Delaware State Innovation Model (DE SIM)

State-Led Evaluation

Quarterly Report

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

Prepared for:

Delaware Health Care Commission
Delaware Department of Health and Social Services
State of Delaware

Submitted by

Concept Systems, Inc.

University of Delaware's Center for Community Research and Service
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Introduction & Overview

Background - The Delaware State Innovation Model (DE SIM) is a broad-based health system transformation effort funded by the Centers for Medicare and Medicaid Innovation (CMMI) and administered by the Delaware Health Care Commission (DHCC). Concept Systems, Inc. (CSI) is under contract with the Health Care Commission to facilitate the state-led evaluation of DE SIM, and University of Delaware's Center for Community Research and Service is participating under a subcontract with CSI. The purpose of this report is to summarize the state-led evaluation team's findings related to the work done in quarter 2 of AY4.

The purpose of this report is to provide insight to HCC about the status of the system. The goal is to provide information that HCC can use to try and strengthen, stabilize, and optimize the system in its effort to achieve the goals for AY4. Because this is the last year information presented is also often tied into the issue of sustainability, and the question of what may happen once the grant funding ends. The first part of this report does focus on progress made towards the drivers, and briefly summarizes achievements and challenges specifically related to those drivers in Q2. The second section is made up of observations from the system more broadly and is framed using the guiding concepts from the AY3 annual evaluation report (i.e., knowledge management, stakeholder engagement, sustainability). This section also indicates within which drivers we have found evidence of that issue and is a way to organize these findings in relation to the work being done.

It is important to also recognize that in Q2 there was a change in leadership at DHCC. This represents the third change in leadership for DE SIM and the content of this report should be contextualized with that shift in mind. Despite these changes progress towards the markers laid out in the AY4 plan continues.

The information for this report comes from data and insight gleaned from meeting observations, committee presentations, meeting minutes, and "progress checks" (i.e., brief interviews) with principal stakeholders involved in DE SIM. We recommend that the summary be shared with stakeholder groups (e.g. Delaware Center for Health Innovation (DCHI) committees; DCHI and HCC staff, as well as other vendors) to check for accuracy. Due to the nature of our data collection, shifting priorities, and varied activities, we may have missed key pieces of information to fully describe progress.

Overall Summary of Progress Across Drivers

The table below references overall progress for the secondary driver action steps, along with the process markers listed in the quarter they are expected to be met. Across the 16 secondary drivers, all but two were on schedule, relative to the action steps specified in the AY4 Operational Plan.

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	1.1b TCC payment model for Medicaid and State Employee program use*	1.1.c 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
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
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

* Process marker not met; moved to next quarter

Plan Progress for Quarter 2 by Driver:

Primary Driver 1: Payment Reform

Progress continues in Primary Driver 1. Process markers for this quarter were not met and their completion dates have been moved to upcoming quarters.

Primary Achievements	Challenges Encountered
• 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.	• The development of recommendations concerning a total cost of care (TCOC) risk-based model for implementation has expanded into the next quarter. • The discussions surrounding the identification of potential implementation barriers and mitigation strategies of value-based payment models is dependent on the development of TCOC model and therefore also delayed into upcoming quarters. • Stakeholders have continued to voice concerns about the Common Scorecard. In particular concerns raised in discussion and public meetings include 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.

Primary Driver 2: Practice Transformation

Cohort 1 practices continue to participate in technical assistance. Challenges exist with regards to the integration of technology into efforts for behavioral health integration.

Primary Achievements	Challenges Encountered
• Recruitment of Cohort 2 was completed with 28 practices enrolled in Cohort 2 (including 14 new practices not currently enrolled in Cohort 1). • 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.	• Practices are expressing concern about the sustainability of practice transformation gains achieved through work with practice transformation coaches in AY 3 and how to support the BHI work going forward without some new payment mechanism during the time of implementation. HMA and Mercer are working with Delaware Health Care Commission to create a summary of payment options to support this work. Further discussion around the State mini-grants and how that could help to build and sustain the BHI models is underway. •

Primary Driver 3: Healthy Neighborhoods

The Healthy Neighborhoods (HN) model has been developed and adopted. Sustainability planning has been moving forward, and some of the local projects have been funded.

Primary Achievements	Challenges Encountered
• Two initiatives from Dover Smryna 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	• Unclear whether knowledge and learning from these projects is being captured effectively. As these projects move forward evaluation should be included to ensure that the progress made can be built upon. Compounding this issue is the suspension of technical assistance due to budget restraints for local councils in using data to identify local needs, monitor progress, and evaluate responses. Although there are expectations regarding monitoring and evaluation of data driven outputs there is a concern moving forward about how this is operationalized and supported at the community level.

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.	• There is still uncertainty among stakeholders about how the sustainability model will be operationalized. The uncertainty is driven largely by the absence of a formal decision about the structure and management of the backbone organization. Work is ongoing to resolve this, but stakeholders are unclear as to the progress of that work. There is also some sense that the model is similar to the structure that had been in place prior to the restructuring that took place in year 3.

Primary Driver 4: Health Information Technology

Work continues on ways to develop a health information technology solution that provides value to Delaware stakeholders.

Primary Achievements	Challenges Encountered
• 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.	• The exploration of electronic consent solutions for sharing behavioral health data with the community health record has been discontinued.

Analysis of the System

This section presents key findings from our interviews with key system stakeholders and our observations at DE SIM related meetings in Q2. These observations reflect the perceptions of key actors in the state who have in-depth understanding of DE SIM specifically, and healthcare transformation more broadly. The points included in this table should be considered opportunities for consideration, and prompt further discussion in an effort to further improve this work.

The table is partitioned by thematic areas that reflect recommendations made in the AY3 evaluation report as issues to review in AY4. The four columns represent the key drivers that are the focus of AY4, and the X's indicate whether an issue was observed or determined to be associated with that driver. The analysis is our interpretation of what we have heard and seen over the course of Q2. We acknowledge our ability to fully understand the system has some limitations and should be taken into account.

Highlights of the "systemness" of the system				
• There appears to be agreement across the system about what should be achieved. Nevertheless, it has become increasingly clear there is a philosophical divide that drives much of the conflict in the system. That divide pertains not to the ultimate outcomes of healthcare transformation, but rather what methods are best utilized to achieve those goals. One perspective of stakeholders is that this work needs to be done using a more top-down and directive approach to facilitate forward 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 can 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.	X	X	X	X
• There is recognition among stakeholders that CMMI has a substantive amount of power and control over the system.	X	X	X	
• There is broad agreement among stakeholders that population health work is critical to the future of Delaware. Sustaining this work and increased investment is and should continue to be a goal of all actors in the system.	X	X	X	X

Highlights of the "systemness" of the system				
• Designation of authority in the system is important for both communication issues, and for facilitating progress. This means that if actors in the system are to be responsible for aspects of this work they need to be granted appropriate authority, and it should be communicated broadly and clearly.	X	X	X	X
• Some stakeholders in the system believe that there continues to be an unclear vision for where "we" want to go as a state with regards to the kind of healthcare system that "we" want for ourselves. This highlights a differentiation made by stakeholders with regards to DE SIM and healthcare Transformation more broadly. In some spaces there seems to be a de-coupling from DE SIM and a focus on healthcare Transformation work independent of it. DE SIM was meant as a catalyst for this Transformation work, and it should be viewed that way as it moves towards its eventual conclusion.	X	X	X	X
• There is recognition among stakeholders that the State has initiated a shift in tone and signaled a willingness to engage in a more collaborative way. The past report highlighted some barriers with regards to the new approach to DE SIM related work, and there seem to have been some positive adjustments. Stakeholders have also expressed the importance of demonstrating this in action not only words. One way this has been done successfully is through the Payment workgroup which has seen strong collaboration between the State and a wide array of actors resulting in honest and authentic conversation and planning for the future.	X	X		
• DE SIM leadership must clearly communicate its commitment to Transformation, and what its plans are for continuing this work. How will key actors be engaged that intersect with one another across sectors? How can there be increased clarity around vision and purpose?	X	X	X	X
• Because of Delaware's small size there are a limited number of major actors. Some of these are subsidiaries of national companies. Because of this there is sometimes limited leverage around what these actors can be compelled to do.	X	X		

Stakeholder engagement

• The aforementioned philosophical difference relates most explicitly to stakeholder engagement. 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.	X	X	X	X
• Some stakeholders recognize an improvement in outreach and a renewed commitment on the part of the state to re-engage stakeholders in authentic collaboration around DE SIM related work. Some doubts remain about how committed DE SIM leadership is to that authentic stakeholder engagement, but recent steps taken by the State (e.g., release of Q1 evaluation report, engagement in the Payment committee) have made headway in addressing these concerns. It is also important to consider whether the right stakeholders are being engaged in the right places. Some believe not all stakeholders need to be engaged in all aspects of DE SIM, but instead engagement and collaboration should be strategic and systematic.	X	X	X	
• The Patient-Consumer committee has been reconstituted and provides an opportunity for broader stakeholder engagement. There is energy around this group and participating parties welcome this opportunity to re-engage around this line of work.	X	X	X	
• There may be a need to consider increased outreach to smaller providers in the state. There is some sense among key stakeholders that they have disengaged. Key stakeholders report what matters to these providers is how they can operate more efficiently and see better patient outcomes. Increasing payment values may not be enough to incentivize their buy-in.	X	X		

Stakeholder engagement

• Stakeholder perceptions are that the communication around DE SIM has been disjointed and fragmented. This resulted in multiple websites, and other information outlets putting out competing information (i.e. reporting different times and locations for the same event or the dissemination of inaccurate information). Although improving according to some stakeholders, it is critical to ensure that communication is clear, consistent, and timely. This fosters transparency and reduces tension or anxieties of key actors in the system.	X		X	
• There exists strong stakeholder commitment to Transformation work. Actors across the state and across sectors want this to succeed and are willing to come to the table to help improve health in Delaware. Whether that willingness extends to DE SIM-related work is unclear. Stakeholders report uncertainty about the progress on Healthy Communities Delaware and due to this lack of information, some actors are reporting that they may invest in promoting healthy neighborhoods in other arenas independent of DE SIM, or in collaboration with other partners.	X	X	X	X
• Stakeholders shared that dissemination of the Q1 evaluation report was a demonstration in transparency and authenticity. The feedback was well received and appreciated. This was viewed as a sign of a good faith and stakeholders appreciated the opportunity to be heard. These reports should continue to be disseminated for limited public consumption to facilitate conversation and improvement.	X	X	X	X

Knowledge management				
• Some stakeholders fear that there is insufficient knowledge management work happening with regards to Healthy Communities Delaware pilot projects. Evaluation should be incorporated into this work to ensure lessons are learned, and progress can be built upon in the post-DE SIM environment.			X	
• There remains a sense by key stakeholders that the work being done by DE SIM now does not build upon the progress and learning made in the first two years. This emerged in interviews in a couple of ways. First, stakeholders felt that some key activities such as workforce development had been ended with little explanation, and little attempt to apply knowledge that had been generated and build upon it. Also, there is some frustration with new Healthy Communities Delaware model that stakeholders believe is very similar to the structure that had been in place prior. Some accept this and feel it is most important to continue moving forward to get the funds deployed on the ground. Others lack faith that contributing to such an effort will lead to effective execution of projects and programs.		X	X	
• There is some uncertainty about the progress made towards releasing funds for Healthy Communities Delaware projects and deploying money to communities. There is evidence that some of these projects have been funded, but there is talk among stakeholders that this is not the case. This perception should be clarified so that confusion is avoided.			X	

Sustainability				
• It is important to consider engaging an additional ambassador from the private sector into the planning for the Healthy Communities Delaware sustainability effort. Key stakeholders believe that without this there will be insufficient buy-in from the private sector, and mistrust in the model. That might			X	

prevent investment from private sector actors who lack faith that whomever is responsible for executing on the model will effectively disburse and spend funds.				
• Broad confidence in the proposed sustainability model for Healthy Communities Delaware is critical to the model's success in the long run. A lack of engagement with stakeholders in developing the model, particularly the private sector, means that those actors are not confident that handing their community benefit dollars to this type of entity will result in the types of programs they hope to see operate at a local level.			X	
• When considering the structure for Healthy Communities Delaware it is important to establish entities that can manage competing interests, have broad credibility, and have a level of independence. That group should also be able to facilitate connections across the system, between initiatives with aligned goals and objectives. This can facilitate collaboration and efficiency, while also giving funders faith that the money will be spent in an objective and transparent way.			X	
• Political will to sustain the work started by DE SIM is critical right now. Some key stakeholders believe that will is there, but others are not so sure. Some of this disagreement is explained by the evident philosophical divide and can be thought of as the will to do what, in what way.	X	X	X	X
• It appears that attention around sustainability has been focused largely on Healthy Communities Delaware. This may be in part due to more engagement around the formal model being developed, and activities taking place related to implementation of that model. But, for other drivers there seems to be varying degrees of organized discussion around sustainability.	X	X		
• The model for Healthy Communities Delaware ultimately executed should explicitly include provisions for providing technical assistance to community level groups that might be candidates for funding. This should include support for groups that may have less technical capacity to ensure marginalized groups have a voice.			X	

Conclusions and Recommendations

This report builds upon the first quarterly report of AY4 in examining both progress towards the four drivers, and the systemic issues that are affecting DE SIM. We recognize that many of the systemic issues raised in the Q1 report might take time to address. This report focused more on gaining additional insight as opposed to explicitly tracking on progress made on those original issues outlined in the Q1 report.

The work of DE SIM is moving along well with regards to the activities and drivers that are the focus of AY4. Both Mercer and HMA appear to have accomplished what they had set out to do in Q2. Nevertheless, this report focuses more on systems-related issues and less on process monitoring considering the bi-weekly reporting done by HMA. Therefore, our conclusions emphasize the systemic issues laid out in the second section of the report. Some key points are highlighted below:

- A philosophical difference around how to engage stakeholders in this work is driving much of the tension in the system. Although tension is common in complex systems as the systems and its actors seek to adapt to changes, these differences requires some attention, and a solution to stakeholder engagement negotiated.

- Key stakeholders report 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, towards a more collaborative approach that fosters authentic bi-directional engagement. A more directive approach does not preclude strong stakeholder engagement and communication. As per key stakeholders, a continued emphasis on collaboration and cooperative problem-solving is necessary to resume confidence and willingness to work cooperatively in advancing a public-private partnership to transforming healthcare in Delaware.

- How knowledge is acquired and used to inform decisions about what is working continues to be variable and inconsistent. For example, there are concerns around if and how learning from pilot programs being implemented through Healthy Communities Delaware is being captured. Continued emphasis on communications, feedback to stakeholders, and consistency of key messages is necessary to ensure meaningful engagement and motivation toward a public-private partnership.

- Transparency and engagement around the sustainability work being done for Healthy Communities Delaware is critical. There seems to be some risk of losing commitment from key actors, particularly the private sector, without an increased effort to generate buy-in and bring some of these actors into the fold as design of the sustainability plan continues.

- Sustainability needs to be more widely considered across all aspects of the DE SIM work. Despite the approaching end of the DE SIM grant period, there is commitment on the part of key stakeholders in the state to advance the work of healthcare transformation in the future. To take advantage of this willingness, the state should signal its commitment to the goals and objectives to a public-private partnership to healthcare transformation beyond DE SIM. This is highlighted by the emphasis from CMMI on achieving payment reform, and the absence of work in this area

- The drivers for DE SIM are interrelated. Major changes such as payment reform cannot happen independent of other system improvements that are or were a part of DE SIM work. Practice transformation, workforce development, and population health are all important components for moving towards payment reform as an overarching goal and coordination between public and private entities will be required for the future.