvals are sought.

Workforce Capacity

The DCHI Workforce and Education Committee finalized and received DCHI Board approval on its consensus paper titled, "Licensing and Credentialing Health Care Providers" in Q3. The Committee began work to facilitate conversations with relevant stakeholders across Delaware to discuss implementation of the recommendations included in the consensus paper. The Committee also engaged Christiana Care Health System (CCHS) and the University of Delaware (UD) in its monthly Committee meeting discussions to review both vendors' work plans and timelines for their respective scopes of work. CCHS was selected to facilitate a health professional education consortium and UD was selected to develop and implement a health care workforce learning and re-learning training curriculum. Committee members provided insightful feedback on effective methods to successfully engage providers and other members of the health care workforce in both initiatives.

The Committee began work on its next consensus paper on developing a sustainable workforce capacity assessment across Delaware. This work included comprehensive research on current provider shortages across a handful of disciplines and the capacity of state institutions to train health care providers in a manner that aligns with the competencies and capabilities expected in the transformed system of care. Committee members agreed on the need for a comprehensive provider data set across a wide range of disciplines within the assessment to better understand the supply of providers in Delaware. With this information in hand, the Committee began writing a first draft of its consensus paper in Q3.

Health Information Technology

The major focus of HIT work in Q3 surrounded the preparation for the release of the Common Scorecard to primary care practices statewide. This included resolving data discrepancies identified during pilot testing, collecting new payer data, working with payers to add new data feeds, and completing development of new functionality.

Q3 work focused on correcting data issues identified during the testing phase that occurred in Q2. The DHIN and SIM technical team also worked to bring a new payer data feed (Highmark Medicaid) onto the Common Scorecard platform. This effort entailed working through attribution issues and ensuring the data met the technical specifications required of data submissions.

New functionality added in Q3 included statewide aggregation of quality and utilization measures, comparison of measure performance against statewide DCHI goals and benchmarks, and improved chart display for quality and utilization measures.

There were many challenges the working team needed to address to ensure payer data submissions adhered to high quality standards. The DHIN and SIM technical team met weekly with each of the three payers submitting data to resolve data quality issues prior to the submission of data for the statewide Common Scorecard release. These issues included ensuring practices' patients correctly reflect attribution to those practices, standardizing file submissions despite differences between payer reporting systems, establishing data sharing agreements, and investigating data discrepancies within and across payers' file submissions.

Enrollment for the Common Scorecard was opened to practices in Q3, supported by a web-based form to collect relevant information from the practice and by informational webinars for new practices interested in learning more about the purpose of the Common Scorecard. The webinars and online provider enrollment platform can be accessed at http://www.choosehealthde.com/Providers/Common-Scorecard

Continuous Quality Improvement

In Q3, Concept Systems, Inc. (the state's selected evaluation vendor) established the design and began to facilitate an implementation/process evaluation plan to gather data across multiple collection efforts to inform a complete view of the SIM initiative. As part of this design, the evaluation team defined evaluation parameters within the context of the logic model, considered data specifications, and reviewed the data collection plan outlined in the operational plan relative to available resources.

The evaluation team worked to determine and develop quantitative and qualitative analysis procedures to synthesize information across the multiple data collection platforms. Quality assurance and data management plans were developed and initiated for each data collection activity to ensure accuracy and consistency. In particular, the stakeholder database initially developed in Q1 continues to be populated as new stakeholders are identified through public meetings and documents. The evaluation team established a system to identify stakeholder's level of involvement related to SIM, which is also used to inform participant samples across the data collection activities. Additionally, the evaluation team identified sensitizing concepts to help organize and frame the evaluation questions. An initial coding scheme was established to inform the analysis of the qualitative data, such as interviews, participant observations, and review of documents. In Q3, the evaluation team facilitated meetings of the Advisory and Utilization Committees. The Advisory Committee advises the evaluation team on processes, methods, dissemination and quality, and the Utilization Committee plans for and informs the system on the use of evaluation findings. Both meetings provided valuable insights in terms of stakeholder engagement and data collection inquires and focused on the evaluation's purpose, design, and operation plan in terms of data collection activities and timeline.

Additional Information

Metrics

Metric Name	Performance Goal	Current Value

Risk Factors

Risk Factors	Current Priority Level	Current Probability	Current Impact	Prioritized Risk Mitigation Strategy	Current Next Steps	Current Timeline
Confusion among providers between TCPI and SIM funding opportunities	2	Low	Low	Maintain dialogue with TCPI grantee to ensure coordinated messaging and strategy	Continue to meet on a monthly basis with the Delaware contact for the TCPI awardee to share information enrollees and strategies	Next call scheduled for Dec. 6
Curriculum is not implemented in timely way to support change	3	Medium	Medium	Establish strong vendor management practices including deliverables-based contracts with intermediate milestones and oversight from State	Vendor developing modules and curriculum content. Continue dialogue with Practice Transformation vendors/program to ensure alignment	First module to be available to providers in Feb. 2017
Elimination of collaborative agreement disconnects APRNs from care team	1	Low	Low	Conduct education and promote awareness of the role of APRNs in care team	Ensure communication with curriculum and consortium development vendors on ways to incorporate APRNs into each activity	Module 1 of curriculum currently being developed
Inability to align on focus area	3	Medium	Low	Realign grant funding strategies to support Healthy Neighborhood initiative	Planning for Year 3 includes HN funding in Ops Plan	Ops plan due Dec. 1, funding included in Year 3 to begin Feb. 1, 2017

Insufficient capacity within DHIN or other agencies to lead HIT initiatives	4	Medium	Medium	Identify external/alternate vendor to lead initiatives	Continue established bi-weekly communication with DHIN/HCC staffs and development teams in order to monitor capacity and project progress	n/a
Lack of funding for sustainability	4	Medium	Medium	Prioritize activities and focus only on those with significant results	Activities noted by State-led evaluator stakeholder survey identified priorities; funding included in Year 3 Ops plan reflects activities with continued progress and stakeholder support	Ops plan due Dec. 1; Year 3 funding to begin Feb. 1, 2017
Lack of measurable success for pilot Neighborhood(s)	2	Low	Low	Ensure adequate staff available to provide support to pilot(s)	Support for HN project included in Year 3 budget/Ops Plan, will provide resources for Wave 1 and 2 communities.	Ops plan due Dec. 1, funding available Feb. 1, 2017
Low consumer interest in engagement tools	2	Medium	Low	Increase awareness through outreach and education	Consumer tools have not been launched yet	Consumer engagement tools to be developed by Q3 2017

Low payer participation	3	Low	Medium	Active, regular conversations with payor representatives across segments	Continue to conduct regular phone and in person meetings with major payer stakeholders to continue engagement	Biweekly calls with Highmark and United teams; quarterly Leadership meetings with Highmark
Low provider participation in practice transformation services	4	Medium	Medium	Conduct additional outreach and education regarding the opportunity	Conduct Learning Collaborative as recruitment opportunity for new practices	Learning Collaborative to be scheduled for Q4 2016; Wave 2 of enrollments to begin Q1 2017
Low provider participation in VBP models	4	Medium	Low	Launch provider education and awareness campaign	DCHI Clinical Committee to develop and execute provider outreach strategy	Provider outreach strategy to be finalized in Q4
Messaging does not reach target audience	2	Medium	Low	Conduct focus groups to test messages and channels for delivery	Review community forum summary and recommendations to determine if messaging/tactics were on target	Review summary and revise strategy for outreach in Q4
Stakeholder participation wanes over time	2	Medium	Low	Provide regular progress reports so stakeholders know the impact of their contributions	Monthly progress reports included in SIM update at HCC meetings; continue regular engagement with stakeholder groups	DCHI conducting outreach to stakeholder groups, professional associations and societies in Q4

Stakeholders unable to deliver necessary data to produce scorecards	5	High	High	Prioritize options with greatest administrative simplicity	Continue to discuss options for Scorecard with DCHI and HCC leadership; continue engaging with payers to ensure data is delivered appropriately	Decide on the inclusion of PT milestone display and practice disaggregation in Q4; Continue weekly call with payers to ensure project remains on track and issues are surfaced and resolved
Vendors unable to deliver HIT functionality on time	4	High	Medium	Establish strong vendor management practices including deliverables-based contracts with intermediate milestones and oversight from State	Continue weekly calls between HCC, DHIN and vendor to ensure project is on track and on time	Bi-weekly calls; Next scorecard release expected in Dec. 2016

WBS

Vendor	Category of Expense	Primary Driver	Total Unrestricted Funding (obligated funds)	Metric Name	Carry Over Funds	Rate/ Unit Cost	Comments/ Notes	Total Payments (spent funds)
Concept Systems Inc.	Contract		$250,000		Yes		Contracted state-led evaluator	$53,894
Delaware Center for Health Innovation	Contract		$35,280		Yes		Contracted administrative support	$18,480
Concept Systems Inc.	Contract		$250,000		No		Contracted state-led evaluator	$20,879
ab+c Creative Intelligence	Contract	Driver 1	$835,125		Yes		Media and public relations firm supporting patient, consumer and stakeholder engagement as well as website maintenance and development.	$129,459
ab+c Creative Intelligence	Contract	Driver 1	$835,125		No		Media and public relations firm supporting patient, consumer and stakeholder engagement as well as website maintenance and development	$81,431
MedAllies	Contract	Driver 3	$1,275,000		Yes		Contracted practice transformation vendor	$40,375
Remedy	Contract	Driver 3	$1,200,000		No		Contracted practice transformation	$35,000

					vendor	
Remedy	Contract	Driver 3	$1,200,000	Yes	Contracted practice transformation vendor	$69,000
Medical Society of Delaware	Contract	Driver 3	$1,200,000	No	Contracted practice transformation vendor	$16,000
Medical Society of Delaware	Contract	Driver 3	$1,200,000	Yes	Contracted practice transformation vendor	$32,000
New Jersey Academy of Family Physicians	Contract	Driver 3	$1,200,000	No	Contracted practice transformation vendor	$28,000
New Jersey Academy of Family Physicians	Contract	Driver 3	$1,200,000	Yes	Contracted practice transformation vendor	$57,000
MedAllies	Contract	Driver 3	$1,275,000	No	Contracted practice transformation vendor	$20,187
Public Consulting Group	Contract	Driver 4	$591,600	Yes	Consulting services supporting Workforce & Education and Patient & Consumer Advisory Committees	$57,120
Public Consulting Group	Contract	Driver 4	$591,600	No	Consulting services supporting Workforce & Education and Patient & Consumer Advisory Committees	$41,760
McKinsey & Company	Contract	Driver 6	$4,100,000	Yes	Consulting support for	$1,877,500

Clinical/Delivery, Population Health, Health IT, and Payment workstreams as well as overall management support