Government of the District of Columbia
John A. Wilson Building | 1350 Pennsylvania Ave, NW, Suite 223 | Washington, DC 20004

July 29, 2016

Mr. Gabriel Nah
Grants Management Specialist
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Mailstop#7700 Bethesda
5600 Fishers Lane
Rockville, MD 20857

Stephen Cha, MD, MHS
Director, State Innovations Group
Center for Medicare and Medicaid Innovation (CMMI)
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Mail Stop WB-02-49
Baltimore, MD 21244

Dear Mr. Nah and Dr. Cha:

We are pleased to submit the District of Columbia's State Health Innovation Plan (SHIP), which describes our strategy to improve the health outcomes of District residents by bolstering our current health care system in a way that links health service payment to quality, value and a person-centered approach to care delivery. This SHIP is possible through the generous financial support and technical assistance made available through a Round Two State Innovation Model Design grant from the Centers for Medicare & Medicaid Services.

Over the past year, more than 500 health care providers, social service workers, payers, beneficiaries and key District government leaders proposed, discussed and debated various methods for reducing preventable and avoidable hospital and emergency room use; decreasing health disparities across District neighborhoods; better aligning health spending with outcomes; and identifying ways to re-invest savings gained from these tactics to promote prevention and health equity. We educated each other on what reaching these goals entail, and strengthened our collective dedication to accomplish them.

The culmination of this work, embodied in the District's SHIP, identifies actionable and measureable goals designed to transform our healthcare system by linking high-cost, high-need

residents to care coordination, aligning payments with health outcomes, and developing a continuous learning health system that supports more timely, efficient, and better quality healthcare throughout the care continuum.

Developing this SHIP is only the beginning. The hardcore work of launching the initiatives described in this care delivery and payment reform strategy, and facilitating their success through data exchange, workforce development and quality measurement, is before us. Stakeholder input will continue to guide our work, and we are pinpointing existing and upcoming community-focused forums to keep our momentum going. With close to a third of District residents enrolled in Medicaid, we also intend to further our partnership with CMS through technical assistance and policy levers to improve the health outcomes of our most vulnerable populations.

We thank you for the remarkable support CMS has provided us through this SIM award. Special thanks to Dr. Cha who helped kick-off one our biggest stakeholder meetings, and to the talented consultants at NORC and SHADAC who consistently delivered high-quality, keenly-developed information needed to inform our many stakeholder gatherings. We look forward to sharing the successes of our health reform efforts in the months and years to come.

Sincerely,

LaQuandra Nesbitt, MD
Chair, District of Columbia State Innovation Model Advisory Committee
Director, District of Columbia Department of Health

Brenda Donald
Deputy Mayor for Health and Human Services
Executive Office of Mayor Muriel Bowser
Government of the District of Columbia

Copy:
Wayne Turnage, Director, District of Columbia Department of Health Care Finance
Claudia Schlosberg, Senior Deputy Director and State Medicaid Director, District of Columbia Department of Health Care Finance
Dena Hasan, Interim Director, Health Care Reform and Innovation Administration, District of Columbia Department of Health Care Finance
Lisa Fitzpatrick, MD, Medical Director, District of Columbia Department of Health Care Finance
Christian E. Barrera, Senior Health Policy Advisor, District of Columbia Office of Deputy Mayor of Health and Human Services
Laura Zeilinger, Director, District of Columbia Department of Human Services

Stephen Taylor, Commissioner, District of Columbia Department of Insurance, Securities, and Banking
Tanya Royster, MD, Director, District of Columbia Department of Behavioral Health
Jacqueline Bowens, Chief Executive Officer, District of Columbia Primary Care Association
Justin Palmer, District of Columbia Hospital Association
Jonathan Blum, MD, Executive VP of Medical Affairs, CareFirst
Karen Dale, RN, MSN, CS, Executive Director, AmeriHealth Caritas
Maria Gomez, RN, MPH, President & CEO, Mary's Center
Mark Weissman, MD, Chief of General Pediatrics and Community Health, Children's National Health System
Christy Respress, Executive Director, Pathways to Housing
Amy Freeman, President & Chief Executive Officer, Providence Hospital
Angela Diop, ND, Chief Information Officer, Unity Healthcare
Reverend Frank D. Tucker, First People Church, Ward 4
Reverend Christine Wiley, Covenant Church, Ward 8
Mara Krause Donahue, Ward 3 Resident, Parent of Medicaid Beneficiary
Christopher King, PhD Associate Director, MHSA Program, Georgetown University School of Nursing and Health Studies
Richard Bebout, Chief Executive Officer, Green Door
Kristy Greenwalt, Director, District of Columbia Interagency Council on Homelessness

DC State Innovation Model

Better Health Together

District of Columbia State Health Innovation Plan

Table of Contents

Residents of the District of Columbia (the District or DC) have one of the highest healthcare coverage rates in the nation. Despite the District's substantial investment in healthcare, inequalities continue to exist between the health outcomes and conditions of many District residents. To address such inequalities, the Centers for Medicare & Medicaid Services (CMS) is collaborating with the District to support the design and implementation of new health service delivery and payment methods through the State Innovation Models (SIM) initiative. SIM provides financial and technical support to states for the development of state-led healthcare payment and service delivery models. In 2015, CMS selected the District to recieve a SIM Design grant totalling $999,998.

The SIM Design grant allowed us to take a step back and collectively determine the best strategy to ***reduce health disparities, improve health outcomes and achieve savings*** *for healthcare delivered to residents in the District, particularly the District's most vulnerable residents. From the summer of 2015, to the summer of 2016, the District's Department of Health Care Finance (DHCF) engaged a diverse group of over 500 private and public stakeholders, including payers, providers and consumers of healthcare services, to develop a State Health Innovation Plan (SHIP) for the District. This SHIP describes how we will achieve five aims to better our resident's health within the next five years (2017 – 2021):*

1. *100% of DC residents enrolled in Medicaid with a qualifying chronic health condition will have access to a care coordination entity, that is primarily responsible for all aspects of care, by 2018*
2. *15% reduction from baseline in non-emergent emergency department visits for all District residents by 2020*
3. *10% reduction from baseline in preventable hospital readmission rates for all District residents by 2020, 15% reduction from baseline for residents enrolled in Medicaid by 2020*
4. *Develop and implement a plan to reinvest savings achieved through system redesign to promote prevention and health equity, using a comprehensive approach not solely focused on healthcare by 2021*
5. *85% of Medicaid payments will be linked to quality and 50% payments will be tied to an alternative payment model (APM) by 2021*

We will launch new, and bolster existing, initiatives related to care delivery and payment model reform and systematic linkages between healthcare and social service providers to achieve these aims; and will use stakeholder input, health information technology, workforce force development, and cross-cutting quality improvement measures to guide and support these initatives.

This plan will be submitted to CMS as a requisite of the District's SIM Design award--- but, serves as more than just a government deliverable. ***This SHIP is a 'living' document****, and will be updated routinely. We invite all stakeholders to read our strategy, and welcome your input and participation as we continue to transform the District's current healthcare landscape into a more value-based care delivery and payment system.*

Transforming Healthcare in the District of Columbia

One Resident's Story

The Current State of Healthcare in the District

Mr. Smith is a 34 year old African-American male with hypertension and diabetes. He has been homeless many times over the past year and has Medicaid coverage. He also has a substance use disorder and depression. He does not have a primary care doctor, nor is he linked to services for his behavioral health needs. Mr. Smith makes frequent trips to the emergency department for non-emergencies, usually via ambulance. He has been admitted to the hospital multiple times in the past 12 months for social and health needs that could have been addressed outside of institutional care. The Medicaid program has spent over $100,000 on his care in the past year.

Mr. Smith is not receiving care for his medical, behavioral or health-related needs or social issues in a community setting and his needs are unmanaged. There have been attempts to connect Mr. Smith to a primary care provider after he's discharged from the hospital, but no single entitiy is responsible for ensuring that he actually visits the physician. Mr. Smith has visited a primary care provider once or twice after hospital discharge, but did not comply with the physician's request for him to return for tests. The physician did not have access to Mr. Smith's health-related history.

Outside hospital care, Mr. Smith does not know what services are available to him or how to access them. He follows the examples of well-being and using services he has seen growing up, and the current habits of his family and friends, which includes accessing medical care through hospital emergency rooms. He intends to continue using healthcare services the same way.

Our Vision for Healthcare in the District

Mr. Smith receives services from an entitiy that is accountable for integrating his full array of health, social and long term supports in a way that is strength-based and person-centered. As an enrolled member of this 'Health Home', Mr. Smith has an interdisciplinary care team, including a primary care provider, that is uniquely designed to meet his needs. His care team worked together to create a care plan that addresses all of Mr. Smith's needs – his diabetes and hypertension, the substance use disorder and depression, and his social needs. Mr. Smith's team has helped him to find housing, get help with food, and they help with transportation to his appointments. He meets with a community health worker close to his apartment to tallk about his care plan. His primary care provider coordinates with his behavioral health and substance use treatment providers.

Mr. Smith knows he can talk to his care team when he thinks he is having an emergency and his care team has taught him how to manage his chronic conditions outside of a hospital. All of his providers use electronic health information exchange to share information about Mr. Smith and make sure they know about his most recent medications and treatments.

Mr. Smith's care team understands and addresses all of his healthcare and social needs. He is getting the help he needs to improve his physical and mental health and can now focus on training, education, finding permanent housing, and looking for work. He is using more effective and less expensive care, allowing the District to reinvest savings into other initiatives that improve health and wellness for DC residents.

Executive Summary

The Centers for Medicare & Medicaid Services (CMS) is collaborating with states and territories to support the design and implementation of new health service delivery and payment methods through the State Innovation Models (SIM) initiative. SIM provides financial and technical support to states for the development of state-led healthcare payment and service delivery models. In 2015, CMS awarded the District of Columbia (the District or DC) a SIM State Health Model Design grant, which was timed perfectly with other DC-focused initiatives dedicated to creating a plan for improving the overall well-being of DC residents.[i] This SIM Design grant sparked a bold commitment to develop, document and implement our collective strategy for transforming the District's current healthcare landscape into a more value-based care delivery and payment system.

Nearly 40% of District residents have healthcare coverage through Medicaid or our local Medicaid-like health insurance plan (DC Healthcare Alliance). However, a small cohort of this population comprises a disproportionately high percentage of the city's healthcare expenditures. Over the past year, the Department of Health Care Finance (DHCF), the District's Medicaid agency, has led the engagement of a diverse group of private and public stakeholders, including payers, community-based clinical and social service providers, hospitals and consumers of health and social care services to develop a State Health Innovation Plan (SHIP) for the District. This SHIP details the District's plan to reduce health disparities, improve health outcomes and achieve savings for healthcare delivered to residents in the District while achieving the Triple Aim[ii]:

Improving consumer health outcomes by addressing social determinants of health, and focusing on preventative activities and care management.

Enhancing consumers' experience of care so that the healthcare system is more accessible and user-friendly.

Creating value for high-cost, high-need consumers through integrated care delivery, coordination with community supports, and alternative payment models.

Specifically, this SHIP details our plan to —

- Create value for high-cost, high-need consumers through integrated care delivery, coordination with community supports, and alternative payment models
- Improve consumer health outcomes and increase health equity by addressing social determinants of health, and focusing on preventative activities and care management
- Enhance consumers' experience of care so that the healthcare system is more accessible and user-friendly

Within this framework, the District ambitiously intends to redesign its healthcare system by linking high-cost, high-need residents to care coordination, aligning payments with health

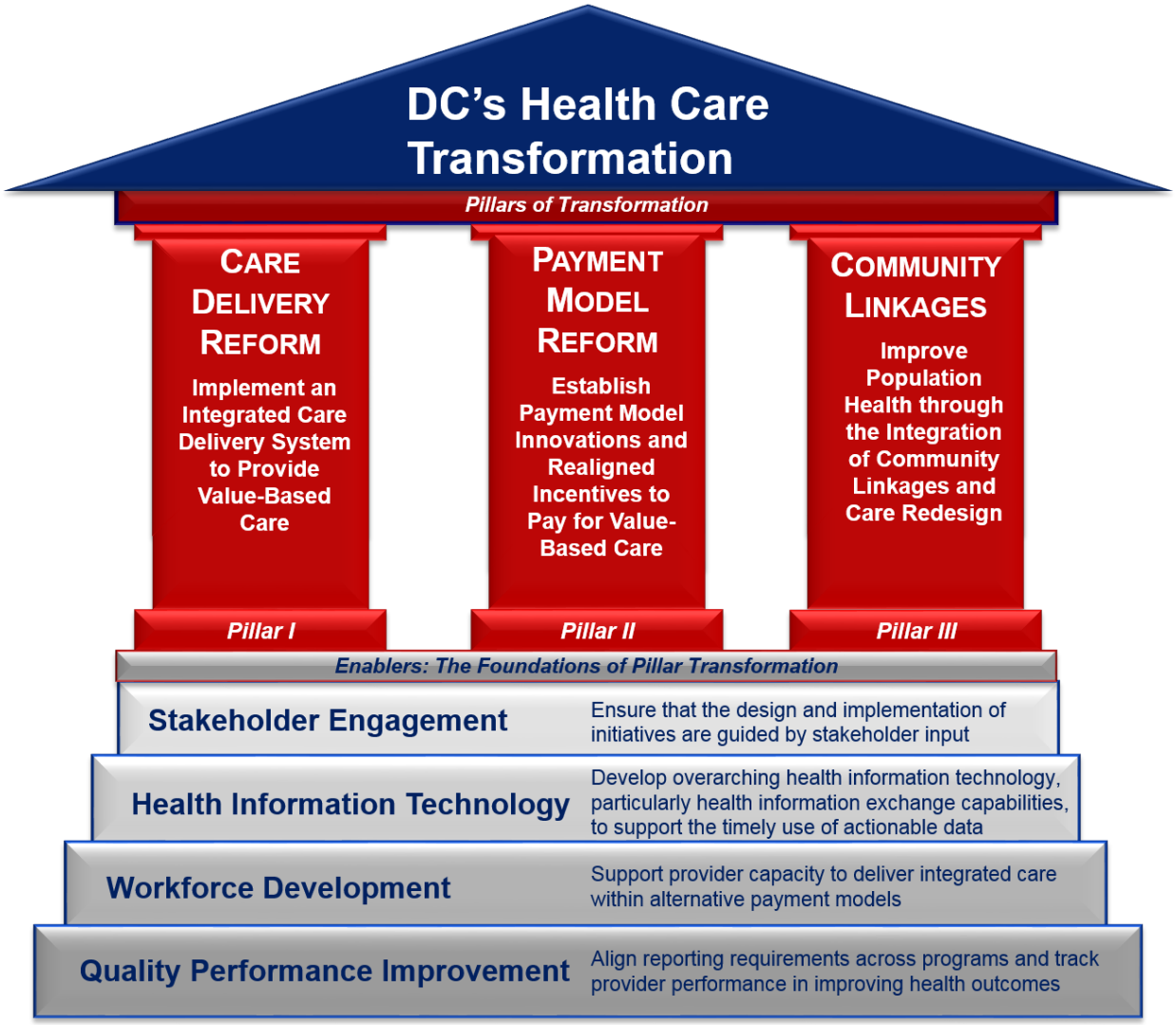
outcomes, and developing a continuous learning health system that supports more timely, efficient, and better quality healthcare throughout the care continuum.

Within the next five years (2017 – 2021), we will achieve five aims--- two of which align with the District's Healthy People 2020 framework goals for reductions in inappropriate ER use and hospital readmissions:

1. 100% of DC residents enrolled in Medicaid with a qualifying chronic health condition will have access to a care coordination entity, that is primarily responsible for all aspects of care, by 2018[iii]
2. 15% reduction from baseline in non-emergent emergency department (ED) visits for all District residents by 2020
3. 10% reduction from baseline in preventable hospital readmission rates for all District residents by 2020, 15% reduction from baseline for residents enrolled in Medicaid by 2020
4. Develop and implement a plan to reinvest savings achieved through system redesign to promote prevention and health equity, using a comprehensive approach not solely focused on healthcare by 2021
5. 85% of Medicaid payments will be linked to quality and 50% payments will be tied to an APM by 2021

This SHIP is structured in '*Pillars*' and '*Enablers.*' The Pillars define the innovations (care delivery reform, payment reform, and community linkages) that are essential to improving our healthcare system. The Enablers (stakeholder engagement, health information technology, workforce capacity development, and quality performance improvement) are the supporting factors critical to the viability of these Pillars. This approach is tailored to the unique needs of the District, is informed by national model practices and commercial insurance, and is centered on the needs of our residents.

Figure 1. District of Columbia's Healthcare Pillars and Enablers



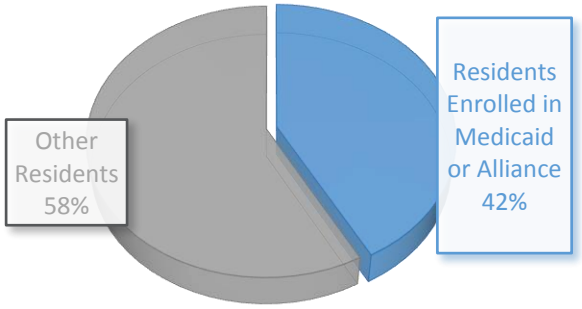
The District's Healthcare Environment

To set the stage for the District's transformation efforts, we conducted an environmental scan of our healthcare landscape to identify opportunities for improvement throughout the SIM design year. With more than 40% of District residents enrolled in either the state Medicaid program or our locally-funded insurance program, the DC Healthcare Alliance (see Figure 2), many of the findings from our analysis were directly related to Medicaid beneficiaries or those enrolled in the DC Healthcare Alliance program. Medicaid and related expenditures, are key because the District's 2017 budget includes $3.6 billion in Federal and local funds for healthcare. Medicaid accounts for approximately 95% of the healthcare budget. The District's FY 2017 local contribution to Medicaid is $6 million lower than FY 2016 at $690 million. This reflects the fact that in recent years the Federal government has paid for a larger share of DC's Medicaid costs

for some participants.[1] A tax of Medicaid hospital's inpatient and outpatient revenues will be used to pay for District expenditures.[2] Four key themes emerged as a result of the scan:

1. **Health disparities exist between racial and ethnic groups (including African American and Hispanic populations), geographic areas, and social-economic statuses across the District.** Residents of Wards 1, 4, 7 and 8 disproportionately experience disparities with higher rates of chronic disease, lower incomes, and poorer health outcomes than the general population.

Figure 2. Percentage of Medicaid and Alliance Enrollment Amongst District Residents



2. **The District's healthcare system is fragmented and disjointed.** Residents navigate between disconnected sites of care as well as between clinical and social services. Without proper coordination, residents do not effectively manage their healthcare and experience poor health outcomes associated with their conditions and social determinants of health.
3. **Individuals use the ED for non-emergent care and are not linked to community-based care after hospital discharge, leading to hospital readmissions.** Inefficient utilization of healthcare services is highest among individuals with chronic conditions and lower socio-economic status, disproportionately consisting of African American and Hispanic populations.
4. **A majority of Medicaid expenditures are attributed to a small percentage of Medicaid beneficiaries with exceedingly high costs in the fee-for-service population.** High spending is driven by inefficient service utilization, poor maintenance of healthcare, and lack of coordination between sites of care.

These findings directly influenced the District's overall SIM Model Design process, and the resulting planned initiatives. Our SHIP addresses these four challenges through a variety of targeted initiatives that bolster the health system infrastructure and reduce the disparities noted above.

Our Plan: Use Multiple Communication Methods to Collect Stakeholder Input

In gathering input for the environmental scan and developing the SHIP, we worked closely with stakeholders to examine current infrastructure, policies, and payment approaches within the

[1] Source: http://www.dcfpi.org/wp-content/uploads/2016/03/Health-Care-Toolkit-FY-2017-proposed-formatted-4-11-20161.pdf
[2] Source: http://mayor.dc.gov/fairshot.

District. Stakeholder ideas, feedback, perspectives and experiences were necessary to crafting a progressive, realistic, and actionable plan for improving coordination and outcomes.

Over 500 unique individuals were involved in the District's year-long SIM Design planning efforts. We implemented a robust stakeholder engagement strategy comprised of five separate, topic-specific SIM Workgroups, a SIM Advisory Committee, healthcare consumer interviews, weekly newsletters, a SIM webpage, and a SIM email address devoted to the two-way exchange of information between stakeholders and DHCF. Recommendations received from stakeholders informed the direction of our SIM efforts and were incorporated into this SHIP.

We also talked with consumers to obtain feedback on their experience with our current healthcare system. We conducted over 100 in-person interviews at FQHCs, hospital EDs and community organizations focused on housing and health issues. Question topics covered a wide range of issues including demographic information, access to primary care and provider satisfaction, gaps in healthcare, ED utilization, access to social services, and overall satisfaction with the District's healthcare system. Upon analysis of the interview data, several themes emerged:

- **Patient experience:** Approximately 30% of surveyed Medicaid beneficiaries do not understand their benefits and would like more education on the benefits for which they are eligible. Patient education on healthy eating and healthy living habits would be the most helpful services to manage chronic disease.
- **ED utilization:** Individuals interviewed in the hospital EDs used in this survey were less satisfied with their primary care provider (PCP) and were more likely to use ED services before calling their PCP. The most common cause for ED visits among the sample population was chronic pain (44%).

Table 1. Stakeholder Interviews

Settting	Individuals Interviews
Health Center (*Mary's Center and Unity Health Care)*	66
Emergency Department (*George Washington and Providence Hospitals)*	31
Pathways to Housing	7

- **Gaps in care and services:** Access to timely primary care appointments and availability of dental and vision care were the most common gaps in health services identified by respondents. Housing and food insecurity were the most common social service gaps stated by the respondents.

We also used social media, such as Twitter, to increase the public's awareness of our SIM activities. Finally, a core team at DHCF routinely contacted stakeholders to increase 'word-of-mouth' spread on upcoming SIM Advisory Committee and Workgroup meetings.

Pillar I – Implement an Integrated Care Delivery System

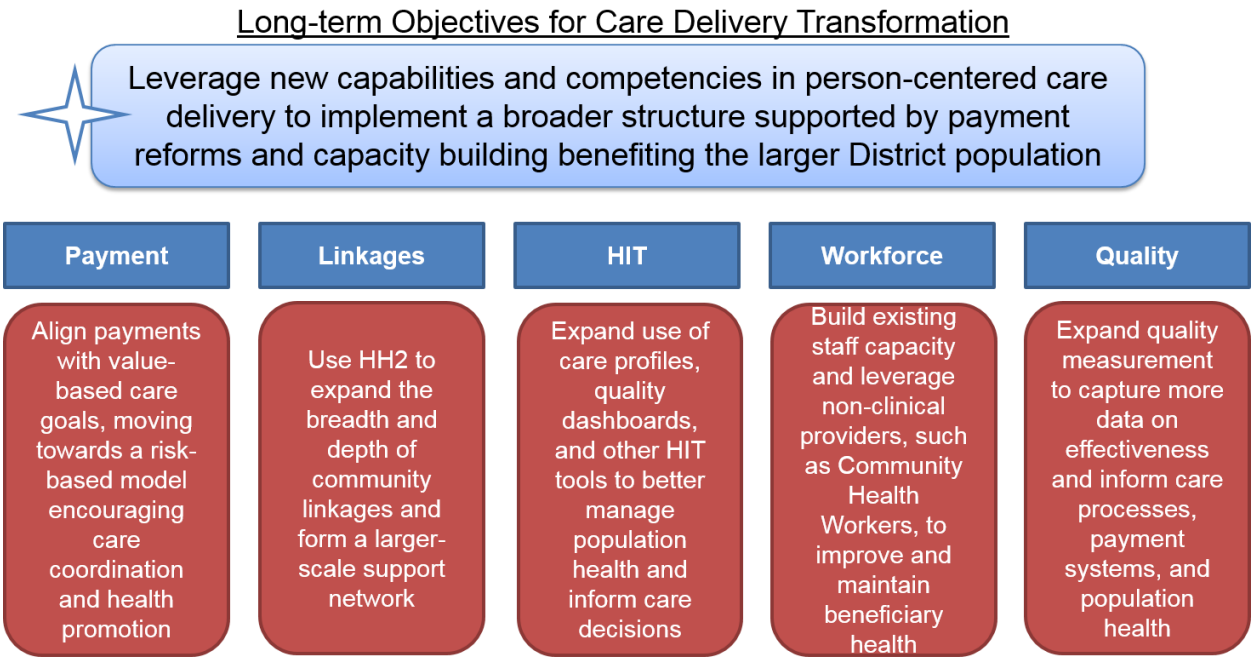
Over-utilization and inappropriate utilization of hospital and ED services are prominent in the District, particularly for the treatment and/or management of chronic conditions. A contributing

factor to the over-reliance on hospital based services is the high degree of fragmentation within the District's healthcare delivery system. Beneficiaries struggle to understand and navigate the vast landscape of independent sites of care. Inter-provider and patient-provider communication is also severely limited by a data infrastructure and system of care that lacks the capabilities for meaningful, patient-centered coordination.

We used lessons learned from ongoing District initiatives and input from stakeholders to identify short-term and long-term goals towards transitioning from a fragmented care delivery system to one that is integrated, strength-based and person-centered (see Figure 3).

- **Short-term goal:** Implement a second Medicaid Health Home benefit in DC (called Health Home 2 or HH2) where primary care providers coordinate and integrate care for high-need residents with certain chronic physical health conditions and social needs that impact health, such as homelessness. Through this new program primary care providers will strengthen their capacity to deliver interdisciplinary care, will be paid a monthly rate to deliver care coordination services, and will eventually be held accountable for the outcomes of their empaneled population.
- **Long-term goal:** Systematically transition to a more cohesive, 'whole person' approach to care in the District that's underpinned by alternative methods of payment linked to outcomes. Our goals will focus on various cohorts of the Medicaid population and settings (e.g., hospitals; primary care and behavioral health providers; home health; nursing homes; social service providers). The path to our long-term goal will be paved by initiatives that include:
  - Leveraging the Health Home 2 benefit, successes from shared savings initiatives in DC commercial insurers, and state-based primary care integrated care models to design and implement tiers of sustainable integration among providers to encourage the development and implementation of risk-based payment models
  - Using Medicaid authorities (e.g., Section 1115 waivers, the Delivery System Reform Incentive Payment (DSRIP) program) that facilitate innovative approaches and shared participation among hospitals and community level health and social service providers to improve outcomes of specific Medicaid populations
  - Using comprehensive assessments to identify both clinical and health-related social needs
  - Sharing person-level data between providers and systems to improve care delivery processes
  - Establishing innovative approaches to ED diversion, such as nurse care triage lines that link users to health homes and telemedicine programs with the District's Fire and Emergency Management System (FEMS) Department
  - Implementing risk sharing for long term services and supports (LTSS)

Figure 3. Long-term Care Delivery Transformation Leverages Payment Models, Community Linkages and Enabling Activities



Pillar II – Establish Payment Model Innovations

New payment models are an integral part of a transformed care delivery system. They include incentive structures that allow providers to effectively and efficiently finance 'whole person' care. In order to transition the District's healthcare system from volume- to value-based care, stakeholders agreed that initiatives must follow two guiding principles:

1. Care delivery and payment reform efforts must align
2. Payment transformation should be incremental, yet purposeful

We used these principles to guide our selection and development of short- and long-term goals, including:

- **Short-term goal:** Incorporating pay-for-performance (P4P) mechanisms into Health Home 2 models, federally-qualified health centers (FQHCs), and Medicaid managed care organizations (MCOs) to encourage better quality care
- **Long-term goal:** Enabling providers to assume risk for their patient populations and move towards value-based alternative payment models (APMs), as defined by CMS, that align with care delivery goals

Our SIM design year laid the foundation for future payment model transformation to occur on a broader scale in the District. Leveraging the experiences and lessons-learned through other state SIM initiatives, we will identify opportunities to transform the payment landscape. We will continue to develop and refine initiatives that improve quality, enrich patients' experiences, and reduce costs of healthcare. Future initiatives 'on the radar' that are under consideration or planned include:

- Incorporating value-based payment models into Medicaid managed care contracts
- Pursuing Section 1115 waivers to enable DC to implement 5-year projects on service delivery model innovations and payment as a vehicle to move towards innovative risk-based payment arrangement, such as: an ACO for fee-for-service (FFS) beneficiaries, wrap-around services associated with an opioid treatment program; an EMS super utilizers program, a sickle cell disease management program, and/or an urgent care program
- Leveraging the Delivery System Reform Incentive Payment (DSRIP) Program to direct funds toward provider-led efforts to improve quality and access, such as: infrastructure development, program innovation and design, population-focused improvement, clinical improvements in care
- Modifying payments to reduce hospital readmissions and hospital acquired conditions
- Instituting a system of beneficiary copays for inappropriate hospital utilization to encourage patient accountability
- Implementing risk-based payment for long-term services and supports (LTSS), such as: Program for All-Inclusive Care for the Elderly (PACE)

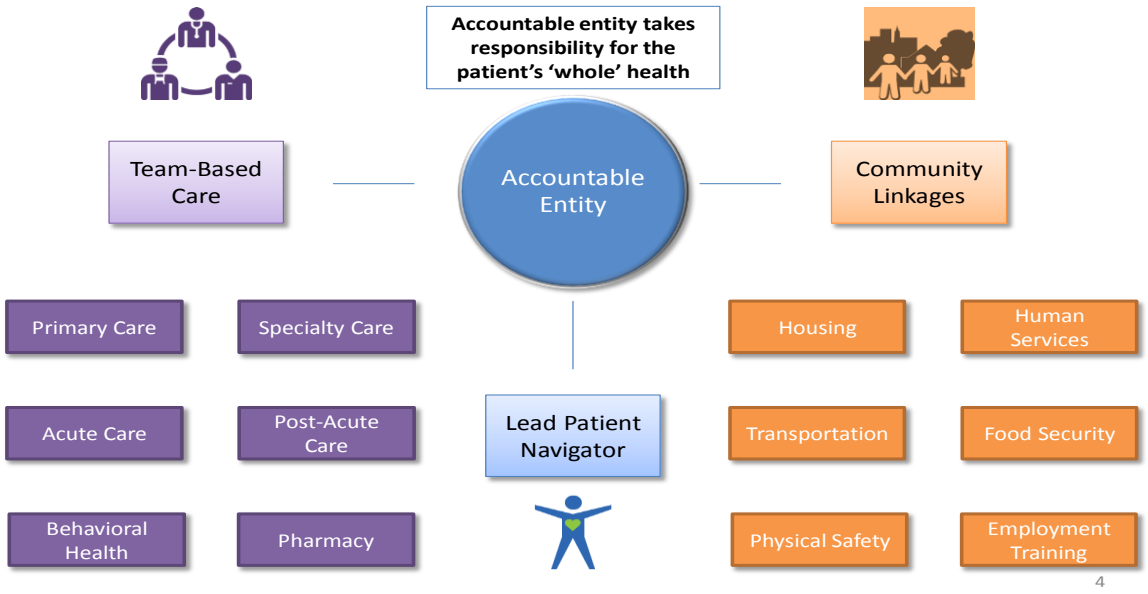
Pillar III – Improve Population Health through Integration of Community Linkages

We envision a healthcare delivery system where the full array of a person's health and social needs are integrated (see Figure 4) by one entity that is held accountable for this 'whole-person' approach through policy, payment and other structured levers. Similar to other states, the District experiences large discrepancies in medical and social factors (e.g., housing, food, employment, safety, and education) that significantly impact a person's and a population's overall well-being.

For the most part, funders and deliverers of health services are separate from their counterparts on the social service side. The systematic integration of a person's 'whole' needs is generally absent from the service delivery, payment, and oversight perspectives. The majority of District residents' physical and behavioral health needs are delivered by doctors and nurses, and are funded publicly (e.g., Medicaid and Medicare) or private health insurers, and are primarily regulated on the local-level by three District government agencies: Departments of Health Care Finance (Medicaid), Behavioral Health, and Health.

Within the social service realm, activities are delivered by social workers and housing specialists and payment is primarily locally-funded or from federal agencies (e.g., Substance Abuse and Mental Health Services Administration and US Housing and Urban Development). These services are primarily regulated locally by another District government agency (Department of Human Services).

Figure 4. District's Vision for an Integrated Healthcare Landscape

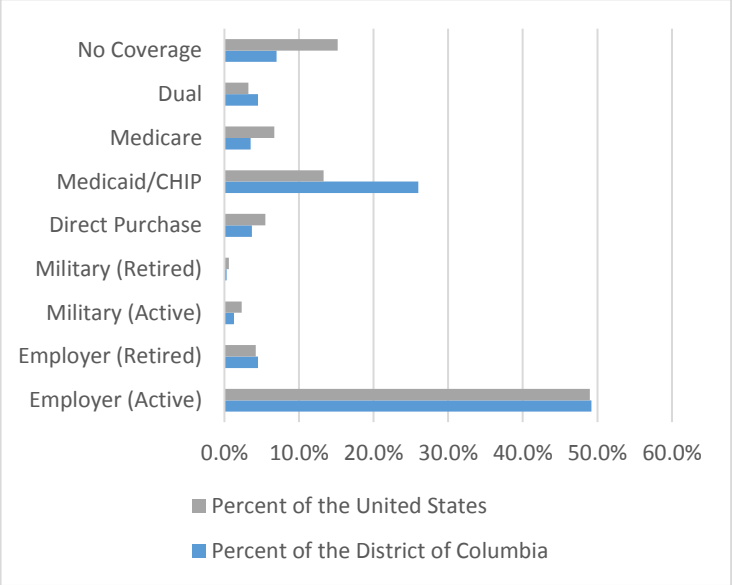


The costs of homelessness are far-reaching, with a substantial portion being attributed to healthcare expenses.[iv] Living without permanent housing can be a health risk, as evidenced in this population's frequent use of the ED, medical and psychiatric inpatient hospital care, and nursing homes.[v] The District's Medicaid program is absorbing most of these costs and nearly all District residents experiencing homelessness are eligible for Medicaid enrollment.

Realizing this dilemma, support for establishing systems that link health and social services exists throughout the District. DC's Mayor Muriel Bowser aims to end chronic homelessness among individuals and families by the end of 2018 and make homelessness in the District a rare, brief, and non-recurring experience by 2025. There is a causal relationship between access to consistent housing and well-being. In our recent examination of chronically homeless District Medicaid beneficiaries, we found that placement in permanent supportive housing caused cost and utilization shifts from ED and inpatient hospital visits to more community-based

care—such as substance abuse and behavioral health services. Affordable housing allows for more household resources to pay for other needs, such as healthcare services and medications, which leads to better health outcomes.[vi] Stable and affordable housing is correlated with scheduling doctor appointments, keeping those appointments, and adhering to medication regiments for individuals with chronic health conditions.[vii] In contrast, poor-quality and inadequate housing are leading contributors to health problems, such as infectious and chronic diseases, injuries, substance abuse, and poor childhood development.[viii]

Figure 2. Breakdown of District and National Health Coverage Trends, 2009



Significant gaps in linking individuals to relevant supports remain within our current system (e.g., the lack of a data sharing and formal referral process between clinical and community providers). The SIM Advisory Committee and Workgroups have agreed to address these gaps through the creation of new programs that systematically foster linkages between health and social services by standardizing expectations for interdisciplinary, team-based care, payment alignment, and tools for information exchanges. Below we describe three short-term initiatives that will enhance provider, patient, and government agency collaboration:

- **Health Homes Model Program:** Commonly called Health Home 2, this initiative will be based in the primary care setting, and build off of the National Committee for Quality Assurance's Patient-Centered Medical Home certification that many of our primary providers either have or are working towards. Focused on beneficiaries with physical chronic conditions, and those with historical chronic homelessness, Health Home 2 primary care providers will be accountable for coordinating their patients' full array of health and service needs.
- **Dynamic Patient Care Profile:** The Dynamic Patient Care Profile is a front-sheet dashboard, available to health and social providers at the point of care, which includes consumer-level key clinical and health-related social data points.
- **Accountable Health Communities (AHC):** AHC will build a health network that consistently and systematically identifies and addresses the social determinants of health, maximizes resources and collaboration between clinical and social service organizations and expands the capacity of organizations to create a seamless accountable community.

We will continue to enhance our ability for collaboration between providers of healthcare and social service providers starting with the following long-term initiatives:

- **Connections with community partners through improved referral process:** Establishing a platform for healthcare providers to refer a consumer to an available social service provider, and vice versa, that addresses the consumer's needs. This platform also advises the healthcare provider if the connection between the consumer and the social service provider actually occurred.
- **Universal needs assessments:** Regardless of where the assessment is administered, or which provider type or District agency conducts it, we aim to have a standardized data collection tool included on all assessments that collects information on an individual's health and social needs. Creating universal needs assessments instills common terminology and creates another data source for measuring the impact of systems installed to facilitate consumer linkages to needed services.
- **Accountable Care Organizations (ACO):** An innovative approach which includes a group of providers who are voluntarily and collectively responsible for the outcomes (cost and quality) of a patient population. By tying payments to costs and quality, the group of providers will have strong incentives to work together to reduce unnecessary utilization and address social determinants of health.

Enabler A – Maintaining Continuous Stakeholder Engagement

The District has a history of actively engaging stakeholders in its health system reform initiatives, including outreach conducted during the creation of DC's Health Benefits Exchange. Throughout this SIM Design year, the District has built a robust stakeholder engagement infrastructure used to communicate, educate, and solicit various stakeholder input. The District will leverage best practices from past stakeholder engagement activities to ensure that vested parties can contribute to both the design and implementation of programs focused on moving healthcare to a value-based system. Tangible tasks include:

- **Leveraging Established Boards and Workgroups:** While the District will continue some of the SIM Workgroups after this SIM Model year, there are a number of existing boards, commissions and workgroups (e.g., the Medical Care Advisory Committee, HIE Policy Board, Inter-agency Council on Homelessness, etc.) that we will use to continue the momentum of stakeholder participation catalyzed over the past year.
- **Disseminate a Continuous Communications Plan and Feedback Loop:** We will continue promoting SIM initiatives to garner support and participation and explore opportunities to efficiently communicate with our stakeholders by updating the DHCF website, continuing the distribution of the SIM Innovation Newsletter, engaging with DHCF and District leadership, and offering opportunities to provide stakeholder feedback.

Insights from the consumer interviews and focus groups conducted throughout our SIM Design year support findings in the literature about the importance of consumer engagement in implementing programs that actually lead to improved health outcomes. We will promote activities to encourage improved health literacy and empowerment for our residents.

Enabler B – Developing Overarching Health Information Technology and Exchange Capabilities

The effective use of data via health information technology (HIT), especially when used for electronic health information exchange (HIE), is fundamental for both the District's short- and long-term health reform efforts. To achieve this, we must have a better understanding of how health-related data currently flows in the District and identify specific gaps or barriers that may affect the success of our SIM goals. The District will improve its ability to store and exchange data at the point of care throughout the healthcare continuum. This includes enhanced approaches to sharing and using electronic health records (EHRs), claims, public health and social services data in order to improve system efficiency, better measure individuals' health outcomes and provider performance, and track costs associated with providing care.

While there is little access to and use of HIT tools among racial and ethnic minorities and less-wealthy individuals, there are also significant gaps in access to and use of HIT among providers serving these populations. To address our existing HIT fragmentation, the District's HIE Policy Board and SIM HIE Workgroup helped to refine a list of recommended initiatives that will bolster the District's HIT capabilities. Initial funding for some of these initiatives was supported by federal SIM Model Design funding, while others will leverage HITECH funds available from CMS for design and implementation efforts via approved Implementation Advance Planning Documents (IAPDs). The five initiatives are:

1. **Generate an HIE Data Map to Reflect the District's Current Data Landscape:** DHCF developed a detailed data map depicting existing HIE systems in use in the District, including associated storage centers and data flows of each major HIE system, and the degree of connectivity between them. By documenting the existing data infrastructure, gaps in accessing and transmitting data can be more easily identified, which can be addressed through updates to current HIT infrastructure, designating new HIE entities, or developing new HIE initiatives.
2. **Create a District HIE Designation Process that Sets Thresholds and Standards for Participation:** DHCF will establish a core set of requirements and standards that HIE entities must meet to be recognized by the District. In doing so, the District will create a more unified, interconnected clinical data architecture that is required to meet the District's SIM goals.
3. **Build a Data Warehouse to Store, Process, and Analyze Medicaid Claims:** The Medicaid Data Warehouse (MDW) is a 3-year project designed to improve access to DHCF's Medicaid Management Information System (MMIS) claims data for business analytics. When completed, the new warehouse is expected to house over 10 years of claims data and over 1,000 CMS-required data variables, with easy-to-use front end interfaces for sharing reports and dashboards with DHCF staff, providers, individuals, and stakeholders. Future plans for the MDW include housing information for other data sources, such as Medicare, and integration with social service data bases.
4. **Develop a Dynamic Care Profile Tool that Pulls Patient-Specific Data to Aid in Care Coordination:** This tool is designed to provide a practitioner, or their care team, with a

high-level summary of a particular patient that is quickly accessible at the point of care. The Patient Care Profile will provide users information not traditionally included in other clinical documents, including information on individual housing status, risk stratification, and patient attribution to designated entities.

5. **Expand HIE Functionality to Include an Electronic Clinical Quality Measurement Tool, Obstetrics/Prenatal Registry, Analytical Patient Population Dashboard, and Increased Ambulatory Connectivity:** Providers and hospitals will be given access to the electronic clinical quality measurement (eCQM) dashboard through a web-based portal, which will enable them to view their own measures, report outcomes, and plan for individual and population health monitoring. A Prenatal Specialized Registry promotes the collection and analysis of important information related to the health and healthcare of pregnant women and will help the District create an interoperable infrastructure that can track, analyze, and engage this specific patient subpopulation. An Analytical Patient Population Dashboard will enable providers to understand the health of their entire panel of patients as they continue to undertake increasing levels of risk, offering a proactive and cost-effective way for providers to reduce spending, encourage healthy behaviors, and streamline workflows. Lastly, funds will support ambulatory providers in technically integrating HIE services into their practice and clinical workflows to aid in transformation to value-based care and payment models.

While the above initiatives help achieve our SIM goals of improving outcomes, enhancing experiences of care, and creating value in the healthcare system, future initiatives will compound SIM efforts to build a truly comprehensive and sustainable HIT infrastructure. Initiatives 'on the radar' include:

- Developing a formal sustainability plan for the District's HIT infrastructure
- Expanding data warehouse functionality to stakeholders and integrating external sources
- Exploring new technologies including telemedicine and remote patient monitoring to gather clinical data from patients outside of traditional care settings
- Establishing an All Payer Claims Database (APCD) to facilitate an increased understanding of healthcare cost, quality, and utilization in the District across all payers

Enabler C – Developing Workforce Capacity

The ability to reach our SIM reform vision and goals depends heavily on the readiness of our healthcare and social service workforce. Our workforce must know how to begin and operationalize various revisions to policy and reimbursement structures that will result from care delivery and payment reform efforts and increased community linkages. We plan to build workforce and organizational capacity by:

- Investing in technical assistance and training for clinical providers, care extenders, and social service providers

- Augmenting communication and collaboration pathways between and among clinical and health-related social services
- Partnering with colleges and job-training programs to better prepare the upcoming workforce for delivering care outside of the FFS reimbursement environment, and within a more holistic, longitudinal, and value-based approach to population health

Specific topics for building workforce and organizational capacity include:

- **Provider Education:** Providers require education on how to deliver 'whole person' care and address social determinants of health, in addition to clinical health issues (e.g., the DSRIP program offers a pathway to fund provider-led efforts to improve quality and access through efforts that include infrastructure development, program innovation and design, population-focused improvement, and clinical improvements in care)
- **HIT Promotion:** Potential end users should be educated on how the use of HIT tools can enhance decision-making, offer expanded access to care information for patients, and modernize billing and documentation practices during care visits so that patient data is complete and accessible.
- **Learning Collaborative Development:** Learning collaboratives will be developed to share best-practice models among providers, systems, community supports, and government agencies.

Specific investments will be targeted towards District initiatives, such as Health Home 2, for which providers will be trained and assisted in establishing care teams and instituting new cultures of care. By building workforce capacities for specific initiatives, the District can test and adjust its commitments to developing the workforce so that it meets program needs and SIM goals.

Enabler D – Quality Performance Improvement

Fundamental to value-based payment systems is performance measurement that promotes information needed to improve provider performance and value of care delivered. Currently, the District does not have a standardized data collection or performance reporting system. Measures are reported in various forms and in silos that make it difficult or impossible to measure population health changes District-wide. Thus, we developed a strategy to implement provider-facing, standardized statewide measurement activities to evaluate the performance of its healthcare delivery system. The Quality Performance Improvement (QPI) plan is based on the stated aims of the District's SHIP, and includes performance and process measures that reflect the key elements of a successful system transformation and aligns with the District's other multi-sector collaborative population health initiative, DC Healthy People 2020. The QPI is a tool to help us collectively improve performance on selected outcome and quality measures, and to reduce health disparities.

In our SIM Design year, we reached initial consensus on a core measure set that aligns with existing performance reporting initiatives which included input from stakeholders that also participated in the DC Healthy People 2020 development process. Alignment across a set of

quality measures is a foundational step towards healthcare transformation. This alignment will send a powerful signal to providers on how their performance is measured for the quality of care they provide, regardless of the health insurance coverage of the patient. The measure set will be representative of the District's current and future priority areas.

Our QPI plan includes many short-term initiatives.

- **Refine the Core Measure Set:** We will continue to refine the core measure set developed in the SIM Design process to further align with existing performance reporting initiatives (e.g., DC Healthy People 2020) as other measure sets are changed and updated.
- **Gain Multi-payer Support:** The District will obtain buy-in from other payers (e.g., commercial payers) to promote measure alignment. As part of a successful QPI, healthcare quality measurement must continue to evolve to reflect transformation priorities and meet stakeholder expectations. It is critical that we develop measure sets that are meaningful to patients, consumers, and physicians, while reducing variability in measure selection, collection burden, and cost. Therefore, our goal is to establish broadly agreed upon core measure sets that can be harmonized across payers.
- **Launch Electronic Clinical Quality Measurement Reporting Tool:** CMS developed electronic clinical quality measurement (eCQM) requirements for very specific clinical quality measures as part of the EHR incentive program. The District is developing and implementing a practice- and population-level eCQM dashboard for Eligible Professionals and Eligible Hospitals to help both entities accomplish their quality improvement goals. The eCQM reporting tools are specific to EHR incentive program reporting but can be used more broadly.
- **Population Surveillance Dashboard:** The District will leverage existing population health measures identified in the DC Healthy People 2020 Framework to monitor residents' well-being which will require the development of a dashboard. Providers will use this dashboard to help manage their patient populations effectively. Providers will access this dashboard in the same way that they access the eCQM reporting tool but will have access to more patient and panel data.

In the future the District will consider new payment approaches for all its health services providers to encourage improved health outcomes and effectively reduce costs. For example, payment approaches could focus on the reduction of elective deliveries as a method to reduce neonatal morbidity.

The District's short and long-term initiatives will strategically position the District to enhance our capabilities to meet the federal requirements and align with industry trends, such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the CMS/AHIP Core Quality Measure Collaborative[ix]

Conclusion

We will share the SHIP with our federal partners at CMS as part of the SIM Design grant requirements but this document is also the living document describing our strategy for healthcare innovation in the District and it will continue to evolve. We look forward to implementing this plan along with our many partner stakeholders that dedicated long hours to creating this roadmap, and to ultimately furthering the transformation of the District's healthcare system to one that meets the goals of the ***Triple Aim: Better Health, Better Care and Lower Cost.***

Introduction

A Tale of Two Cities

Our vision is to **reduce health disparities, improve health outcomes and achieve savings** for healthcare delivered to residents in the District of Columbia, particularly the District's most vulnerable residents. We aim to accomplish this goal by transforming the District's current healthcare system into a sustainable and **integrated** system that delivers **person-centered care delivery** and in which **healthcare payments are linked to quality.** Our vision aligns with the Centers for Medicare & Medicaid Services' (CMS) Triple Aim, and reinforces District Mayor Muriel Bowser's mission to improve pathways to the middle class by prioritizing affordable housing, education, and public safety, and by ending homelessness.

Health disparities are preventable differences in health status, prevalence of disease, health behavior risk factors and social determinants by sex, race and ethnicity, income, education, disability status, geography and other social and environmental factors.

To realize this vision, we must change the District's healthcare paradigm, and the challenges that have hindered success in the past. The District has excellent rates of health insurance coverage with an uninsured rate of 6% – which ranks third lowest after Massachusetts at 4%, and Rhode Island and Hawaii who are tied at 5%.[x] However, this level of coverage has not translated to broad success in key health outcomes. Instead, we have significant disparities in health status that vary by race and ethnicity, income, education, disability status, geography and other social and environmental factors.[xi]

A Tale of Two Cities: Disparities in Health across the District

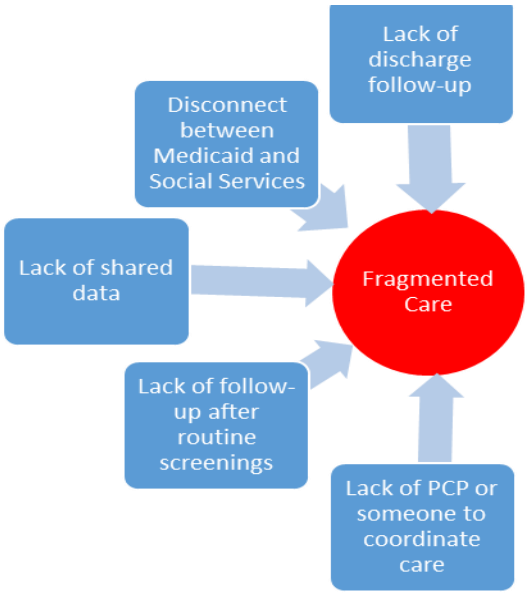
- The average life expectancy is almost 15% higher for White District residents compared to African-American residents.
- The mortality rate for African-Americans in the District is more than double the rate for White District residents; 963 versus 464 deaths per 100,000.
- Wards 7 and 8 have the lowest incomes in the District, and diabetes rates in these wards are nearly twice the national average.
- Compared to White and Hispanic women, Black women have a higher rate of premature infants, infants with low birth weights (<5 lbs. 8 oz.) and very low birth weights (<3 lbs. 5 oz.), and infant deaths.*

* http://kff.org/state-category/health-status/

Over 40% of District residents are enrolled in Medicaid or the DC Healthcare Alliance Program, which is our locally-funded program designed to provide medical assistance to District residents who are not eligible for Medicaid. However, there are many individuals who still need help to effectively manage their care. These individuals must often navigate between disconnected providers and sites of care, and figure out how to access clinical and social services. Individuals who receive healthcare services reimbursed through Medicaid may also need and receive health-related social services that address low-income, no housing or inconsistent housing, food

insecurity, etc., that are paid for and/or monitored by federal agencies (outside of CMS) and District government agencies, such as the Department of Human Services. Individuals are required to communicate and coordinate with multiple departments and agencies, who in turn must work to coordinate services on behalf of the individual. This siloed, and occasionally duplicative, process is challenging for all involved. Figure 1 depicts several of the factors that influence the fragmented care experienced by current residents.

Figure 1. Factors Influencing Fragmented Care



Lack of service coordination, access and follow-up with various health-related programs and / or providers leads many of our residents to use the ED, and can result in a hospital stay for conditions that could have been prevented or addressed through appropriate community-based preventive and primary care. This fragmentation, over-utilization of hospital services, under-use of primary care and lack of coordination result in a small percentage of Medicaid beneficiaries driving the largest percentage of the Medicaid budget.[xii]

The District's 'tale of two cities' story for health outcomes is not only about services delivered within the healthcare arena. There is a new focus by policymakers at the state and federal level on the link between social determinants of health and overall well-being. Evidence suggests that a person's health status is attributed in part to clinical services, meaning that other conditions in our residents' environments, including where they are born, live, learn, work, play, and worship, are also important to an individual's well-being.[xiii] These are sometimes referred to as social determinants of health. We must provide 'whole person' services that address social determinants of health and subsequently improve residents' health outcomes.

In 2015, CMS selected the District for a (State Innovation Model) SIM Design grant of $999,998. The SIM grant provided us access to targeted technical assistance from staff within CMS, other federal agencies (including the Center for Disease Control) and federal government contractors to design a strategy to improve the well-being of District residents through health service delivery and payment reformation. The grant allowed us to engage stakeholders and build consensus for a new strategy for transforming healthcare in the District.

Social determinants of health greatly impact an individual's health status and health outcomes. In the District, one of the most prominent factors influencing health status is housing (neighborhood and built environment).

This State Health Innovation Plan (SHIP) is the final report of this work. This document is the product of a year-long push to engage District healthcare stakeholders in developing our collective approach to better meet the health-related needs of District residents, improve health outcomes, and address and reduce the disparities in health outcomes among certain populations. We expect that improving the effectiveness of care and appropriate use of healthcare services will help us to achieve cost savings.

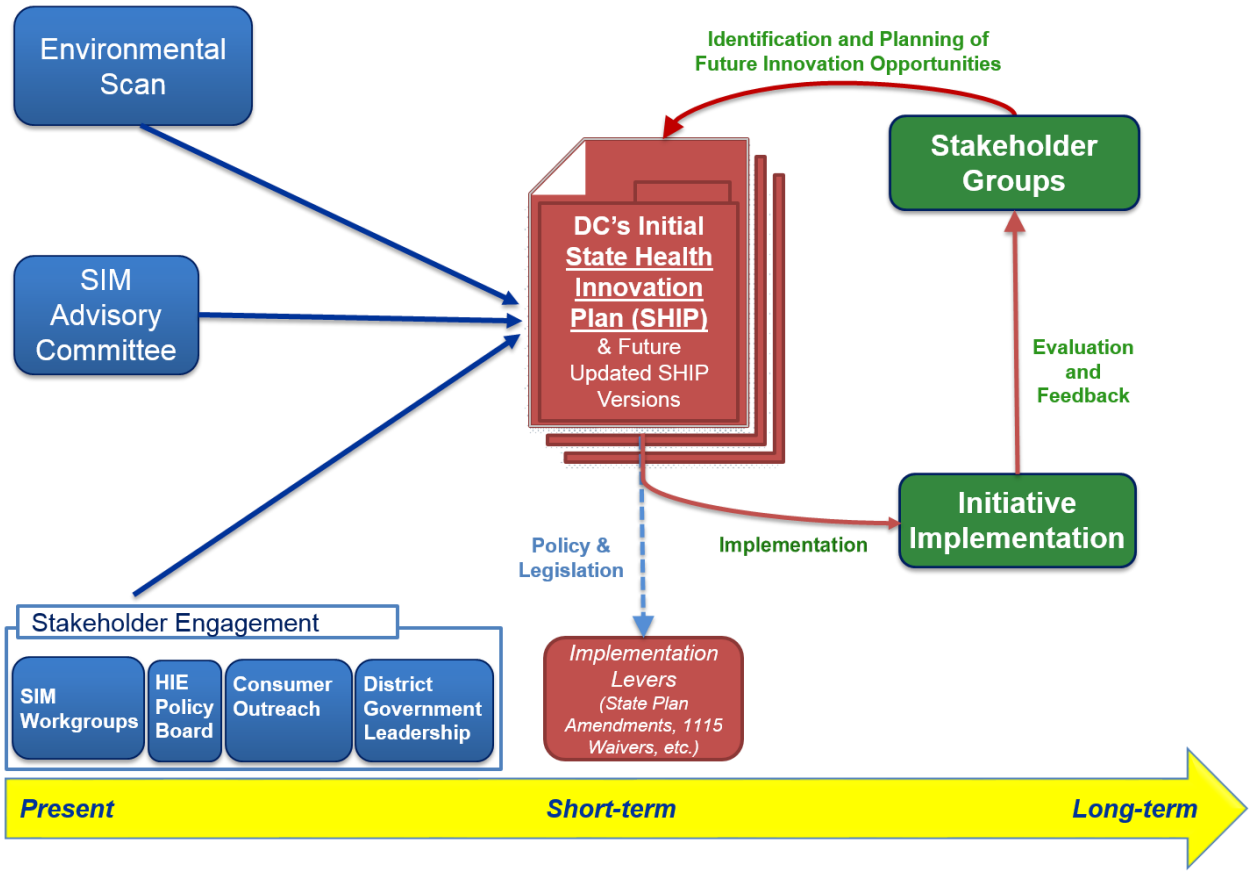
Transforming a healthcare system takes place over years, not months. Our strategy sets forth a long-term vision and a plan to implement incremental new initiatives (short-term activities) over the next 3-5 years. These short-term activities in turn lay the groundwork for achieving our long-term vision. We will leverage existing processes including the update to Medicaid Quality Strategy to drive our aims.

As we begin implementing the initiatives described in this document, we will continue working with stakeholders and evaluating the process, feasibility and sustainability of each initiative. We anticipate that this strategy will change as we navigate the best route towards meeting our long-term goals of value-based care delivery and payment.

Figure 2 below illustrates the process which we have taken to develop this current roadmap and how this process will evolve as we begin implementing these initiatives. To gather information for developing this SHIP we conducted an environmental scan of the District's healthcare and demographic landscape. We also formed a SIM Advisory Committee to guide the SHIP's direction and engaged with public, non-profit, and private sector stakeholders including District leadership and through five topic-specific Workgroups, an HIE Policy Board, stakeholder surveys and focus groups. We identified key areas ripe for innovation, themes from data, and points of consensus from all parties involved to develop an overall innovation plan that reflects the District's vision for healthcare innovation. The SHIP documents this plan as a 5-year strategy for reforming care delivery, payment models, and community linkages in the District.

The SHIP will be used to guide implementation of short-term initiatives aimed at reducing disparities in health outcomes and improving population health. The efficacy of these short-term initiatives will be monitored and evaluated over the course of their existence to inform future operations and measure quality improvements. The SHIP also plans longer-term initiatives in each key area, which will be further refined through ongoing stakeholder engagement, headed by the Medical Care Advisory Committee (MCAC) and other groups, over and beyond the 5-year plan. This will result in updates to the original SHIP, additional initiatives implemented at a later stage, and pursuit of formal policy and implementation levers, such as State Plan Amendments or Medicaid waivers, that will solidify innovations as part of official policy and regulation.

Figure 2. SHIP Development Process and the Future Transformation Process



The remainder of this document is organized by the following focus areas:

- Vision, Goals, Design and Current Environment in the District
- Pillar I: Care Delivery – This section discusses our short and long-term objectives for implementing an integrated care delivery system to provide value-based care
- Pillar II: Payment Reform – This section discusses our short and long-term objectives to establish payment model innovations and realign incentives to achieve value-based healthcare
- Pillar III: Community Linkages – This section discusses our short and long-term objectives to improve the well-being of the District's population through the systematic integration of clinical and social needs
- Enabler A: Continuous Stakeholder Engagement – This section describes how we will solicit and incorporate stakeholder input throughout the design and implementation of healthcare transformation initiatives

'Pillars' define the innovations essential to improving our healthcare system.

'Enablers' are the supporting factors critical to the viability of these Pillars.

- Enabler B: Developing Overarching Health Information Technology Capabilities – This section describes how overarching health information technology capabilities will support the initiatives described in the Pillars
- Enable C: Enhancing Workforce Capacity – This section describes how we will enhance our current workforce to support the implementation and sustainability of the initiatives described in the Pillars
- Enabler D: Quality Performance Improvement – This section describes our plans to align reporting requirements across programs and track provider performance in improving health outcomes
- Evaluation and Monitoring – This section discusses our plans for measuring the impact of the SIM efforts described in this SHIP
- Operational Plan – This section discusses our plans for future governance, our proposed roadmap for health system transformation and our financial analysis

Figure 6 graphically depicts the relationship between the Pillars and Enablers, as well as how we broadly define them within the overall framework of the District's health system reform goals. A different version of this graphic is at the beginning of the SHIP section dedicated to each Pillar. Within each customized graphic, the short- and long-term goals related to the Pillar are highlighted, and the Enabler definitions are adapted to reflect how they facilitate the accomplishment of these goals.

This SHIP is a long and complex document, with terms that may be new and unfamiliar to some readers. Thus, we have included a Glossary at the end of this document which provides a definition or description of key terms used throughout this SHIP. We've also created Appendices to this document that provide background and further explain and/or clarify concepts for the healthcare delivery and payment reform initiatives discussed in this SHIP.

Vision, Goals, Design and Current Environment

We aim to reduce disparities in health outcomes by targeting vulnerable populations for specific interventions. Building upon multiple ongoing initiatives, including the Health Home effort implemented earlier this year, we will expand coordination and integration of care for vulnerable populations. We are proposing a holistic approach to addressing residents' healthcare needs and achieving the Triple Aim of:

Improving consumer health outcomes by addressing social determinants of health, and focusing on preventative activities and care management.

Enhancing consumers' experience of care so that the healthcare system is more accessible and user-friendly.

Creating value for high-cost, high-need consumers through integrated care delivery, coordination with community supports, and alternative payment models.

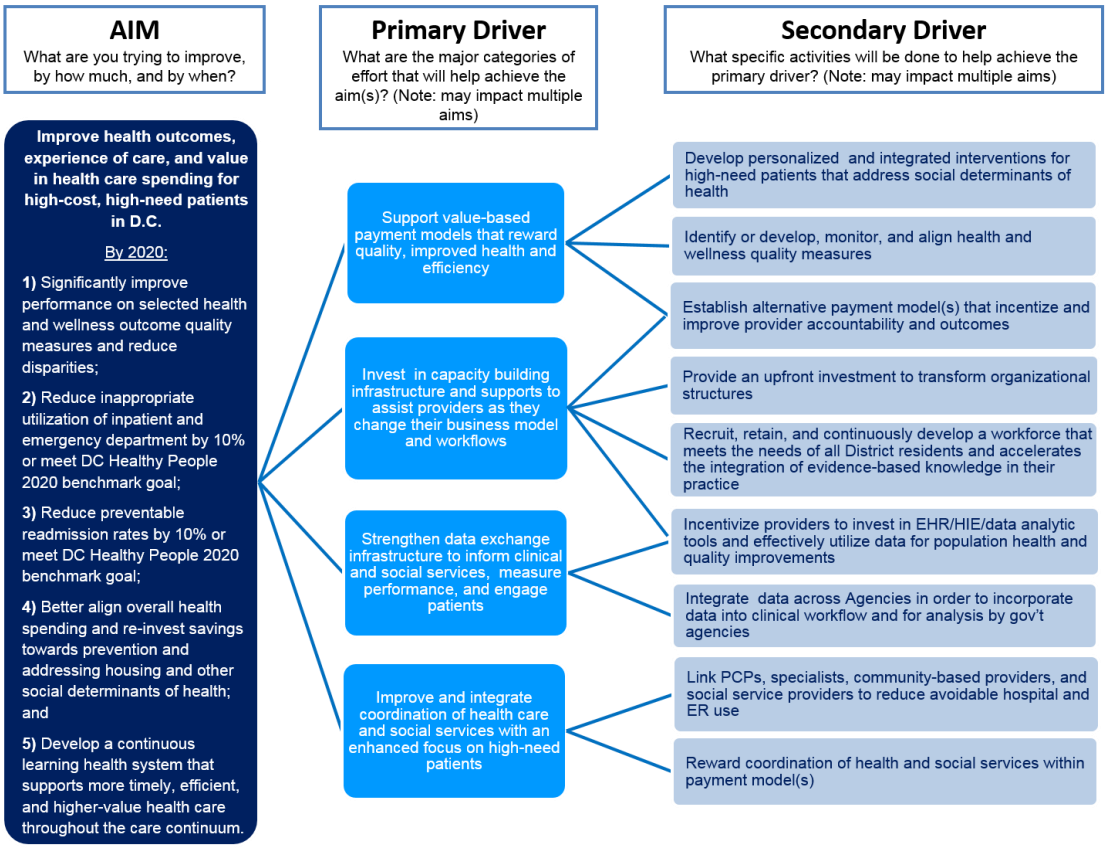
Over the next five years, we will plan and execute infrastructure and system improvement initiatives to meet our goals that align with the Triple Aim.

The District's SIM Goals:

- Create value for high-cost, high-need consumers through integrated care delivery, coordination with community supports, and alternative payment models
- Improve consumer health outcomes and increase health equity by addressing social determinants of health, focusing on preventative activities and care management
- Enhance the experience of care for patients so that the healthcare system is more accessible and user-friendly

The driver diagram, Figure 3 below, was the result of initial meetings, emails and discussions with various stakeholders. To drive ongoing discussion, we identified broad SIM aims to align with the Triple Aim and our SIM goals. These primary drivers also have 'secondary drivers,' which break the overarching aims into more specific action points.

Figure 3. The District's High-Cost, High-Need Driver Diagram



As discussions progressed with our stakeholders though the SIM design year, we identified opportunities to strengthen the initial aims to include quantifiable targets and align to the District's Healthy People 2020 framework goals. These strengthened aims are included below. Over the next five years, we will achieve the following five aims in five years. We will also continuously monitor progress towards meeting these aims and will modify the targets, including raising the bar, as necessary.

District's Five Aims in Five Years:

1. 100% of DC residents enrolled in Medicaid with a qualifying chronic health condition will have access to a care coordination entity, that is primarily responsible for all aspects of care, by 2018
2. 15% reduction from baseline in non-emergent ED visits for all District residents by 2020
3. 10% reduction from baseline in preventable hospital readmission rates for all District residents by 2020, 15% reduction from baseline for residents enrolled in Medicaid by 2020

4. Develop and implement a plan to reinvest savings achieved through system redesign to promote prevention and health equity, using a comprehensive approach not solely focused on healthcare by 2021
5. 85% of Medicaid payments will be linked to quality and 50% of payments will be tied to an APM by 2021

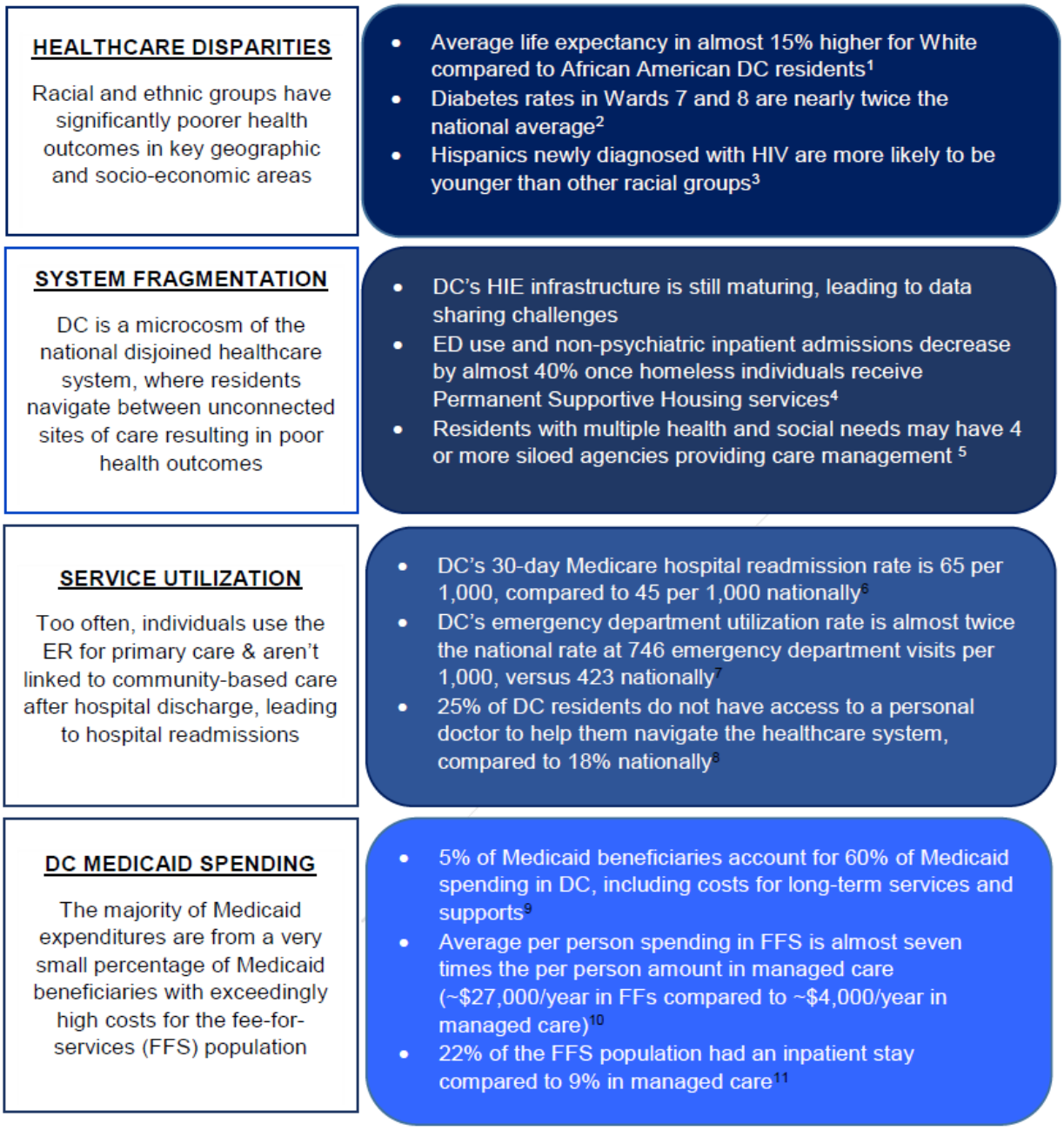
These aims informed the development of the Pillars and Enablers that are discussed in much more detail in the SHIP. The Pillars define the innovations (care delivery reform, payment model reform, and community linkages) that are essential in crafting and executing our vision for transformation, and the Enablers (stakeholder engagement, health information technology, workforce capacity development, and quality performance improvement) include the support that is critical to the viability of these Pillars.

The District's Current Environment

To set the stage for the District's transformation efforts, we conducted an environmental scan of our healthcare landscape to identify opportunities for improvement and where attention throughout our Model Design year should focus. With more than 40% of District residents enrolled in either the state Medicaid program or our locally-funded insurance program, the DC Healthcare Alliance, many of the findings from our analysis were directly related to our Medicaid beneficiaries.

The environmental scan describes the current state of healthcare in the District. It also describes the District's health system and population health baseline, including population demographics, health risk factors, healthcare utilization, and rates of healthcare coverage. The scan also identifies and discusses several policy initiatives already underway in the District including Medicaid waivers, Permanent Supportive Housing, Health Homes, and health information exchange. Detailed results from the full environmental scan can be found in Appendix 1. Key themes that emerged as a result of the scan are included in Figure 4.

Figure 4. Key Themes from the Environmental Scan



In addition to the environmental scan, we conducted robust stakeholder engagement to inform our strategy.

Stakeholder Engagement

In gathering input for the environmental scan and developing this strategy, we worked closely with stakeholders to examine current infrastructure, policies, and payment approaches within the District. This stakeholder input was essential to crafting a plan for improving coordination and outcomes while reducing health disparities that is progressive, realistic, and actionable.

We deployed a robust stakeholder engagement strategy throughout the year that included over 500 unique individuals. Stakeholder engagement included Workgroups, healthcare consumer interviews, weekly electronic newsletters, a dedicated SIM webpage, and robust social media presence. Input received from stakeholders drove the direction of our SIM efforts, and are incorporated into this document.

Engagement through Topic-Specific Workgroups

We convened stakeholder Workgroups to help inform our transformation efforts. SIM Workgroups assisted with the planning and development our healthcare reform initiatives. There were five SIM Workgroups, each dedicated to a specific matter, including:

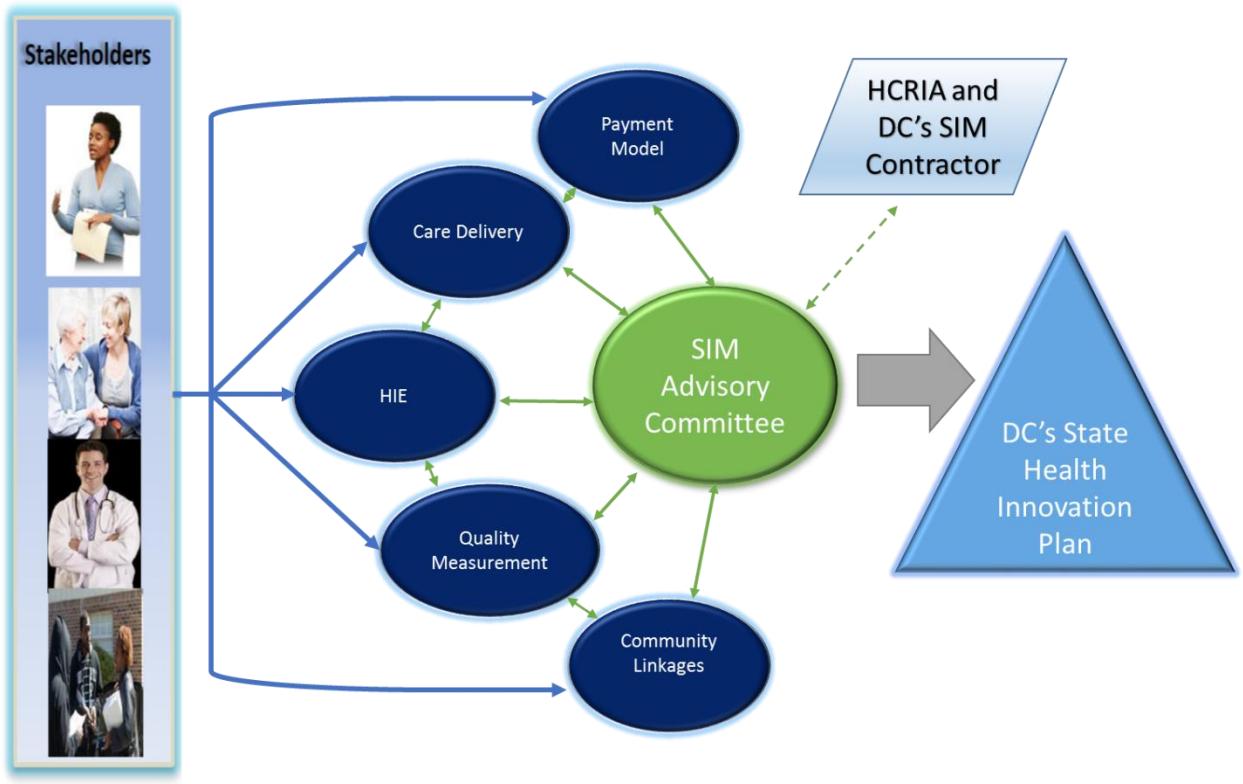
- Care Delivery
- Payment Reform
- Community Linkages
- Quality Measurement
- Health Information Exchange

Engagement through the SIM Advisory Committee and Topic-Specific Workgroups

The SIM Advisory Committee consisted of key decision makers in the District who have the authority and resources to implement the transformative initiatives envisioned – including those from local government agencies, the Mayor's office, City Council, commercial and public health insurers, providers, and beneficiary advocates. From October 2015 to June 2016, the SIM Advisory Committee met quarterly and provided guidance to the SIM Design Model Core Team housed within the District's Department of Health Care Finance (DHCF).

Each SIM Workgroup was chaired by an Advisory Committee member and comprised a wide range of payers, providers and consumers. Details about the SIM Advisory Committee and Workgroups can be found in Appendix 2. The work dynamic and information flow between the Workgroups and SIM Advisory Committee is depicted in Figure 5.

Figure 5. Workgroup Recommendation Flowchart



In addition to providing and discussing innovation recommendations, the Advisory Committee provided comments on the full draft of this document. A subsequent public comment period gave groups and individuals outside of the Advisory Committee, including Workgroup members, the opportunity to submit written feedback on this SHIP.

Consumer, Community and Provider Input

The SIM Design grant process gave us the opportunity to engage with healthcare consumers and providers in the District. We used a multifaceted approach to reach out to these groups and used several forums to gain in-depth perspective from the eyes of the consumers and providers. Over the course of the Design grant period, we conducted more than 100 consumer interviews, held a focus group, and surveyed a wide network of healthcare providers.

Consumer Interviews and Focus Group Provide a Direct Line to the Consumer

The goal of the consumer interviews and focus group was to understand the healthcare system through the eyes of consumers. We engaged in a thoughtful interview and focus group development process resulting in the interview questions found in Appendix 3. Topics covered a wide range of issues including demographic information, access to primary care and provider satisfaction, gaps in healthcare, ED utilization, access to social services, and overall satisfaction with the District healthcare system.

Limitations of Consumer and Provider Engagement Findings

- Approximately half of all interviews were conducted in health clinics where consumers were actively seeking care
- Some interview questions were confusing to participants - this lead to inappropriate answers that could not be used in the analysis.
- We interviewed over 100 individuals with a small number of interviews conducted at Pathways to Housing. This small sample is not a representative or statistically reliable sample.
- Focus Group recruitment was dependent on the availability of phone numbers and reliability that those numbers were in service. Focus group participation required that participants travel which was difficult for many of these individuals.
- Low response rate for the Provider Survey limits the generalizability of the findings.
- The majority of Provider Survey respondents were federally qualified health centers weighting the results towards their perspective.

We conducted interviews at federally qualified health centers (FQHC) including Mary's Center, and the Anacostia and Minnesota Avenue sites of Unity Health Center; hospitals including Providence Hospital and George Washington University Hospital, and a housing and social services agency, Pathways to Housing DC. We conducted over 100 in-person interviews with consumers including Spanish-speaking consumers. Additionally, we conducted a focus group of Medicaid beneficiaries with a high utilization of the Office of the Ombudsman.

Key interview findings include:

- **Patient Experience:** Approximately 30% of surveyed Medicaid beneficiaries do not understand their benefits and would like more education on the benefits they are provided. Patient education on healthy eating and healthy living habits would be the most helpful services to manage chronic disease.
- **ED utilization**: Individuals interviewed in the hospital EDs used in this survey were less satisfied with their primary care provider (PCP) and were more likely to use ED services before calling their PCP. Chronic pain (approximately 44%) is the most common cause for ED visits among the sample population
- **Gaps in care and services**: Access to timely primary care appointments, availability of dental and vision care were the most common gaps in health services identified by respondents. Housing and food insecurity were the most common social service gaps among respondents.

Key focus group findings include:

- **Consumer experience:**
  - Participants did not understand their Medicaid coverage benefits
  - Beneficiaries valued independence and feeling in control of their lives and health
  - The Office of the Ombudsman is a valuable resource for beneficiaries. Those that contacted the Ombudsman are satisfied with their resolution
  - Feelings of mutual trust and respect with providers have a great impact on when and how often individuals seek care from that providers
  - Office staff are a significant part of the healthcare experience. Patients reported not calling offices for advice on visiting the ED when they were unsatisfied with the office staff
- **Gaps in care and services:**
  - Access and acceptability of vendors for wheelchairs and other supplies greatly influence experiences in and opinion of the health system
  - Participants expressed the need for mental health services and apprehension to seek such services due to the significant stigma associated with mental health

Consumer Interview Process

- Consumers were interviewed at locations where they were seeking health or community services.
- Consumers were approached in waiting rooms by interviewers as they waited for appointments or a service.
- Prior to conducting the interviews, consumers were asked to confirm consent to participate in the interview by signing a form of consent, including in Appendix 3 The consent form was available in English and Spanish
- Interviews were conducting in approximately 10-15 minutes
- Subjects who reported visiting the ED 5+ times in the last year were asked addition questions regarding connections to the community and prevention of future ED visits.

Provider Engagement

Several healthcare providers serve on the SIM Advisory Committee and in SIM Workgroups; however, the District is home to thousands of providers. The District developed and fielded a provider survey to collect a diverse provider perspective. Twenty-eight providers including providers in federally qualified health centers and hospitals, private practice physicians and specialists participated in the survey. Findings include:

- **Missed appointments:** Approximately 57% of providers surveyed reported 26-50% of their patients miss their scheduled appointments. The most common reasons for missing these appointments included lack of transportation, forgetting they scheduled an appointment and other competing priorities.

Focus Group

One individual stated, 'I want my doctor's office to be like the show Cheers. I walk in and everyone knows your name and says hello.'

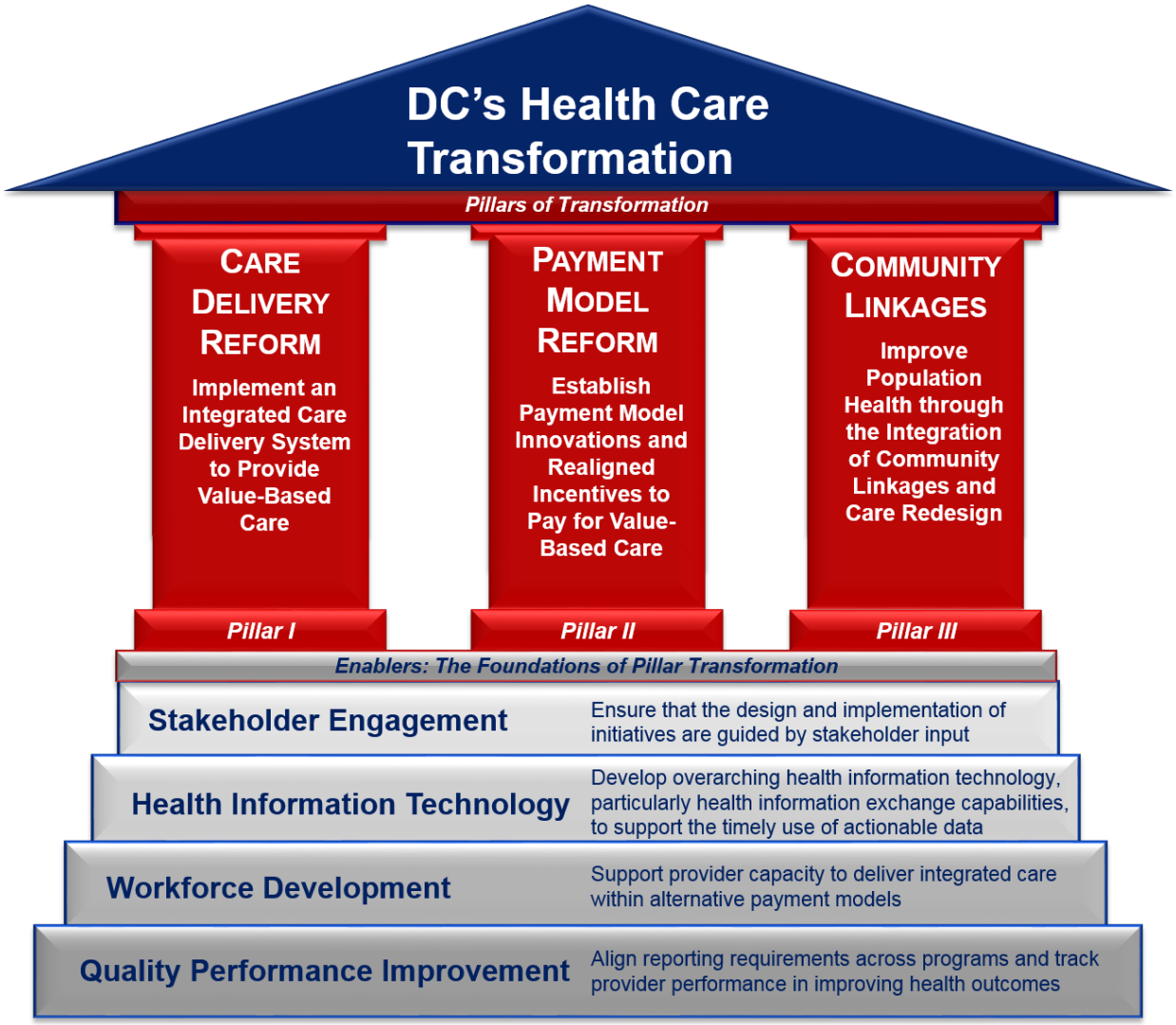
- **Lack of connection to social services:** Approximately 75% of providers screen patients for social needs. Housing can be disruptive to healthcare access as 95% of providers reported their patients demonstrating hardship in making and keeping doctor's appointments due to housing instability. Housing will continue to be an obstacle to care that providers cannot address. 90% of providers surveyed do not have the resources or assistance needed to refer patients to social services and other supports. Despite this obstacle, 87% of providers attempt to independently address the barriers that prevent patients from accessing care.
- **Medicaid policy:** Two-thirds of providers reported that Medicaid policies adversely affect enrollees' access to care. Policies that adversely impact beneficiaries include:
  - Lack of a funding mechanism to support health-related housing tenancy needs for beneficiaries
  - Medicaid has not identified ways to integrate underutilized allied healthcare professionals, such as pharmacists, into medical homes
  - Unreliable transportation and medical equipment vendors
- **Lack of resources:** Approximately 58% of providers felt they did not have the resources to care for complex Medicaid patients. Access to specialists and access to social services were the most daunting barriers for providers to serve Medicaid patients.
- **Data sharing:** Sharing with social services is lacking. Only 20% of providers share data with social service organizations compared to approximately 50% share with doctors' offices and hospitals. Providers overwhelmingly believe, at 92%, that sharing information resulted in better care for their patients.
- **Value-Based purchasing:** Only 50% of providers are aware of value-based purchasing models and only 4% are currently participating in such a model. However, approximately 75% of providers surveyed would be interested in participating in value-based purchasing.

The stakeholder engagement feedback collected during the SIM Design grant process was a cornerstone of the transformative ideas, plans and throughout this document. This input was used to develop care delivery, payment reform, and community linkages initiatives. We will continue to value and collect feedback from stakeholders as we move forward to implement the initiatives described in the SHIP.

Health System Design and Drivers of Reform

Our strategy is structured by Pillars and Enablers. The Pillars define the innovations (care delivery reform, payment model reform, and community linkages) that are essential in crafting and executing our vision for transformation. The Enablers (stakeholder engagement, health information technology, workforce capacity development, and quality performance improvement) include the support that is critical to the viability of these Pillars. This approach is tailored to the unique needs of the District, is informed by national model practices and commercial insurance, and is centered on the needs of our residents. This approach was also informed by the driver diagram described under our goals. Figure 6 below describes the relationship between the Pillars and Enablers.

Figure 6. The Relationship of the Pillars and Enablers to Drive Transformation

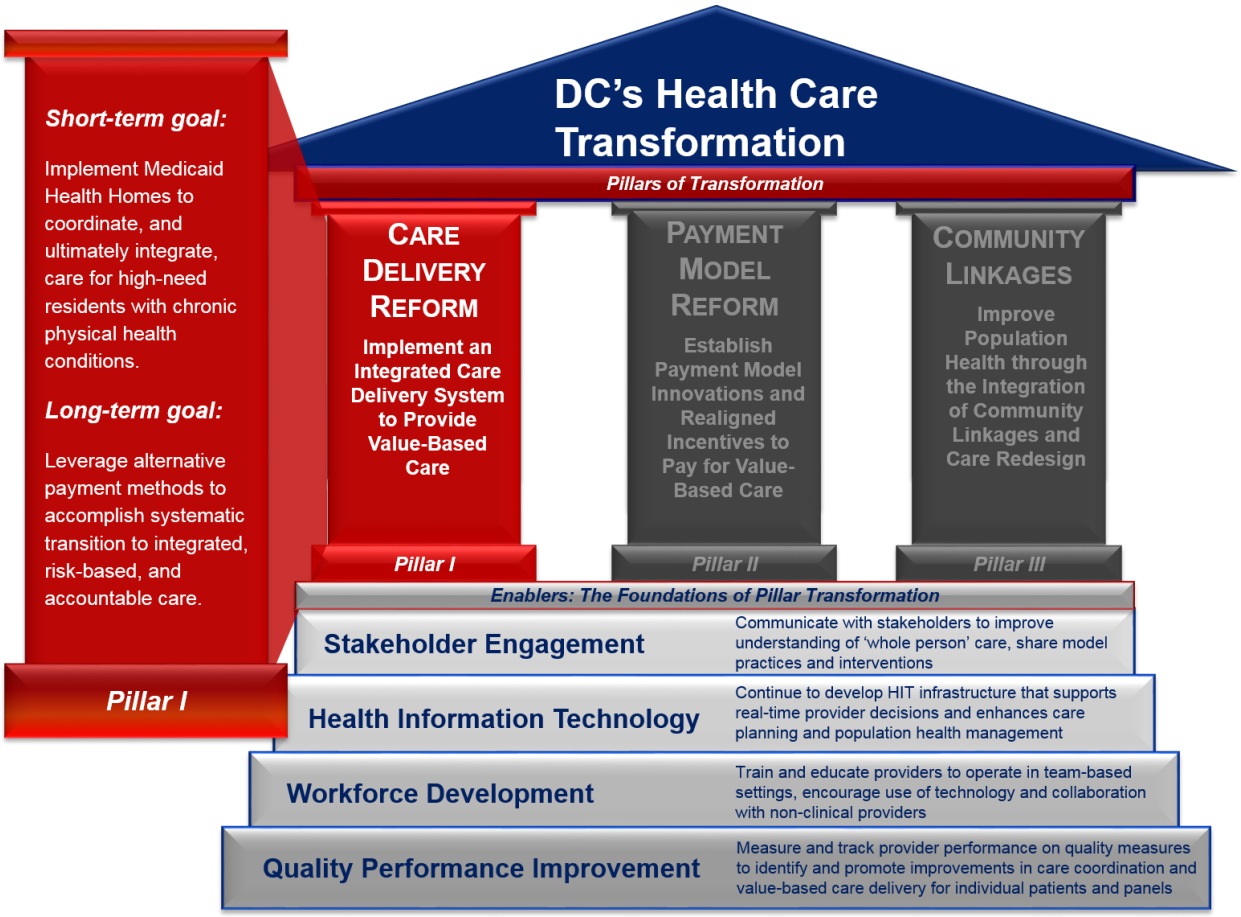


We will now transition to our discussion of the Pillars that will drive to our vision for transformation: Care Delivery Reform, Payment Model Reform, and Community Linkages.

PILLAR I – Care Delivery Reform: Implement an Integrated Care Delivery System to Provide Value-Based Care

Too often District residents inappropriately use hospital and ED services, particularly to manage their chronic conditions, such as diabetes. Inappropriate utilization of healthcare services, including avoidable use of the ED and preventable inpatient admissions/readmissions, are inefficient uses of healthcare resources that result in high costs and poor care management. This section discusses our short and long-term objectives for implementing an integrated care delivery system to provide value-based care.

Figure 7. Pillar I – Care Delivery Reform Short and Long-term Goals



As described in more detail in the environmental scan (Appendix 1), examples of inefficient utilization in the District include:

- 30-day Medicare hospital readmission rate, which is 65 per 1,000 persons, compared to 45 per 1,000 persons nationally
- ED utilization rate, which is almost twice the national rate (746 ED visits per 1,000 persons in the District versus 423 per 1,000 persons nationally)

- A quarter of residents do not have access to a personal doctor to help them navigate the healthcare system, compared to the national average of 18%

Fragmented care is a main contributing factor to inappropriate utilization. Fragmentation occurs when sites of care, such as hospitals, primary care offices, and specialist providers, do not communicate with each other regarding a patient's care needs and services provided. This results in critical patient information going missing when patients visit different care sites, and ultimately leads providers to duplicate services and patients to seek inappropriate care. Individuals with chronic and behavioral health conditions may not understand or be able to navigate the fragmented healthcare landscape. Fragmentation also makes it difficult for providers to communicate with each other and with their patients. Despite District residents' relatively high levels of access to primary care, over-use and misuse of care negatively impacts health outcomes and adds undue financial stress to the healthcare system.[xiv]

As discussed in the Environmental Scan included in Appendix 1, these challenges are most prominent among residents in marginalized sections of the community (Wards 5, 7, and 8) where health disparities are most prevalent. Findings from stakeholder interviews, a focus group, and the environmental scan reinforced that such challenges negatively impact both residents' health outcomes and their care experiences. The fragmented care delivery system, inefficient service utilization, and high levels of spending disproportionately impact racial and ethnic groups in these Wards. Residents subsequently experience disproportionately high rates of chronic disease and poor social determinants of health.

We engaged stakeholders, including industry experts, health systems, providers, government officials, community groups, and consumers to inform our approach to addressing these challenges. This process led to the development of short- and long-term goals:

- **Short-term goal:** Implement a second Medicaid Health Home benefit in DC (called Health Home 2) where primary care providers coordinate and integrate care for high-need residents with chronic physical health conditions and social needs that impact health, such as homelessness. Through this new program primary care providers will strengthen their capacity to deliver interdisciplinary care, will be paid to deliver care coordination services, and will eventually be held accountable for the outcomes of their empaneled population.
- **Long-term goal:** Systematically transition to a more cohesive, 'whole person' approach to care in the District that's underpinned by alternative methods of payment linked to outcomes. Our goals will focus on various cohorts of the Medicaid population and settings (e.g., hospitals; primary care and behavioral health providers; home health; nursing home; social service providers). The path to our long-term goal will be paved by initiatives that include:
  - Leveraging the Health Home 2 benefit, successes from shared savings initiatives in DC commercial insurers, and state-based primary care integrated care models to design and implement tiers of sustainable integration among providers to encourage the development and implementation of risk-based payment models

- Using Medicaid authorities (e.g., Section 1115 waivers, the Delivery System Reform Incentive Payment (DSRIP) program) facilitate innovative approaches and shared participation among hospitals and community level health and social service providers to improve outcomes of specific Medicaid populations
- Using comprehensive assessments to identify both clinical and health-related social needs
- Sharing person-level data between providers and systems to improve care delivery processes
- Establishing innovative approaches to ED diversion, such as nurse care triage lines that link users to health homes and telemedicine programs with the District's FEMS
- Implementing risk sharing for long term services and supports (LTSS)

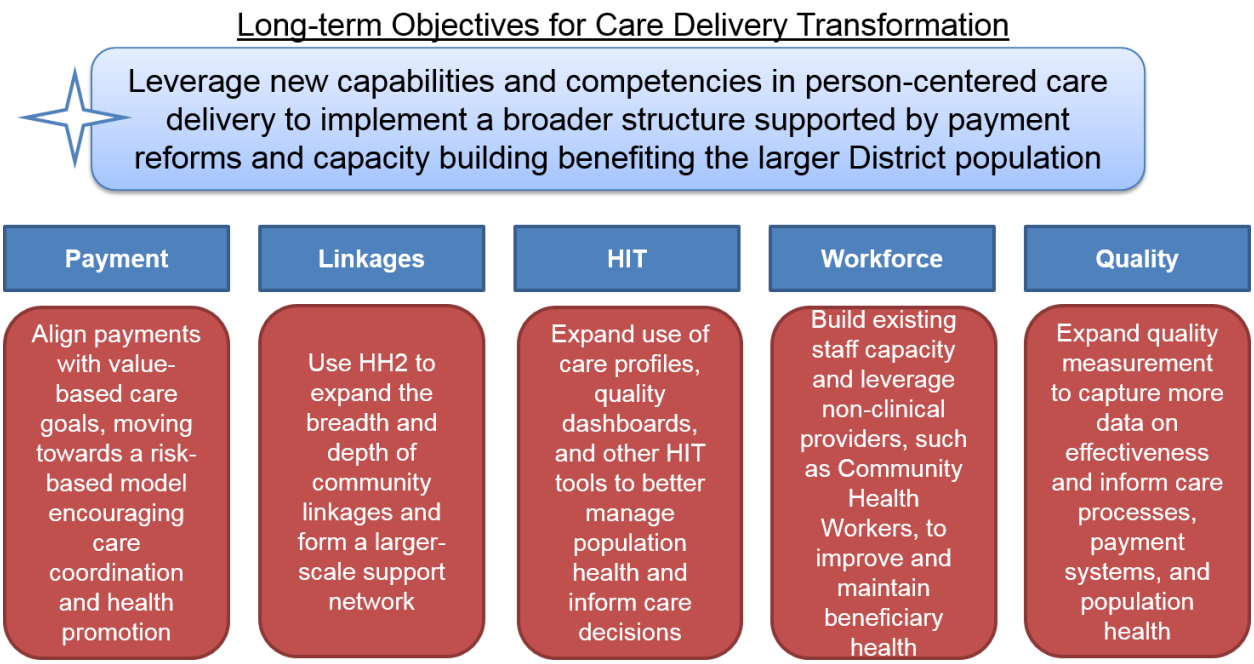
Through a mix of Care Delivery Workgroup meetings, stakeholder engagement, lessons learned from other states and CMS, and the environmental scan, we identified challenges, ongoing initiatives, and promising approaches to improve the care delivery system. This process led to a new vision of care delivery, starting with one of the first tangible products of the SIM planning process: development of the Health Home 2 initiative.

The **Medicaid Health Home (HH) benefit** improves coordination of physical and behavioral healthcare and addresses key social determinants of health, with a view towards future clinical integration of such services. Our short-term goal for transforming the care delivery system will build upon the launch of DC's first HH benefit for individuals with severe mental illness that began in January 2016, by implementing a second HH benefit for the District's high-need individuals with physical chronic health conditions—and later expanding this benefit to include individuals who experience chronic homelessness. This initiative, called **Health Home 2 (HH2),** requires significant investment in provider practice infrastructure, workforce, HIT and quality improvement capabilities in order to better coordinate care for enrollees. The HH2 benefit will incorporate elements of value-based payment and person-centered care delivery to realize enhanced quality of care, improved experiences of care, and better patient health outcomes.

We will build off of the infrastructure and competencies advanced through the Health Home 2 model to accomplish systematic transition to a more integrated, 'whole person,' and accountable model of care throughout the District. The Health Home 2 framework sets the stage for our long-goal of spurring providers' transition from FFS care delivery to integrated care delivery systems

using alternative payment models (see Figure 8).

Figure 8. Long-term Care Delivery Transformation Leverages Payment Models, Community Linkages, and Enabling Activities



Ongoing Initiatives Provide a Foundation for Care Delivery Transformation

While this is not an exhaustive list of initiatives, below is a short description of some applicable past and current initiatives discussed that have laid the groundwork for broad care delivery transformation. For a more comprehensive list of initiatives, see Appendix 14.

Table 1. Current and Past District Care Delivery Initiatives

Initiative and Operating Institution	Initiative Description
My DC Health Home – DHCF	Implemented in January 2016, a benefit for Medicaid individuals with severe mental illness that's designed to integrate the targeted population's physical health needs into the community mental health setting. My DC Health Homes are community-based mental health providers that have hired nurses, primary care doctors and others with social and health-related backgrounds, to create care teams that work with individuals and their caregivers to address and coordinate a person's full array of health and social service needs, while reducing costs and improving quality of care.
Federally Qualified Health Center (FQHC) Advanced Primary Care	Tested the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for Medicare patients. Participating FQHCs were expected to achieve Level 3 patient-centered

Initiative and Operating Institution	Initiative Description
Practice (APCP) Demonstration – Unity Health Care	medical home recognition, help patients manage chronic conditions, as well as actively coordinate care for patients. FQHCs were paid a monthly care management fee for each eligible Medicare individuals receiving primary care services and agreed to adopt NCQA care coordination practices.[xv]
Patient Centered Medical Home – CareFirst BlueCross BlueShield	Provides incentive payments to primary care providers and supporting care coordination teams to encourage development of care plans and achievement of quality milestones for patient outcomes. The program helped lower hospital admissions and improve outcomes for enrolled members, while increasing provider revenue.[xvi]
Medicaid Managed Care Case Management Programs – DHCF	The District's Medicaid agency (DHCF) contracts with Medicaid managed care organizations (MCOs) to deliver services to their enrolled patients, which comprise two thirds of all Medicaid enrollees in the District. MCOs are contractually obligated to provide case management activities to its enrollees, helping to coordinate and manage their care in an attempt to prevent future readmissions or costly provider visits. In October 2016, DHCF will begin a pay-for-performance initiative where 2% of each MCO's administrative rate will be withheld if certain hospital utilization based metrics are not met.
Coordinating All Resources Effectively (CARE) – Children's National Health System (CNHS), HSCSN	A collaboration between CNHS and Health Services for Children with Special Needs, Inc.,(HSCSN) to pursue about 600 high-need children for interventions to improve outcomes and reduce costs through realigning provider incentives and payments. The focus will be on reducing ED visits via improved care coordination and promoting prevention through medical home services.[xvii]
Racial and Ethnic Approaches to Community Health (REACH) – Centers for Disease Control and Prevention (CDC)	REACH is a national program aimed at reducing racial and ethnic disparities in health. The CDC supports awardee partners that establish community-based programs and culturally-tailored interventions serving African Americans, American Indians, Hispanics/Latinos, Asian Americans, Alaska Natives, and Pacific Islanders. Current REACH programs underway in the District include:[xviii] • George Washington University: The project will select, implement, evaluate, and disseminate best practices to address the key risk factors of poor nutrition, resulting in positive changes in obesity, diabetes, and heart disease. This effort will focus on populations in Langley Park and Prince George's County, MD. • Leadership Council for Healthy Communities (LCHC): LCHC collaborates with local community organizations to increase access to services that help prevent and manage chronic diseases; establish a health information exchange system that permits efficient delivery of

Initiative and Operating Institution	Initiative Description
	health services; and promote community preventive health resources in underserved, low-income communities in the District.
Prevention at Home (HIV/AIDS + IT) – George Washington University	Study of a new model to prevent new cases of HIV and improve outcomes for those with HIV/AIDS while lowering healthcare costs. This relies on mobile technologies, home testing and integrated care for HIV/AIDS patients.[xix]
Capitol Clinical Information Network – Mary's Center/ Providence	Past project to implement and test the use of an integrated clinical network to improve care for high-utilizing chronically ill Medicaid recipients. The project used care teams and telemedicine to communicate with patients, develop care plans for them, and personally manage their care as they were gradually transitioned into patient-centered medical homes. This became the Capital Partners in Care – Community Health Information Exchange.[xx]

Common themes of these programs and information gathered during research and Care Delivery Workgroup discussions inform essential principles underpinning SIM care delivery redesign. The principles of this new vision for care delivery are detailed in the following section.

Embrace New Concepts of Value-Based Care to Drive Innovation

We have identified four key principles for our vision of SIM care delivery redesign that can help address gaps in the care delivery system and lead the District towards an integrated, accountable system of care:

1. Address Physical and Behavioral Healthcare, as well as Social Services and Supports to Treat the 'Whole Person' and Move towards Clinical Integration

Fragmentation in care delivery is particularly challenging for individuals with multiple chronic physical health conditions who use the most services. These conditions require continual treatment and management to achieve positive patient health outcomes. However, patients with these conditions are disproportionately racial and ethnic minorities who are often ill-informed and unengaged about how to treat and manage their chronic conditions or how to navigate a fragmented delivery system to seek appropriate care. This leads patients to seek duplicative or inappropriate avenues of care and subsequently drives health spending upwards. Many of these individuals also have behavioral health needs which make it harder for them to seek appropriate care. Coordination and monitoring across both physical and behavioral health needs can help to manage and improve such individuals' health. Care models, such as Health Home 2, aim to bridge the gaps in the

'Whole person' is an individual's entire scope of physical, mental, behavioral, community and social needs with care coordinated across the continuum in a patient-centered manner to produce better health outcomes and more efficient and effective utilization of care resources.

fragmented care delivery system by shifting the focus away from treating individual acute episodes to a more comprehensive, coordinated way of treating 'whole person' needs.[xxi]

Efficiencies created through coordination can lead to more integrated care delivery systems that leverage data and multidisciplinary care teams, enhanced care coordination capabilities, and use community linkages to foster a new wave of individual and population health management. Integrated models systematically coordinate primary care with physical and behavioral healthcare, and connect providers to a network of community supports. These efforts will support the District's goal of providing 100% of DC residents enrolled in Medicaid with a qualifying chronic health condition access to a care coordination entity (e.g., managed care organization, provider, health home, accountable care organization) by 2018.

2. Accurately Assess Needs and Preferences to Improve Care Planning

Information gathered in comprehensive needs assessments should be used to develop comprehensive care plans and establish trust between patients and their providers. We can also gather social determinants of health as part of the assessment which allows individuals to work with their interdisciplinary care teams (described in Appendices 5 and 6) to address both medical and social needs, and to develop individualized care plans. These care plans become the basis for treating individuals, aligning their needs and preferences with the resources required for health maintenance and promotion.

The information gathered in assessments and screenings can also help MCOs and payers to stratify individuals into different risk categories, understand their utilization patterns, and further pursue high-need individuals for specific services that may improve their health.

3. Use Care Management and Coordination Partnerships to Cover Gaps in Care

Coordinating care for individuals through care plans, community linkages, streamlined referrals, and follow-up patient contact offers a more comprehensive and person-centered experience for the patient. Using care coordinators in integrated care teams facilitates the development and use of care plans and can also increase patient adherence to care plans. Care coordinators create links between providers and sites of care so that information can flow without being lost during care transitions (e.g., when patients move from inpatient hospital to outpatient care, emergency care to primary care). Care coordinators can communicate individual needs and preferences to providers and organize patient care activities according to these preferences. They also work directly with individuals to maintain and monitor health behaviors and care plan adherence.

Essential Care Coordination Functions

- Appointment scheduling and telephonic reminders
- Telephonic outreach and follow-up to individuals who do not require face-to-face contact
- Ensuring that all regular screenings are conducted through coordination with the primary care or other appropriate providers
- Assisting with medication reconciliation
- Assisting with arrangements such as transportation, directions, and durable medical equipment requests
- Obtaining missing records and consultation reports
- Motivational interviewing and Patient education
- Participating in hospital and ED transition care
- Documentation in certified electronic health records (EHRs)

The scope and intensity of coordination activities varies according to individual need, preferences, and level of risk.[xxii] Individuals with more complex needs (higher acuity) may receive more intense and frequent coordination services than individuals who have a single condition (relatively low-acuity). The level of coordination needed is also affected by the scope of social and community services and supports, such as housing providers, child care, transportation, and disability services required by individuals.

4. Use Health Information Technology (HIT) to Improve Care Coordination and Patient Outcomes

Leveraging HIT capabilities, which includes EHRs, HIE, telemedicine, web portals, patient registries, on-demand Patient Care Profiles, and other electronic tools, was identified by the Care Delivery Workgroup as critical to enabling care coordination, monitoring population health, and improving patient outcomes. HIT tools allow patient data to be captured and transmitted across care sites. Encounter Notification Services (ENS), such as Admission, Discharge, and Transfer (ADT) alerts, notify care teams of individuals' critical medical visits, allowing teams to react and treat individuals appropriately. Providers can then use additional tools, including Patient Care Profiles and telemedicine, to access the patient's history and care plan(s) and treat the patient accordingly or direct the patient to appropriate care sites (e.g., using primary care versus ED for non-emergent issues).

Using HIT to improve care delivery is not limited to informational updates via notification systems; HIT paves the way for data to be aggregated, analyzed for trends, and shared with care team members to address numerous gaps in care and encourage proactive patient treatment. HIEs can help to create a more longitudinal view of a patient's health that is accessible at the point of care. This can include a snapshot of an individual's medical history, recent utilization trends, and care plans, among other key health-related data. This care profile can help fill information gaps and improve provider decision-making and patient outcomes. Providers can also report outcomes measures through certified EHRs transmitting information through HIE systems, which simplifies the quality measure tracking process. This data can then be analyzed to provide rapid-cycle feedback to care teams on their performance and their patients' outcomes, which can help guide providers in making appropriate care decisions and dedicating future care resources.

Implement a Broader Transformed Care Delivery Structure

Currently, coordination between and among clinical providers and community supports or social service providers is limited due to resource restrictions, relatively sparse adoption and use of HIT, and a lack of reimbursement mechanisms for making linkages. However, the short-term and long-term SIM initiatives described will help us move towards an integrated approach. The short-term objective is to implement a Health Homes benefit in accordance with Section 2703 of the Affordable Care Act. This will be the second Health Homes initiative undertaken by the District, referred to as Health Home 2. The Health Home 2 model will help us meet the goals for reform and further integrate care by:

- Documenting clinical, behavioral, and social needs documented in the care plan and assessing social determinants of health that influence health status and behaviors
- Encouraging co-location and integration of services using an interdisciplinary team to address 'whole person' needs and improve care experiences
- Using nurse care managers and care coordinators to link patients to social services and supports, promoting broader information sharing and longitudinal care management
- Exchanging information among providers, bolstering patient access to information, and moving towards population health management supported by alternative payment models

Care delivery transformation will:

- Put the patient first and meet them where they are in the community
- Deliver the right care, right time, right place, right cost
- Foster team based care
- Align across all providers
- Include effective care transitions, resourced at the provider level

The long-term objective is to leverage capabilities and competencies built through Health Homes to implement a broader integrated and accountable care delivery model benefiting the larger District population.

This model will be sustained by a larger and better-trained workforce, a more robust HIT infrastructure, a comprehensive quality strategy tracking outcomes and performance, and a payment structure that links provider compensation to patient outcomes. We will offer technical assistance and training to prepare our stakeholders for the implementation of new initiatives.

Short-term Goal: Health Home 2 will Serve High-Cost, High-Need Individuals through a Coordinated and Person-Centric Approach to Care Delivery

The Health Home 2 initiative for individuals with chronic conditions (including HIV/AIDS, diabetes, and chronic homelessness) will be implemented in January 2017. Health Home 2 will improve care coordination and management activities for individuals with chronic conditions through services and supports promoting care for the 'whole person.'[xxiii] Health Home 2 will be a main driver in providing all residents enrolled in Medicaid with a qualifying chronic health condition access to a care coordination entity.

Health Home 2 complements traditional healthcare services, addressing gaps in the system that typically raise barriers for individuals with chronic conditions, particularly for individuals experiencing health disparities in District Wards 5, 7, and 8. Health Home 2 providers may be embedded in primary care settings to effectively manage the individual full scope of needs. This includes providing Health Home 2 enrollees with enhanced care management and care coordination services that bridge gaps in traditional acute care.

Health Home 2 care teams will guide enrollees to more appropriate services and decrease their reliance on the ED for managing chronic conditions. Individuals will undergo comprehensive needs assessments resulting in the formation of care plans that will guide care delivery tailored toward each individual. Health Home 2 will focus on increasing preventative care services to address potential health issues before they arise. Furthermore, enrollees will be treated by interdisciplinary care teams that integrate physical and behavioral healthcare, as well as linking individuals to social and community supports needed to maintain and improve social determinants of health. This care delivery structure reduces fragmentation within the system and addresses needs of the 'whole person' to improve and maintain positive health outcomes.

Health Home 2 Target Population: Chronically Ill and Chronically Homeless Individuals

To be eligible for Health Home 2 services, an individual must have two or more of the specified chronic conditions. We also plan to expand eligibility to individuals with one chronic condition and at risk of developing another. For the purpose of Health Home 2, chronic homelessness will be considered a risk factor for developing a chronic condition. This population is of focus due to its higher rates of chronic physical and behavioral health conditions, health disparities, and health spending, as compared to the general population. These individuals are frequent users of hospital services, especially of ED services.[xxiv] This population is comprised largely of racial and ethnic minorities residing in lower socio-economic areas of the city (Wards 5, 7, and 8) where concentration of providers is low, and rates of chronic conditions and homelessness, health disparities, and Medicaid spending are high.

To help address the need for housing and other social services and supports, the District's Permanent Supportive Housing (PSH) program, a locally funded initiative focusing on the primary need for housing and supports in this population, will be leveraged to forge partnerships within the community and among disparate District agencies.

The proposed Health Home 2 population is approximately 25,000 to 30,000 people, where the majority are enrolled in the District's Medicaid fee-for-service (FFS) program. However, Health Home 2 enrollment is open to individuals participating in either Medicaid FFS or a Medicaid MCO. See Appendices 5 and 6 for a more comprehensive description of the Health Home 2 initiative.

Long-term Goal: Development of Broad-Spanning Integrated Care Delivery and Payment Model

Our long-term goal is to leverage care delivery enhancements made through the Health Homes model to accomplish systematic transition to a 'whole person' approach which include more integrated, risk-based, and accountable care. Our vision for care delivery reform will align with

CMS' Triple Aim and its strategy for transforming care delivery as outlined in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).This future vision of care delivery relies upon robustly coordinated team-based care, underpinned by a strong HIT infrastructure and outcomes-based payments. These will enable providers to more effectively and efficiently deliver care for the 'whole person.' The broader vision for care delivery will still be guided by the four guiding principles described previously in this section. However, the long-term goal will also be supported by initiatives discussed in the remaining Pillars and Enablers that follow this section.

Expanding coordination to the larger population requires an increased commitment to screening for and addressing health-related social needs. Using such information to inform care processes and connect patients to supportive services in the community will enable broader population health and better individual health outcomes. The care delivery system will therefore move towards incorporating key elements of integration, described in Appendix 7. As providers become more comfortable in coordinated team-based care settings, such as Health Home 2, they will begin to incorporate more value-based models of payment that promotes clinical integration to achieve better health outcomes, resulting in enhanced provider compensation. The following characteristics will embody the long-term vision for the District's care delivery system:

CMS Value-Based Care Initiatives

- Implementing payment penalties for readmissions and hospital-acquired conditions
- Bonus payments for achieving quality milestones on clinical processes
- Patient experiences, outcomes and efficiency, bundled payments for hospitals and post-acute care
- ACOs with various levers for introducing risk and shared and extend care into the community

1. ***Use of Assessments to Identify Need.*** To best allocate resources for care, future care delivery models will dedicate resources based on patient acuity, much like Health Homes. Informed by needs assessments and comprehensive data reported to the District, high-risk individuals can be identified for specific interventions that address their unique care needs. Such initiatives will span medical, behavioral and social care needs, addressing the 'whole person' and delivering services in keeping with individuals' care plans.
2. ***Tiers of Integration among Providers Encourage Development and Risk Assumption.*** As providers have varying levels of infrastructure, resources, and experience necessary for population health management and care integration, they will require flexibility in changing their care delivery methods. Providers with less advanced care delivery structures, payment methods, and infrastructure may opt for a less advanced tier, which requires less patient risk assumption and fewer potential rewards. Providers more ready to integrate care based on their capacities and care delivery methods, such as Health Home 2 providers, may be choose to participate in more advanced tiers. These providers will assume more risk for their patients' health outcomes and subsequently be eligible for additional compensation through shared savings and alternative payment models. This structure gives providers the flexibility to choose a tier of integration that best

suits their respective practices, with stronger incentives to support providers taking on increased levels of accountability.

Tiering providers by readiness for integration therefore prepares providers to assume risk and creates a path towards achieving both more integrated care delivery and more potential financial rewards. This structure makes providers more accountable for the care they provide, encouraging 'whole person' care and leading to better patient health outcomes and reduced health disparities.

Model practices regarding care team structure, use of technology, and new provider functions needed to achieve higher tiering can be disseminated through learning collaboratives and ongoing technical assistance to the provider community. Meanwhile, workforce development will continue to focus on training and deploying clinical and non-clinical providers to work in/with integrated care teams, building skills necessary for 'whole person' care.

3. ***Data Sharing Connects Providers and Systems to Improve Care Processes*.** The future system will be reinforced by an overarching data infrastructure that connects disparate sites of care, enables care coordination and planning, and encourages integration. Increased adoption of HIT through SIM will allow care history, utilization updates, and person-centered needs and preferences to be displayed in real-time. These capacities can aid in care planning and provider decision-making, connecting previously disjointed sites of care through information sharing. Information systems can then house data essential to individuals care so that it is available to partners across sites of care.

   Data sharing via HIEs will allow for care teams to build capacities towards automating referrals and transmitting information to providers and community partners across care sites. This data can be pulled in to populate an on-demand Patient Care Profile used by providers to aid in care decision-making. Care partners and providers outside of the formal care team can view Patient Care Profiles and aggregated patient panel data to appropriately dedicate resources to and treat each patient.

   Providers can more easily integrate by leveraging the advanced data capabilities developed through SIM to capture physical, behavioral, and social components of care delivery. Co-location allows for seamless sharing of these data points within an interdisciplinary care team, while HIEs transmit such data to care partners in the community and reduce access barriers for patients and providers alike.

4. ***Outcomes-based Payments Underpin Care Delivery.*** The long-term vision will aim to reduce disparities in healthcare, improve patient outcomes, and achieve savings for healthcare delivered to the District's most vulnerable residents through reform of the current healthcare landscape into a more outcomes- and value-based care delivery and payment system. This system will promote team-based and coordinated care, and will gradually incorporate increased accountability through value-based payment arrangements. Providers will be increasingly spurred to collaborate as they assume risk and make changes to their practice structures to better serve patients. Investments in information systems, workforce, and quality measurement help providers achieve improved outcomes at the individual and

population levels, translating to increased compensation according to the level of risk they assume under such models.

As providers move towards integration, they can choose from a 'menu of options' of alternative payment models that will gradually improve their capacity and ability to assume risk for their patient panels. Eventually, providers with advanced integrated infrastructures may be able to take on full-risk for a patient population through an accountable care organization (ACO) or ACO-like arrangement. Such systems will use HIT to collect, report data, aggregate, and manipulate data to devise quality and payment benchmarks. This will allow for population health monitoring and identification of high-value care delivery processes.

This future system of care will likely increase its focus on preventative care, health promotion and wellness, and 'whole person' health maintenance. Dedicating more resources to these 'upstream' services will aim to reduce potential health issues later in a patient's life while also maintaining their current health. This will result in improved social determinants of health, better health outcomes, and increased provider payments and savings. Initiatives such as Health Home 2 set the stage for such efficiencies to be realized. By building a care delivery and payment framework that facilitates flexibility in transitions to value-based models, providers can move at a slower or faster pace towards achieving SIM goals of better care, improved outcomes, and reduced costs.

5. ***Build a Consumer Accountability Structure that Promotes Self-Care.*** Truly integrated systems have structures that makes consumers partially accountable for their own healthcare utilization and choices. Such systems can help remedy high rates of appointment no-shows and inappropriate care seeking behaviors in the District. Research of other states' policies reveal several ways to encourage consumer accountability, including instituting co-payments for use of the ED to address non-emergent issues. This method is designed to engage consumers in their choice of healthcare utilization and facilities. It is also designed to promote primary care utilization in place of costly acute care utilization, enhancing patient education on emergent and non-emergent healthcare services. By educating consumers and providing a monetary deterrent, consumers will better understand their healthcare benefits and build lasting, trusted relationship with their various providers

   We are considering opportunities to use the flexibility afforded through 1115 waivers to implement innovative approaches to improve outcomes of specific Medicaid populations. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or waiver projects that promote the objectives of the Medicaid and CHIP programs. Table 2 below includes examples of initiatives which we are considering to reach our goals and which may require 1115 authority.

Table 2. Examples of Integrated Care Delivery and Payment Model Initiatives

Initiative	Descriptions
Emergency Department (ED) Diversion	The District will implement ED diversion programs to meet our goal of 15% reduction in non-emergent ED use from baseline. We are considering: • Nurse care triage lines: Triage lines staffed by nurses could evaluate the need for ED use and recommend non-emergency care for non-urgent needs. The nurse would also link callers to health homes to which would assist in long-term care coordination and the use of primary care. • Telemedicine programs: Fire and EMS Department may use telemedicine technology to communicate with doctors to prior to an individual arriving at the ED to reduce the non-emergent ED use.
Risk sharing for long-term services and supports	The District is considering opportunities linking nursing home payments to quality, and eventually move toward 'shared savings. We are currently in the infancy stage of this development and are researching options for developing Medicaid value-based purchasing (VBP) arrangements in nursing facilities similar to the Medicare Nursing Home Value-Based Purchasing Demonstration. We are also considering initiatives to reduce hospitalizations among nursing facility residents and are observing the implementation of Tennessee's Quality Improvement in Long Term Services and Supports (QuILTSS) Initiative.
Delivery System Reform Incentive Payment (DSRIP)	We are considering options for using Delivery System Reform Incentive Payment (DSRIP) funding for Medicaid reform activities including infrastructure development, system redesign, clinical outcome improvement or population focused improvements.

Initiatives on the Radar

While Health Home 2 represents a significant step towards care delivery integration, we are considering and planning other initiatives that will build on expanded capacities and further SIM aims for care delivery redesign. One initiative 'on the radar' is:

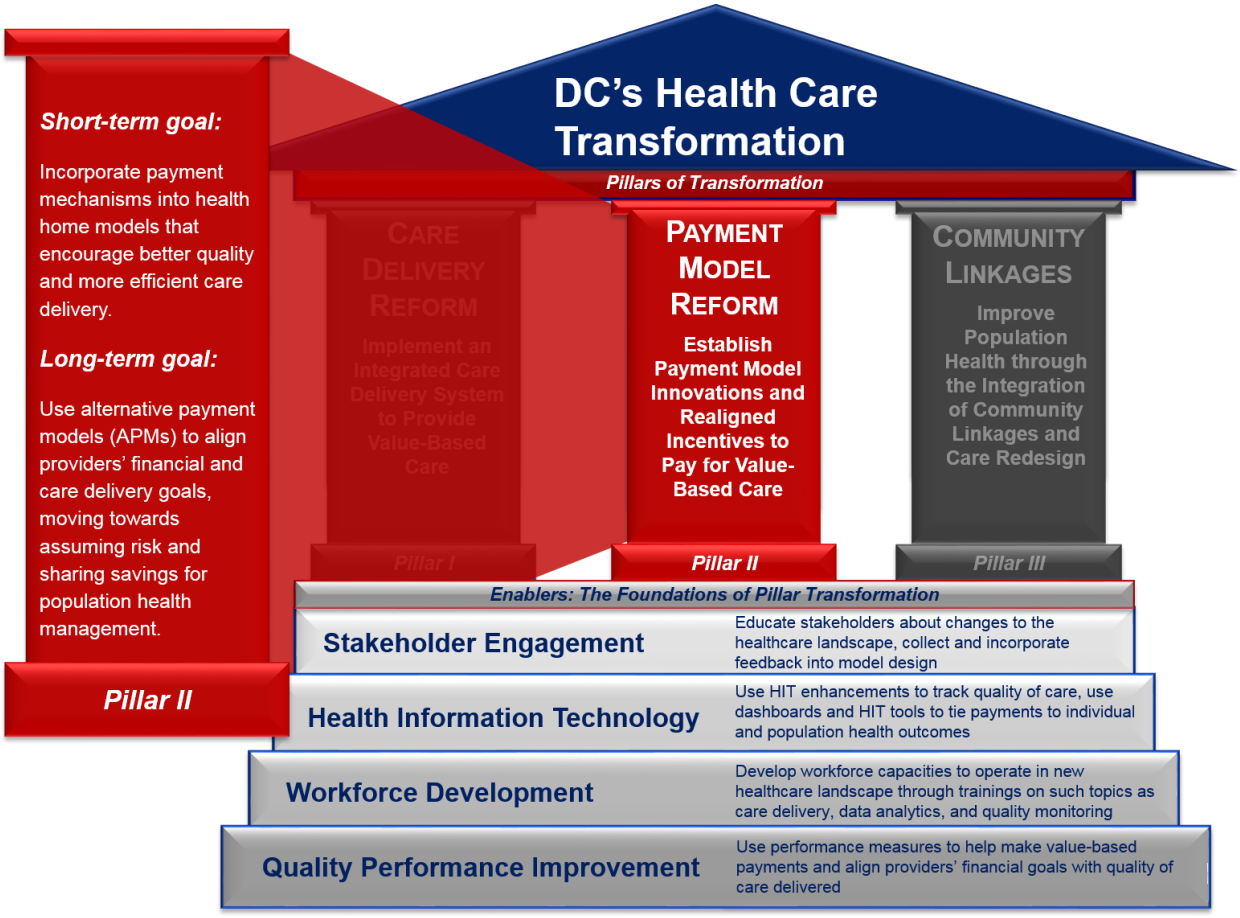
- Designing a model of integrated advanced primary care underpinned by risk assumption

The next section will discuss how incorporating value-based payment and alternative payment models will support the care delivery transformation initiatives discussed in this section.

PILLAR II – Payment Model Reform: Establish Payment Model Innovations and Realigned Incentives to Pay for Value-Based Care

Designing a payment structure that aligns provider compensation with improvements in health outcomes is critical to improving our residents' health and the efficiency and effectiveness of the District's healthcare system. Encouraging 'whole person' care planning and collaboration with community support providers is difficult in a Fee-for-Service healthcare system, where payment is not aligned with care delivery models that promote proactive, patient centered care across the care continuum. This section discusses our short and long-term objectives to establish payment model innovations and realign incentives to achieve value-based healthcare.

Figure 9. Pillar II – Payment Model Reform Short and Long-term Goals



In the District's current health care system, the majority of health related payments are based off of a FFS reimbursement methodology. While most Medicaid beneficiaries are enrolled the Medicaid managed care plans, where they have access to some level of care coordination services, approximately one fourth of Medicaid beneficiaries are not. For this 'unmanaged' cohort enrolled in the FFS care delivery system, the following exists:

- Financial incentives to deliver volume-based instead of value- and quality-based care
- Potential duplication of services and inefficient use of care resources
- Lack of incentives or compensation for care coordination and care management, which are non-clinical services that treat 'whole person' needs

Inefficient use of services leads to the mismanagement of chronic conditions, such as diabetes, and ultimately to higher costs associated with care for these conditions. Over 75% of the stakeholder interview respondents reported using the ED in the past year. ED utilization in the District is nearly twice the national average (see Appendix 1 for additional information about service utilization in the District). Additionally, the majority of Medicaid expenditures are attributable to a very small percentage of Medicaid enrollees with high rates of utilization and high costs. For example, the top 5% of enrollees with the highest costs account for 60% of total Medicaid spending, including costs related to long-term services and supports.

Embrace New Concepts of Value-Based Payment to Drive Innovation

Confronting these issues requires the development of a payment structure that rewards providers for improved patient outcomes instead of for volume of services rendered. However, new payment structures are complex and resource-intensive to design, and such payment structures will require new skills and infrastructure in order to successfully implement, operate, and sustain. Therefore, we are considering a tiered approach to payment redesign which incorporates a flexible structure for providers to implement new payment models. This will help providers transition to more value-based payment models and allow us achieve our overall SIM transformation goals. The Operational Plan discussed later in the SHIP includes a timeline of implementation activities.

Value-Based Purchasing Aligns Payment with the SIM Mission

- Aligns financial incentives with health system goals to promote shared accountability among providers and patients
- Promotes innovation and use of technology
- Enables providers to address social determinants of health
- Develops more integrated systems that aim to eliminate disparities and reduce inappropriate utilization
- Allows the full use of care teams to achieve goals
- Drives alignment between Medicaid MCOs and FFS systems

Two key principles of our vision for payment transformation guide the development and implementation of SIM payment transformation initiatives. These principles address key barriers to transitioning the healthcare system from volume to value-based care in the District. The principles are described below.

1. Care Delivery and Payment Transformation Efforts Must Align

Care delivery and payment transformation efforts must be complementary to successfully meet our goals of eliminating health disparities and reducing inappropriate service utilization. Payment models should use financial incentives to shape care delivery approaches that attain desired outcomes. In value-based models, financial payments should encourage:

- Delivery of high-quality and efficient care to improve patients' health
- Incentives for achieving and maintaining positive outcomes, increasing provider and patient accountability for health

This type of population health monitoring requires more long-term incentives for delivering 'the right care, at the right time, in the right place, at the right costs'

Payment models' financial incentives must support health system goals and facilitate a system of shared accountability. Gradual progression towards financial risk-sharing and shared savings models allows providers to realize increased compensation and assume accountability for care, while patients also take responsibility for their own health. Providers who gradually move towards value-based payments may choose from a 'menu of payment options' to identify a methodology that best suits their practice and care delivery capacities.

Aligning payment and outcomes for **providers and improving the way care is delivered and the way information is distributed** will help provide better care at lower costs across the healthcare system.

Additionally, efforts to transform payments must leverage existing strategies and resources where possible. This will help reduce provider burden during transitions since they can use such experiences as a stepping stone to instituting more value-based payments that align with their capacities for care delivery.

2. Payment Transformation Should be Incremental, Yet Purposeful

Healthcare transformation is incremental and will require support from all stakeholders to ultimately succeed. Given the diversity of provider types and infrastructure capabilities of disparate practices, providers will need varying amounts of time, support, infrastructure development, and resources to achieve payment transformation. We will empower providers to use a range of tools to achieve high-quality outcomes to increase their buy-in for delivery and payment transformation – payment model transformation, in particular, requires significant investments in:

- **HIT:** Stakeholders must have information systems capable of analyzing and exchanging data on care processes, services rendered, patient needs and preferences, health outcomes, and costs of care. Other stakeholders, such as state and federal agencies, will be responsible for investing in payment processes, quality monitoring, and HIT infrastructure.
- **Workforce and Capacity Building:** Increased investments to support providers can help expedite their successful transition to new payment models. This includes hiring new or retraining existing staff required for an interdisciplinary care team, where

appropriate, in addition to forging partnerships with non-clinical staff embedded in the community. Furthermore, technical assistance and training is beneficial to prepare stakeholders for the transition to value.

- **Quality:** Patient outcomes must improve, which requires providers delivering more person-centered and evidence-based care. An increased focus on delivering, achieving, and maintaining better quality healthcare over a sustained period of time will ultimately lead to a healthier population. As providers incorporate such practices, they will transition to more risk-based, quality-driven models of care that offer increased provider payments for better patient outcomes. Similarly, other stakeholders will need to refine their quality strategies and develop plans to help drive improved quality across the system.

Learning collaboratives among and partnerships with providers, community leaders, industry experts, educational institutions, and government agencies will be critical to sharing model practices and developing such capabilities to achieve successful transformation.

To enable adoption, providers will be encouraged to gradually implement value-based components of care delivery to build their capacities. As providers become more comfortable with value-based care and risk assumption, they can move towards more sophisticated value-based payments. Other stakeholders, such as payers, patients, government agencies, and community partners, will similarly have to build their capacities in a balanced and gradual manner.

We used these principles to guide our selection and development of short- and long-term goals, incuding:

- **Short-term goal:** Incorporating pay-for-performance (P4P) mechanisms into Health Home 2, federally qualified health centers (FQHCs), and Medicaid managed care organizations (MCOs) to encourage better quality care.
- **Long-term goal:** Enabling providers to assume risk for their patient populations and move towards value-based alternative payment models (APMs), as defined by CMS, which align with care delivery goals.

New and Ongoing Initiatives Provide a Foundation for Transformation

There is currently a national shift away from FFS payments towards value-based payments. For example, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) presents two main tracks for achieving quality through value-based payment. CMS has set targets of reaching 85% of Medicare service payments linked to quality by 2018 and 50% of which should be through Alternative Payment Models (APMs).[xxv] See Appendix 8 for more information about MACRA and APMs. We are planning to incorporate elements of both MACRA tracks into its vision for payment transformation. We also use pay-for-performance (P4P) to move providers

from FFS towards more value-based forms of payment, including APMs. Adopting P4P results in improved provider capacities, such as the ability to measure, report, and improve quality performance in response to measured outcomes. We will use the capacities fostered through P4P adoption to encourage transition to APMs which promote integrated, coordinated, and value-based care delivery.

Alternative Payment Models (APMs) were developed under the Medicare Access and CHIP Reauthorization Act (MACRA). APMs encourage providers to make changes in care delivery processes that improve quality and patient outcomes and reduce healthcare costs. APMs reward high quality care delivery with enhanced value-based payments to providers.

We identified ongoing District initiatives that incorporate value-based payments to leverage as we pursue short-term and long-term payment transformation goals. We are using lessons learned from these efforts to construct our vision for payment transformation over the 5-year SIM plan. Below are brief descriptions of past and current initiatives that help lay the groundwork for payment transformation.

Table 3. Current District Payment Model Initiatives

Initiative and Operating Institution	Initiative Description
My DC Health Home – DHCF[xxvi]	Community-based mental health providers, known as Core Services Agencies (CSA), created care teams by hiring nurses, primary care doctors and others with social and health-related backgrounds to work together under the umbrella of a Health Home led by the CSA. Each enrollee is linked with a Care Team who will work with the person's doctors, family and anyone else the person selects to pay special attention to their healthcare needs; make sure needed medical services are received; and help get needed social services, such as housing and food. Such care is reimbursed via per-member-per-month (PMPM) payments to the care team.
CareFirst Patient Centered Medical Home - Blue Cross Blue Shield Value-Based Care Program[xxvii]	Primary care providers (PCPs) are organized into Panels to coordinate the care of attributed members. Panels can earn incentives based on the level of quality and degree of savings they achieve against projections. The program is designed to provide PCPs with a more complete view of their patients' needs and of the services they receive from other providers so that they can better manage their individual risks, keep them in better health and produce better outcomes. The program meaningfully compensates providers for increased engagement.
Hospital Acquired Condition Program (HAC) – Medicare	This program reduces payments to hospitals that rank in the worst performing quartile of hospital-acquired conditions, based on risk-adjusted performance.

Initiative and Operating Institution	Initiative Description
Hospital Readmissions Reduction Program – Medicare	This program reduces payment to hospitals based on readmissions related to heart attack, health failure, pneumonia, hip/knee replacement and chronic obstructive pulmonary disease (COPD). Performance is based on a national average from a retrospective three year period.
Hospital Value-Based Purchasing Program – Medicare	This program provides incentive payments or penalties to hospitals for meeting agreed upon metrics related to clinical process, patient experience, outcomes, and efficiency. Performance is based on national benchmarks and accounts for hospital improvement.

Short-term Goal: Instituting PMPM and P4P Payments to Support Health Home 2 Models, MCOs, and FQHCs

The short-term objective of implementing pay-for-performance (P4P) mechanisms in Health Home 2 is an initial step in our transition to value-based care delivery. As described in Pillar I, Health Home 2 serves patients who have multiple chronic conditions through a team-based approach care. This care delivery model addresses each patient's unique health and social needs, including homelessness, and is supported by a per-member-per-month (PMPM) payment to the interdisciplinary care team that provides enhanced services.

Health Home 2 members are assigned to groups based on acuity and PMPM payment rates are based on the member's level of need. We will review PMPM rates annually and update them as necessary (the methodology used to devise PMPM rates are described in Appendix 5). Since MCOs also provide services covered through Health Home 2 PMPM payments, such as care coordination and care management, we will use the process described in Appendix 5 to reduce duplication of services and payments in accordance with Federal requirements.

PMPM payments have various advantages over FFS payments in increasing accountability of care. PMPM payments encourage:

- **A shared financial interest:** Supplemental PMPM payments are delivered to the interdisciplinary care team to cover the costs for providers to coordinate care. This flexible payment arrangement allows Health Home 2 providers to invest in staffing capacity, and non-clinical services to help improve the beneficiary's health.
- **Enhanced care coordination:** PMPMs offer incentives to manage patient care beyond the clinical setting to avoid inappropriate utilization of services (e.g., avoidable ED visits, preventative inpatient visits, and hospital readmissions) which increase the total cost of care. By coordinating care, improving patient health literacy and education, and partnering with community organizations that address patients' social determinants of health, providers can help maintain health beyond clinical settings. This strategy also has the added benefit of fostering patient accountability for their care.

- **Population health management:** This system of payment encourages providers to review the entire panel of patients to identify trends in utilization and health behaviors, appropriating care resources accordingly to address patients' needs. Providers can and are expected to incorporate and use HIT tools, such as quality dashboards and on-demand Patient Care Profiles, to monitor patient health, inform care decisions, and adequately allocate resources to improve the health of their entire patient panel.

PMPM payments encourage provider practices to better coordinate care and deliver more non-traditional services that benefit patients' long-term health. As providers build internal capacities to delivery more coordinated care, they can transition to even more value-based methods of payment, such as pay-for-performance (P4P) and APMs.

Pay-for-performance (P4P) refers to healthcare payment systems that offer providers financial incentives for realizing, improving on, or surpassing their performance targets for certain quality and cost measures. Payments are based on measures divided into three buckets: structure, process, and outcome measures.

To transition to the long-term goal, providers need a supporting incentive structure that allows them to build practice capacities to assume risk. This includes developing and promoting the use of HIT to report clinical outcomes and care processes. Such capacities will be developed through Health Home 2 investments among participating provider practices, but also through P4P bonus payments. P4P will be implemented in year two of Health Home 2, as well as in upcoming payment arrangements for FQHCs and MCOs, giving providers time to adjust to value-based practice operations and set baselines for performance. P4P will allow providers to continue this transition to value by offering them additional payments upon meeting or surpassing certain cost and quality measure milestones set by the District. These additional payments serve two main functions in transitioning providers to value-based care:

1. P4P ties provider payments to quality outcomes, a staple of value-based payment models. As providers become more comfortable with outcomes-based payments, they will adopt more high-value practices, such as care coordination, and transition their care delivery culture.
2. Bonus payments allow providers to build internal infrastructure that support value-based concepts, such as risk and accountable care. Providers can then move to more risk-based payment models with greater potential rewards, but also risk of losses for poor outcomes.

The key to P4P is making payments that are, at a minimum, proportionate to the practice improvements made to achieve care targets. This payment structure will allow providers to more easily transition to value-based care models and, eventually, adopt APMs that incorporate risk-based payments for care.

Long-term Goal: Achieving Provider Readiness to Assume Risk and Move towards Value-Based APMs that Align with Care Delivery Goals

We will use increased capacities built through Health Home 2's payment structure to spur providers' transition to new care models and value-based payment, in particular the APMs created by CMS under MACRA. APMs offer a vehicle for providers to improve their quality of care delivery, financial compensation, and patients' health. Advancements made by transitioning to APMs will have repercussions for the entire health system. All providers have the option to participate in value-based payments and P4P initiatives, leading to gradual transition towards APMs. By leveraging SIM's increased focus on population health that underlies this value-based model, we can achieve our tangible targets of:

- Reducing preventable hospital preventable rates for all District residents by 10% and 15% for residents enrolled in Medicaid (aligned with Healthy People 2020)
- Reducing inappropriate ED use by 15%
- Improving performance on wellness outcome quality measures and reducing disparities
- Aligning overall health spending and reinvesting savings towards prevention and addressing social determinants of health, including housing by 2021

APMs Promote Value-Based Care Delivery Approaches

- Implementing new modes of billing, documenting and transmitting care information
- Paying for non-clinical service including care planning, management, and coordination activities
- Addressing social determinants of health through community linkages
- Enhancing patient access via online tools and using HIT to inform care decisions
- Adding patients to registries and managing population health
- Tracking outcomes at both the patient and population levels
- Educating patients regarding health maintenance and health promotion

We are planning for providers to have at least a year's experience with P4P before the option to adopt APMs becomes available. Depending on capacities, resources, and practice needs, providers will have the option to adopt APMs at different rates. The flexibility afforded to providers means that providers can form partnerships with each other based on the APMs they adopt, or they can work internally to further augment their own practice capacities. The goals of such a structure are to have providers:

- Assume increased risk and accountability for their patient population
- Share in savings accrued through provision of value-based care

Starting in year three of Health Home 2, we will offer participating providers a 'menu of payment options' that allows them to adopt and implement payment models that best fit their practices. The goal is for providers to leverage efficiencies built through their experience with PMPM and P4P in adopting these APMs. However, APMs will be more geared toward accountable, risk-

based care. This means that providers will have the potential to both realize savings from improved care processes, and to incur losses for inefficient care and poor patient outcomes.

- **Development and integration of a comprehensive HIT and quality infrastructure:** As provider payments will be outcomes-based, providers need to have systems in place that will capture, transmit, and analyze data on patient care, outcomes, and costs of care. We anticipate that providers, as well as non-clinical providers and social supports, will require significant technical assistance and education for successful wide-spread adoption of these systems. This will promote better care delivery through streamlined coordination, referrals, monitoring, and decision supports while also simplifying the quality reporting structure. Tools such as HIE, Patient Care Profiles and quality dashboards will grow the District's HIT infrastructure and will aid providers in completing these functions both inside and outside of formal care settings.
- **APMs will promote community care to better monitor and manage population health:** Community partners and care extenders are vital to seamlessly transitioning patients from clinical care into community settings. They provide social supports that address social determinants of health key to maintaining patient outcomes. Substantial investments will be required to train and educate such staff, as well as the providers they work with, in how to deliver care in the community and monitor population health. These concepts aim to help keep patients healthy longer, which will translate into more savings for providers who assume risk.

APMs encourage provider coordination with community partners, especially with high-touch staff, such as non-clinical, community based health navigators. Using needs assessments informing person-centered care, providers can collaborate with and pass on care management duties to more these appropriate non-clinical staff. Health navigators can then meet patients in the community to monitor care plan observance, medication adherence, and overall

- **APMs encourage integration and shared infrastructure:** In APMs, if actual costs of patient care exceed the assumed level of financial risk, then providers incur losses for that patient. However, if actual costs of patient care are below the assumed level of financial risk, then providers accrue savings that can later be reinvested to build the practice and its capabilities for instituting other forms of value-based care and APMs. If all providers on a care team share the same financial goal, it is in their interest to share resources as well. Clinical integration and co-location allows providers to work together using a shared infrastructure to meet their financial and care goals for the patient population and achieve savings for care delivered to the patient panel.

CMS Guidance on Co-Payment for ED Use for Non-Emergent Care: States have the option to impose higher copayments when people visit a hospital emergency department for non-emergency services. This copayment is limited to non-emergency services, as emergency services are exempted from all out of pocket charges. For people with incomes above 150% FPL, such copayments may be established up to the state's cost for the service, but certain conditions must be met.

- **Build a consumer accountability structure that promotes self-care:** As we move to value-based payment, we will also build a structure that makes consumers accountable for their own healthcare utilization and choices. We continue to conduct research into best practices regarding consumer accountability. Research of other states' policies revealed several ways to encourage consumer engagement including co-payment for ED use for non-emergent care.[xxviii] This method is designed to engage consumers in their choice of healthcare utilization and facilities. It is also designed to promote primary care and educate consumers on emergent and non-emergent healthcare services. By educating consumers and providing a monetary deterrent, consumers may better understand their healthcare benefit and relationship with their various providers. The District aims to reduce non-urgent ED use by 15%.
- **Build a provider accountability structure that encourages 'whole person' health:** We plan to implement strategies that will encourage providers to assume more responsibility for the health outcomes of their patients. We have conducted research on the most effective ways to achieve provider accountability and we continue to work with our Payment Model Workgroup to discover the most effective and actionable method to align value and payment. These methods and discussions will be considered in future payment model reforms as the District moves towards a post-MACRA payment methodology, while also considering methodologies being advanced by Medicare and commercial payers.

Initiatives on the Radar

SIM lays the foundation for future payment model transformation to occur on a broader scale in the District. Building off of experiences of and lessons learned through SIM initiatives, we will identify further opportunities to transform the payment landscape. We will continue to develop and refine initiatives that improve quality, enrich patients' experiences, and reduce costs of healthcare. Future initiatives 'on the radar' that are being considered or planned include:

- Incorporating value-based payment models into Medicaid managed care contracts
- Pursuing Section 1115 waivers that will enable DC to implement 5-year waiver projects on service delivery model innovations and payment as a vehicle to move towards innovative risk-based payment arrangements (e.g., an ACO for fee-for-service (FFS) beneficiaries, wrap-around services associated with an opioid treatment program; an EMS super utilizers program, a sickle cell disease management program, and/or an urgent care program)
- Leveraging the Delivery System Reform Incentive Payment (DSRIP) Program to direct funds toward provider-led efforts to improve quality and access (e.g., infrastructure development, program innovation and design, population-focused improvement, clinical improvements in care)
- Modifying payments to reduce hospital acquired conditions

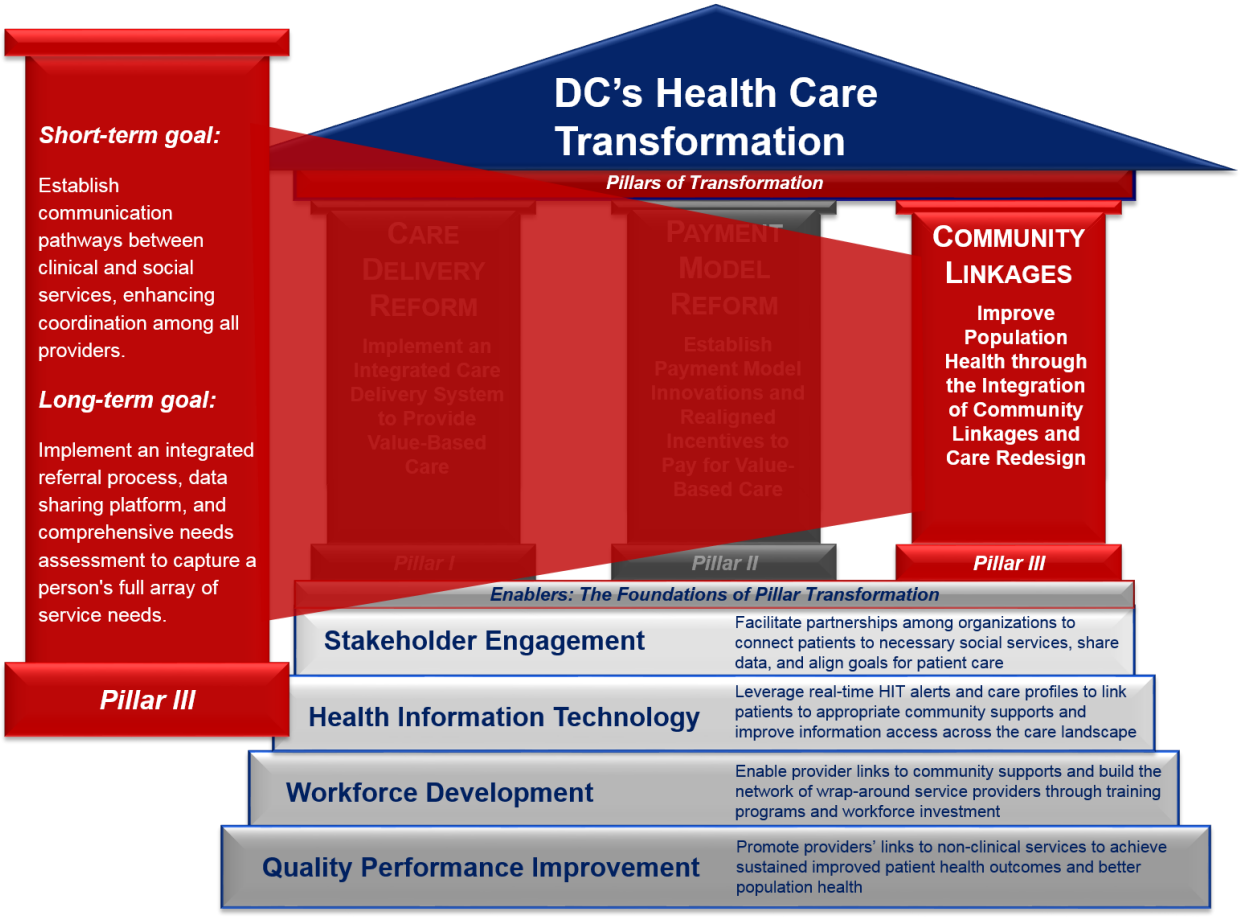
- Exploring avenues to engage beneficiaries in their care in order to reduce inappropriate hospital utilization
- Implementing risk-based payment for long-term services and supports (LTSS), e.g., Program for All-Inclusive Care for the Elderly (PACE)

The next section will discuss necessary steps to improving collaboration between physical health and social services to reach our overall transformation goals.

PILLAR III – Community Linkages: Improve Population Health through Integration of Community Linkages and Care Redesign

There are varying degrees of economic stability in the District. While we are experiencing a recent increase in high-income-earning individuals deciding to call the District 'home', we have one of the highest poverty rates nationally (18.6%) and a high rate of homelessness (about 1% of District residents experience homelessness on any given night).[xxix] These statistics primarily reflect residents in the District's Wards 5, 7 and 8, where additionally persons in these areas report the highest rates of high blood pressure, obesity, diabetes and smoking among District residents. There is a link between the economic status of these individuals and their poor health outcomes. This section discusses our short- and long-term objectives to improve the well-being of the District's population through the systematic integration of clinical and social needs.

Figure 10. Pillar III – Community Linkages Short and Long-term Goals



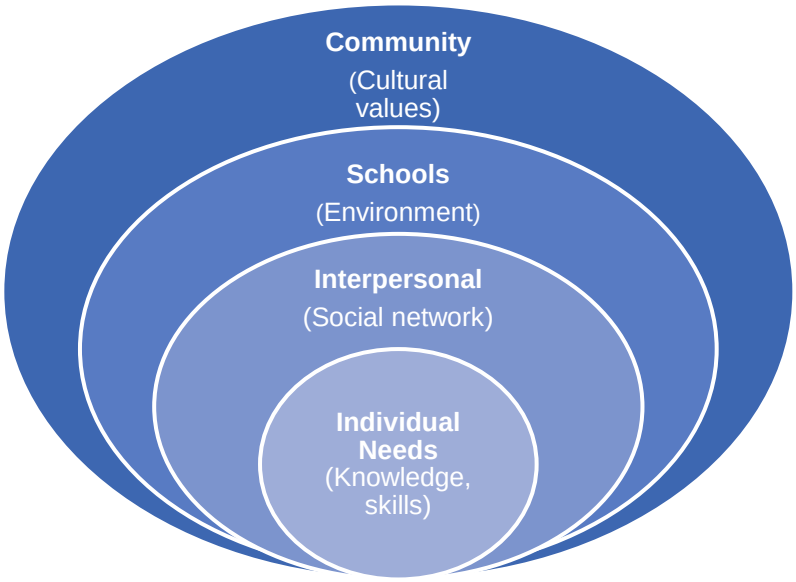
Mayor Muriel Bowser has prioritized reducing disparities and improving pathways to the middle class, while eliminating chronic homelessness for individuals and families by 2018, and making homelessness in the District a rare, brief and non-recurring experience by 2025. An essential

step in meeting the Mayor's goals is improving the health outcomes of our most vulnerable residents, as poor health status is a key barrier to reaching the middle class.

In a recent analysis of 293 chronically homeless District Medicaid beneficiaries, we reviewed health utilization and costs before and after PSH placement (claims from October 1, 2010 to September 30, 2014). From the year before thru the second year after move-in, total cost of claims increased by 2.2% ($4,586,649 to $4,687,748). Although before and after change in total cost was minimal, there were substantial differences in inpatient, ED, substance abuse treatment and behavioral health costs. Non-psychiatric inpatient cost decreased by 49% ($1,463,348 to $750,632) and ED costs decreased by 46% (55,823 to $26,932). Substance abuse treatment costs increased by 152% ($36,229 to $91,190). Outpatient behavioral health costs increased by 23% ($588,038 to $722,460) between the year before move-in and the first year after move-in, but declined 8% during the second year after move-in.

To improve the health of our residents, we must treat the 'whole person' by addressing contributors beyond health, including housing and social needs. As shown in Figure 11, there are many factors that affect an individual's health. Addressing the 'whole person' needs requires the consideration of each of these factors. The healthcare system must foster collaboration amongst different provider types and integrate physical and behavioral health, social services and community supports (e.g., churches, clinics, community organizations, housing and social service supports, educational resources and cultural institutions). Evidence suggests that programs that comprehensively address where we live, work, learn and play can have greater impact on health outcomes at the population level than programs utilizing interventions aimed solely at individual behavior change.[xxx]

Figure 11. Factors Affecting Overall Health



In the District, physical and behavioral healthcare and social services are currently provided in silos and there is a lack of integration and coordination across the community. For the majority of residents, their health needs are delivered by doctors and nurses and are paid by public (e.g., Medicaid and Medicare) or private health insurers and are regulated by one or two District government agencies while social services are delivered by social workers and housing specialists. Social services

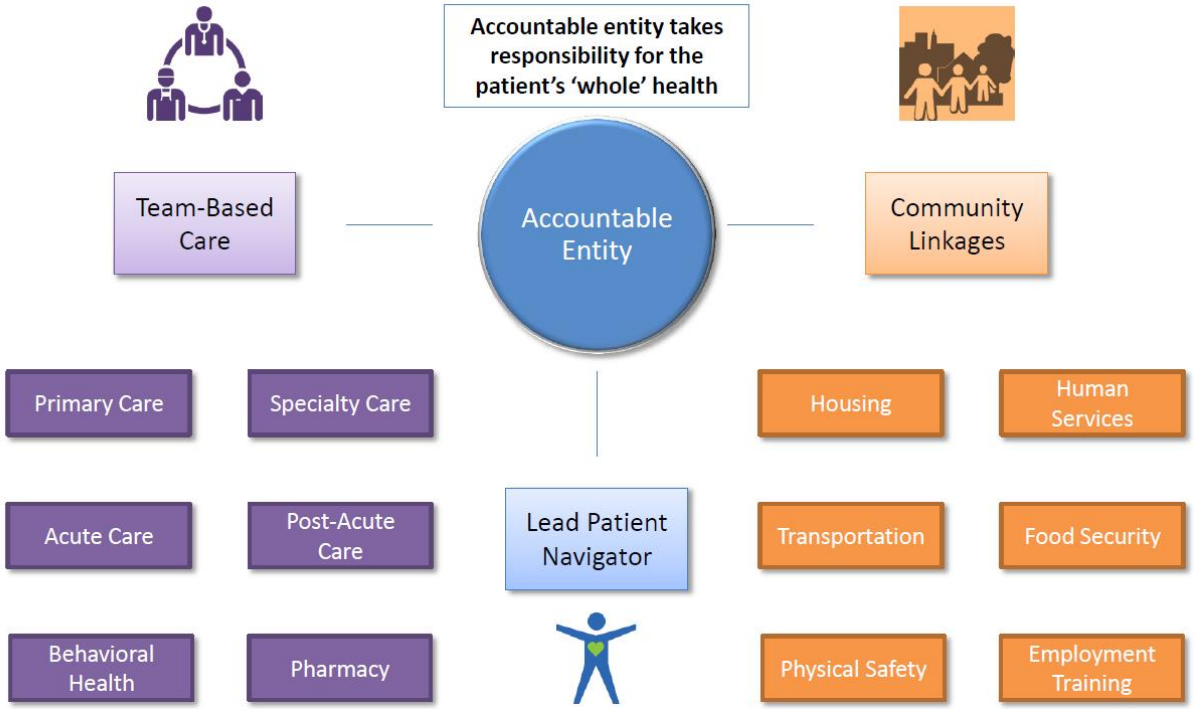
Wards 5, 7 and 8 report the lowest median average incomes, and the highest rates of high blood pressure, obesity, diabetes and smoking among District residents.

payment is locally-funded or from federal agencies and regulated by another District government agency. With few exceptions, systematic integration of a person's 'whole person' needs is absent from our service delivery, payment or oversight perspectives.

Additionally, limited infrastructure and HIT capabilities obstructs opportunities for collaboration between different providers and across care settings. According to our SIM Provider Survey, medical providers are aware of their patients' needs outside of their immediate clinical needs but do not have the resources or connections to make a proper referral to a social or community services. Current data capabilities do not support the sharing of information between providers and social services entities and even different provider types are often not able to share data**.** Without real-time data sharing, providers struggle to understand the whole picture of an individual's needs.

As shown in Figure 12 below, the healthcare system that we envision for the future integrates health and social services.

Figure 12. Envisioned Community Linkages Landscape



Through SIM initiatives we will build upon current District initiatives aimed towards facilitating collaboration among organizations that have been siloed, included in Table 4 below.

Table 4. Current District Initiatives Addressing Community Linkages

Current District Initiative	Initiative Description
No Wrong Door	In October 2014, The District received a one-year grant from the Federal Administration on Community Living (ACL), in partnership with the Centers for Medicare and Medicaid Services (CMS), and the Veteran's Health Administration (VHA), to develop a three-year plan to transform current long-term services and supports (LTSS) programs and processes in the District into a single, No Wrong Door (NWD) system for all populations and all payers. The District envisions implementing a user-friendly NWD system that is highly visible and accessible for all people with disabilities, seniors, and their families to learn about and have easy access to a full range of integrated LTSS. The District will create a network of government and non-profit organizations that will engage in person- and family-centered planning and provide responsive and comprehensive information about and referrals for LTSS. The information received will enable people with disabilities, seniors, and their families to make informed choices regarding the LTSS they need to live with dignity in their homes and be fully included in their communities for as long as possible.
DC CrossConnect	The DC Department of Human Services (DHS) provides cross system unified case planning for families served by the District of Columbia Child and Family Services Agency, DHS, and other health, human services, and educational agencies in the District. Unified Case Planning is a multiagency initiative led by the Department of Human Services and Child and Family Services and involves additional agencies and service providers, such as Department of Behavioral Health, Department on Disability Services, Department of Youth Rehabilitative Services, Department of Health, Office of the State Superintendent for Education, and D.C. Public Schools.
My DC Health Home	In 2016, the District began implementation of the Health Home program, My DC Health Home. My DC Health Home is a care coordination initiative that will develop partnerships with primary care, specialists, and behavioral health providers, as well as community-based organizations to improve the health and quality of life of the severely mentally ill in the District. Each person that receives services though the DC Health Home benefit will be linked with a Care Team who will work with the person's doctors, family and other selected parties to address medical and social service needs. The Health Homes Care Team, comprised of a Health Home Director, Primary Care Liaison, Registered Nurse Care management and Care Coordinator, is responsible for several care coordination tasks, comprehensive transitional care and referrals.
Permanent Supportive	The Department of Human Services' Permanent Supportive Housing Program (PSH) offers case management services to individuals and families [xxxi] experiencing homelessness and meeting specific criteria. Case managers facilitate the search

Current District Initiative	Initiative Description
Housing (PSH) Program	and retention of housing for individuals. Organizations that offer PSH also facilitate other supportive services, such as food security, career coaching, and family counseling.

Explore New Strategies to Integrate Clinical and Social Needs

Three key principles are driving our vision towards a more integrated clinical and community services system. We identified these principles through a review of model practices of existing community linkages programs as well as through stakeholder engagement and other research. These principles served as a guide to our stakeholders in considering additional opportunities to enhance community linkages.

1. Social Determinants of Health Impact an Individual's Ability to Address Health Issues

Social determinants of health impact an individual's ability to find, understand and address their healthcare needs. Barriers to better health may include lack of housing, lack of education to understand a health condition and inability to afford healthcare. Addressing these issues requires integration at the provider and program level. Developing the infrastructure to streamline referral processes and encourage relationships and information sharing between clinical and social services providers, will enhance the ability to address the 'whole person' needs.

2. Interdisciplinary Care Teams Create Connections and Facilitate Dialogue with Healthcare and Social Service Professionals

Interdisciplinary care teams, as defined in Pillar II: Care Delivery, unify healthcare and social services professionals in one dynamic care delivery team to address all the needs of an individual. A team with a set of diverse backgrounds and specialties works together to address barriers to improved health. An interdisciplinary and integrated care team benefits the patient, their caregiver, providers and the larger healthcare system as a whole.[xxxii] Evidence has shown that interdisciplinary care teams can improve safety and enhance the quality of care for a wide array of patients.[xxxiii]

3. Health Information Exchange Establishes Communication Pathways and Common Terminology Across Clinical and Social Services Providers

In order for an interdisciplinary care team to work together, they must be able to clearly communicate regardless of whether they are co-located or not. The electronic exchange of health information enables care teams to communicate remotely and share critical information about their patients and clients. The sharing of this information will inform clinical and social services decisions, create a community of support around patients, and enable professionals to work together to address all needs in order to achieve the best health outcome possible.

Short-term Goals: Health Home 2, Dynamic Patient Care Profile, and Accountable Health Communities

Below we describe three short-term initiatives that will enhance provider, patient, and government agency collaboration:

- The Health Home 2 initiative (also described in more detail in Appendix 5)
- The Dynamic Patient Care Profile under development using HIE efforts
- The Accountable Health Communities initiative

These initiatives address connectivity at the organization level by creating formal partnerships, sharing information, and agreeing upon a common terminology and language. These initiatives will help build a seamlessly connected community dedicated to providing 'whole person' care.

1. Health Home 2

The Health Home 2 program targets high-cost, high-need individuals and facilitates the link to housing services for those who need such services. This program is especially beneficial to the chronically ill and the chronically homeless populations. It requires collaboration between clinical and social services professionals, focusing on building partnerships between physical healthcare providers and Permanent Supportive Housing (PSH) providers. PSH providers that meet provider eligibility, may become Health Home providers, while other PSH providers will be a member of the Health Home team. The Health Home 2 program addresses clinical health needs while also addressing barriers to healthy living. As described in Pillar II, care plans will include physical and behavioral health and social needs.

Health Home 2 providers may be embedded in community-based settings to effectively manage an individual's full scope of needs. This includes providing Health Home 2 enrollees with enhanced care management through comprehensive, interdisciplinary care teams and care coordination services that address gaps in 'whole person' care.

2. Dynamic Patient Care Profile

The Dynamic Patient Care Profile is currently under development and will provide clinical and social service providers a common tool that draws on systems not typically connected to each other including the Homeless Management Information System (HMIS) and Medicaid claims databases. The profile will include patient demographics, risk stratification, attributed providers and payers, care management programs, chronic conditions, medications, immunizations, housing status, encounter notifications and Medicaid claims data from the last 12 months. Thus, this tool will facilitate connectivity between clinical and housing providers and promote care coordination and communication among these providers. A sample mock-up of the Patient Care Profile, which may be modified for future stakeholder input, is provided in Appendix 9 (See the Enabler B section for more details).

3. Accountable Health Communities

The Accountable Health Communities (AHC) model addresses a critical gap between clinical care and community services in the current healthcare delivery system by testing whether systematically identifying and addressing the health-related social needs of an individual impacts total healthcare costs, improves health, and quality of care. In taking this approach, the AHC Communities model supports the CMS 'better care, smarter spending, and healthier people' approach to improving healthcare delivery.

The DC Primary Care Association (DCPCA) applied to serve as a 'bridge' organization in the AHC Cooperative Agreement. The goals of this bridge organization are to:

- Build a consortium or health network that consistently and systematically identifies and addresses the social determinants of health for DC Medicare and Medicaid beneficiaries
- Maximize resources and collaboration between clinical delivery sites and community service providers (and to expand this to include non-consortium members)
- Expand the capacity of all partners to function as a seamless accountable health community over time and across sites of care

In addition to the screening, referral, and navigation services, DCPCA will build upon existing practice transformation and quality improvement activities and leverage local experience addressing the social determinants of health. Together, partners, including the District, will amplify and extend the DC health ecosystem to address persistent inequity in health outcomes for District residents.

The DCPCA AHC model will leverage DCPCA's clinical and community relationships and augment this with an innovative technology platform that can be integrated into partners' existing records systems. The components of the model include:

- **Outreach** to engage new partners, both clinical delivery and community social services. DCPCA has a strong track record of identifying and connecting new partners to technology solutions.
- **Clinical delivery site service support,** which includes site-level technical assistance to address screening, referral, and navigation integration into staffing plans and process workflows.
- **Navigator learning community,** community health workers located at AHC clinical sites and Navigator staff hired, trained, and deployed by DCPCA will help to promote continuous quality improvement and best-practice innovations.
- **Technology platform** that supports service delivery, tracking, reporting, and interaction with individuals, and follow through across the continuum of care, including the social determinants of health.

- **Robust partner convening** that engages District clinical delivery sites and community service providers in building shared accountability as a network for the health of our residents.

Our short-term strategies to enhance collaboration and integration of healthcare and community supports will build upon initiatives currently under development. We will tackle the link between homelessness and poor health outcomes through our Health Home 2 program. The Dynamic Care Profile will create HIT linkages to benefit providers and patients. Accountable Health Communities will further address the gap between clinical care and community services in the current healthcare delivery system by testing whether systematically identifying and addressing the health-related social needs of individuals' impacts total healthcare costs, improves health, and quality of care.

Long-term Goals: Improved Referral Process and Universal Needs Assessment

We will continue to enhance our ability for collaboration between healthcare and community providers starting with the following initiatives.

1. Connections with Community Partners through Improved Referral Processes

Referrals for social services allow individuals to access a wide array of support amenities that will help them overcome access or service barriers, increase self-management skills, and improve overall health. This involves facilitating individuals' access to various types and levels of community-based supports that address medical, behavioral, and social issues that impact health. The primary scope of work for Health Home 2s is comprehensive care management of individuals' full-array of primary and acute care, behavioral health and social service needs. The Health Home 2 will establish direct lines of communication with community and social support agencies in order to establish collaboration, follow-up, and reporting standards.

Types of Social Support Services Referrals

- Wellness programs, including smoking cessation, fitness, weight loss programs
- Specialized support groups
- Substance treatment, support groups, recovery coaches, and 12-step programs
- Housing resources and social integration
- Financial assistance (TANF, Social Security)
- Supplemental Nutrition Assistance Program
- Employment and educational training
- Legal assistance resources
- Faith-based organizations

2. Universal Needs Assessments

A needs assessment that considers both physical and behavioral health, as well as social determinants of health, is a critical element missing in our system today. Such assessments would create a path for dialogue between clinical and social service providers and provide a vehicle for capturing an individual's 'whole person' needs. Currently, clinical and social services operate in silos and often use conflicting terminology. This needs assessment would be used across the care continuum with mutually agreed upon definitions and protocols. Common definitions will allow providers across the spectrum of care to effectively discuss needs while protecting against duplication of services. This assessment,

regardless of where and by whom it is performed, will depict the individual's full service needs and communicate those needs to both clinical and social services providers in a common format.

3. Accountable Care Organizations (ACO)

Supporting the development of a provider lead ACO which ties improvements in certain aspects of well-being to payment will enhance collaboration between health care providers and the various administrators of social services in the community. Entities electing to participate in an ACO will assume the responsibility of providing person-centered integrated care to individuals and coordinating with other providers and community supports to improve health outcomes. By tying payments to costs and quality, the group of providers will have strong incentives to work together to reduce unnecessary utilization and address social determinants of health.

Initiatives on the Radar

Our short-term initiatives will help address the need for collaborations for high-need, high-cost populations by building the infrastructure for strong relationships between clinical and social services. However, we are continuously seeking additional opportunities and supporting initiatives that enhance community linkages and drive the transformation of our health care system. We will continue exploring opportunities to:

- Develop an electronic referral process between health and social service providers.
- Assess workforce needs and consider expanding the use of community healthcare workers to promote collaboration and person-centered care.

Enablers: The Foundations of Pillar Transformation

This concludes the description of the three Pillars. We will now transition to the discussion on the Enablers, starting with Maintaining Continuous Stakeholder Engagement. We will also discuss Developing Overarching Health Information Technology Capabilities, Developing Workforce Capacity, and Quality Performance Improvement. All Enablers will incorporate and encourage four main ideals:

Enablers will leverage existing strategies and resources within the District to help build capacities within each Pillar while reducing the overall burden of transformation.	Enablers will encourage sharing of information that is accurate, actionable, and accessible to aid in Pillar transformation and align information systems across the District.	Enablers will allow all available options to remain on the table; all proposals for building capacity are welcomed and will be given due consideration.	Enablers will be bold, but thoughtful with timelines for transformation, providing realistic targets for building capacity to achieve transformation goals.

Enabler A – Maintaining Continuous Stakeholder Engagement

As part of the SIM Design process, we built a robust stakeholder engagement infrastructure to communicate, educate, and solicit input from various stakeholder groups. We will continue to leverage model practices from past stakeholder engagement activities that allow stakeholders to actively contribute to both the design and implementation of programs focused on moving healthcare to a value-based care delivery and payment system.

Stakeholder engagement has been a necessary and valuable part of the design and implementation of multiple initiatives. We included a diverse group of stakeholders as part of the SIM Advisory Committee and Workgroups as well as consumers and providers to inform decision makers and offer expert advice on the potential challenges and solutions for the operation of our initiatives. We will continue to engage with our stakeholders, and use the input to influence the direction, structure, implementation methods and mid-course corrections used to reform healthcare in the District.

Engaging stakeholders helps increase their investment in the success of these initiatives and encourages stakeholders such as providers and patients to participate and make improvements in the quality of care and consumer experience. Table 5 illustrates how stakeholder engagement affected the SIM Pillars and their potential success in the future.

Table 5. Stakeholder Engagement Interaction with SIM Pillars

Pillar	Utilizing Stakeholder Committee	Executing a Communication Plan
Pillar I – Care Delivery Reform	• Monitor care delivery interventions and develop corrective action plan to enable success • Continue to build additional pathways between clinical and social services	• Provider education and awareness increases participation in care delivery reforms • Disseminate policy, regulatory, and program changes in care delivery
Pillar II – Payment Model Transformation	• Continue to build a healthcare payment system in anticipation of MACRA implementation, commercial payment trends and other payment initiatives • Develop a payment system and technological supports that are effective and built in the existing DC landscape	• Educate workforce on upcoming payment changes and efforts to align payment with value • Alert potential participants of new payment reform opportunities

Pillar	Utilizing Stakeholder Committee	Executing a Communication Plan
Pillar III – Community Linkages	• Keep connection between health and housing and other social services at the forefront of healthcare reform • Build data platforms that facilitate and support linkages to community service providers though appropriate data sharing • Align goals and initiatives with sister agencies	• Facilitate organization partnerships • Encourage stakeholders to populate shared databases

The District Will Continue to Engage Stakeholders Throughout and Beyond the Implementation Process

As we begin implementing SIM initiatives, we will continue to assess and revise our plan and engage stakeholders. Future iterations of this document will reflect these changes. Using model practices from our design year, we will continue working with stakeholders to identify opportunities to revise the strategy, educate providers and non-clinical staff and promote change under SIM. We will engage stakeholders through formal meetings, website updates and e-newsletter communications. These continued activities and recommended improvements will continue stakeholders' level of investment in transforming the District.

Short-term Goal: Leverage Existing Advisory Boards and Communicating SIM Implementation

Throughout the SIM Design process, we have facilitated a transparent and active dialogue with stakeholders. We will continue building off the momentum developed through the design process and keep healthcare reform efforts at the forefront of our stakeholders' priorities.

Integrate SIM into Existing Advisory Committees and Policy Boards

- **Medical Care Advisory Committee:** The camaraderie and momentum generated though the SIM stakeholder engagement activities will continue on into the future as part of the DC Medical Care Advisory Committee (MCAC). The MCAC, facilitates discussion around health topics including the population health in the District, Medicaid enrollment, and the DHCF annual budget. Several SIM Advisory Committee members already serve on MCAC however. DHCF plans to keep SIM initiatives at the forefront of the MCAC discussions and implementation of the initiatives described in this document will be monitored and supported by MCAC. There may also be a need in the future to form smaller workgroups under the MCAC initiative to collect meaningful input.
- **HIE Policy Board:** We will also continue to work with the HIE Policy Board as they remain in their role providing advice regarding the enhancement and sustainability of HIE in the District. The SIM HIE Workgroup activities were in partnership with the HIE Policy Board. The Policy Board will provide recommendations related to the current and

future HIE activities including the implementation of a District HIE designation process and integration of DHCF's data warehouse.

- **Inter-agency Council on Homelessness:** Ongoing collaboration with the Inter-agency Council on Homelessness provides an ongoing opportunity for dialog between health and social services agencies and providers and alignment with Mayor Bowser's priorities to improve the pathway to the middle class and end homeless. We may also identify opportunities for collaborative initiatives aimed at addressing homelessness and health.

Disseminate a Continuous Communications Plan and Feedback Loop

We will continue promoting SIM initiatives to garner support and participation and explore opportunities to efficiently communicate with our stakeholders including:

- **Revamp the DHCF website:** We will maintain transparency as part of implementing the SIM initiatives. We will provide materials for public consumption and engage stakeholders through formal feedback structures. To support ongoing engagement, DHCF's webpage may be redesigned to serves as a clearinghouse for relevant emerging issues on payment reform and delivery system transformation. The webpage will also outline the goals, vision and progress of the District's SIM aims.
- **Continue to distribute the SIM Innovation Newsletter:** We will continue providing weekly electronic newsletters to interested stakeholders, a communication implemented throughout the SIM Design grant process. This newsletter includes information on emerging issues, funding opportunities for providers, progress reports on implemented initiatives, meeting minutes of past meetings and reminders of upcoming meetings. A sample electronic newsletter can be found in Appendix 10 of this document.
- **Continue to engage with DHCF and District leadership:** We will continue to communicate our successes and challenges to DHCF and District-wide leadership through Front-Burner Reports, a weekly report to leadership, and one-on-one meetings. It is crucial to the success of SIM initiatives to have the support and awareness of DHCF and Mayoral leadership. Support from community and government leaders can legitimize the initiatives and assist in communicating the goals and priorities of initiatives to the larger healthcare system and the public.
- **Offer opportunities to provide stakeholder feedback:** We provide opportunities for stakeholders to offer comment through several modes of communication. Beyond the methods already mentioned, we intend to offer public comment periods, host hearings and forums, and engaging providers on a one-on-one basis.

This constant communication with providers, payers, and consumers will engage all parties in healthcare transformation. The continuous feedback loop will allow interventions to be refined and corrective action to be taken in order to produce the best results.

Long-term Goal: Engaging Consumers and Providers to Enhance Personal Investment in Healthcare Transformation

The success of these SIM interventions is heavily dependent on the personal investment and buy-in of consumers and providers. As we found in our focus group data collection, the relationship between consumers and providers is a strong driver of healthcare utilization and both providers and patients would benefit from education and engagement opportunities. We plan to facilitate and meet these needs through consumer education and empowerment and provider incentives.

Increasing Health Literacy of Consumers

Respondents from the consumer engagement activities requested that we provide more information on how to navigate the healthcare system, share personal information with their health providers and manage their health conditions, as well as learn about current health topics in a culturally-appropriate way. The District will follow the U.S. Department of Health and Human Services' National Action Plan to Improve Health Literacy goals which include:

- **Goal 1:** Develop and disseminate health and safety Information that is accurate, accessible and actionable
- **Goal 2:** Promote changes in the healthcare delivery system that improve health information, communication, informed decision-making, and access to health services
- **Goal 3:** Incorporate accurate, standards-based and developmentally appropriate health and science information and curricula in child care and education through the university level
- **Goal 4:** Support and expand local efforts to provide adult education, English language instruction, and culturally and linguistically appropriate health information services
- **Goal 5:** Build partnerships, develop guidance, and change policies
- **Goal 6:** Increase basic research and the development, implementation, and evaluation of practices and interventions to improve health literacy
- **Goal 7:** Increase the dissemination and use of evidence-based health literacy practices and interventions[xxxiv]

With these goals in mind, the District is considering creating a plan to improve health literacy across the District through consumer education, provider training, and technical assistance. The District also recognizes the need for health literacy assistance in understanding health status, health benefits and how to use the health system. The health literacy plan will utilize model practices in each of these categories to elevate the level of health literacy of every component.

Encouraging Consumer Empowerment to Invest in Personal Health

Informed and engaged consumers are at the center of effective healthcare systems and high-quality patient-centered primary care. Providing patients with the tools and resources that reflect their individual values, perspectives and lifestyles can help reduce variation in service utilization across health service areas.

Feedback received from consumer interviews and focus groups through the SIM Design process provided unique and pertinent information needed to discover barriers to care and services of greatest need and benefit to consumers. We will utilize these consumer feedback methods again to determine the most beneficial, efficient, and actionable ways to promote consumer empowerment and education. We will build and implement initiatives based on this feedback so access to and quality of care can be improved.

Initiatives on the Radar

We are considering and planning other initiatives further into the future that will enhance stakeholder engagement and in turn enhance the care delivery, payment reform and community linkages. Initiatives 'on the radar' include:

- Using technology to engage stakeholders such as patient portals, texting campaigns, and consumer focused media presence
- Measure the effectiveness of stakeholder engagement as part of the performance and evaluation activities for the SIM

The next Enabler we discuss is Developing Overarching Health Information Technology Capabilities. The three SIM Pillars are supported by sophisticated and interactive systems of health information technology. By collecting, using and disseminating data in a timely fashion, providers can act in the best interest of their patient using the most current information available. The availability of more data elements, such as social determinants of health, will also influence care plans and move the District towards comprehensive whole-person care. The continuously maturing infrastructure of HIT in the District will enable current healthcare transformations to be a success, as well as, provide the building blocks for future innovations.

Enabler B – Developing Overarching Health Information Technology Capabilities

Effective use of data via health information technology (HIT), including through health information exchanges (HIE), is fundamental for both our short- and long-term health reform efforts. Improving HIT capabilities for providers and patients has tremendous potential to improve health outcomes. This is particularly true for racial and ethnic minorities, who comprise large percentages of the District's low income population, and who typically have worse access to healthcare, poor health outcomes, and more chronic conditions when compared to the general population. These individuals have the most to gain from increased coordination of care through HIT, but also display significantly lower rates of online access to their health information and lower rates of HIT engagement.[xxxv] Significant gaps in HIT access exist for providers, as shown in Table 6**,** which describes electronic health record (EHR) adoption rates.

Table 6. Provider Adoption of EHRs, 2014

HIT Data Point	District Rate	National Average
Office-based physician EHR adoption[xxxvi]	65%	74%
Small-practice office-based physician EHR adoption[xxxvii]	60%	72%
Specialist physician EHR adoption[xxxviii]	47%	70%
Office-based physicians Meaningful Use demonstration[xxxix]	36%	N/A

The District has one of the lowest rates of office-based physician EHR adoption among all states. However, we have made great progress over the last several years in building a concrete HIT foundation with the assistance of federal grants. Previously disjointed care sites will be connected through improved HIT capacities, especially leveraging improved HIE platforms. Information sharing can improve care coordination and make sure providers have the information they need at the point of care. HIT also includes new tools, such as clinical decision supports, to improve care delivery. We will enhance our approach to sharing and using clinical data from EHRs, claims, public health and social services, with the goals of:

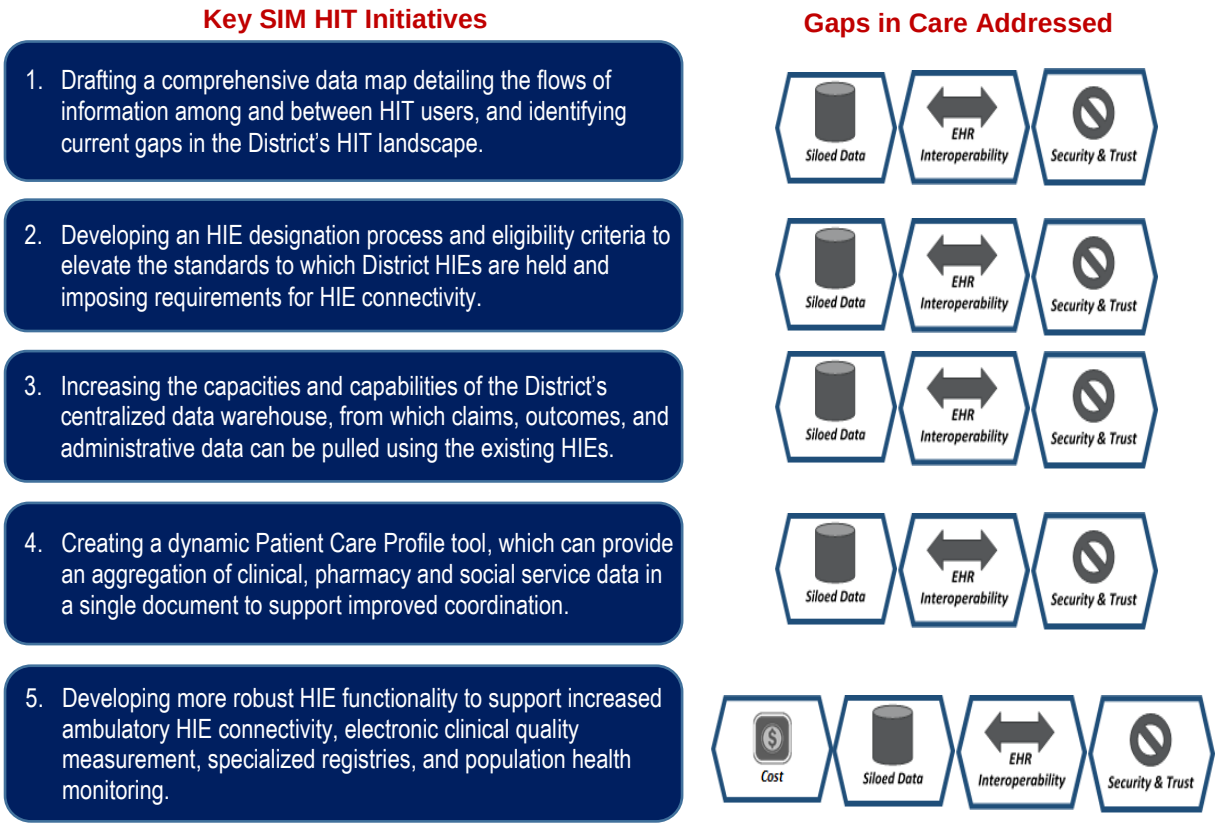
- Enabling provider, patient, and local government agency access to clinical information that can better inform care delivery processes, including care planning and clinical decision-making
- Enhancing care system efficiency through the use of HIT tools that provide real-time information updates to providers and care partners
- Automating referrals and bolstering mobility of Patient Care Profiles, enabling community linkages and care coordination

- Better measuring individuals' outcomes and provider performance, tracking costs associated with providing care
- Enhancing data capture and analysis, clinical oversight, reporting, and transparency for purchasers so that payments to providers are tied to patient health outcomes

In 2014, we convened over 150 executives from across the healthcare system for three executive roundtables to discuss opportunities to improve our HIT capabilities. These groups met several times throughout 2014 and 2015 as part of the eHealth Initiative, resulting in the development of the 2020 DC Health IT Roadmap that includes priorities and recommendations for interoperability, clinical champions and data use. These components are essential building blocks of our SIM HIT initiatives.

Using the SIM Design grant, we created a plan for implementing and sustaining five HIT initiatives that enables us to successfully achieve our vision for health system transformation in the District. An Implementation Advance Planning Document (IAPD) update will be used to obtain addition Federal Financial Participation (FFP) from CMS to help cover the design and implementation costs of several of these initiatives. The five main HIT initiatives are described in Figure 13.

Figure 13. The District's Five SIM Initiatives



Each initiative will leverage existing HIE infrastructure and HIT components to build bridges between current systems and improve technical functionality. The goal is to limit the burden on stakeholders in implementing these initiatives and more easily build a reporting infrastructure to track performance metrics, utilization and real-time use of services. Additionally, these initiatives will enable better population health management and more coordinated care delivery as utilization, quality, performance, and outcomes data is aggregated, analyzed and shared.

Current District Initiatives

HIT allow providers and payers to measure and track performance and outcomes, communicate with each other and across sites of care, and further integrate care delivery processes. Initiatives such as value-based payment cannot be effectively implemented without the collection and timely exchange of performance and outcomes data. This will help us transition from a fragmented fee-for-service system of care delivery and payment to an integrated, accountable, and value-based healthcare ecosystem.

By integrating physical and behavioral healthcare in a **Health Home**, especially in cases of co-location of such services, connectivity gaps will be bridged by both the physical location of providers and improved technological capacities. **HH2** moves the District towards such integration by encouraging providers to adopt HIT as part of clinical processes. Initiatives discussed later in this section, such as Patient Care Profiles, HIE, quality dashboards, and population health monitoring dashboards are examples of improved technological capacities encouraged through SIM to aid HH2 providers in delivering patient-centered care. HH2 providers will receive technical assistance and funding from the District to help develop their HIT infrastructure to support such

We will continue to build and improve HIT capacity for health system transformation by leveraging current initiatives. This includes efforts to increase the adoption and meaningful use of EHRs, in addition to those supporting the development of a secure, sustainable health information exchange infrastructure. Table 7 reviews some ongoing initiatives already completed by previously approved Advance Planning Documents (APDs), in addition to some key future EHR-related initiatives.

Table 7. Completed and Ongoing HIT APD Initiatives

Completed APD Initiatives	Future APD Initiatives
A survey tool to conduct a landscape assessment of EHR adoption	Offering provider support regarding the Medicaid EHR Incentive Program application process
Operation of an automated, web-based application tool which will allow providers to apply for the Medicaid EHR Incentive Program and make required attestations electronically	Outreach and communications with key stakeholders such as professional associations or directly with providers
An identification of national statistics to serve as a comparison and plan for adoptions rates	Developing business requirements for monitoring interfaces and exchanges between provider EHR

Completed APD Initiatives	Future APD Initiatives
and impacts on the Medicaid EHR Incentive Program	systems and the application tool for meaningful use data
A review of the types of systems most commonly used by District providers	Reviewing clinical trends including standard and ad hoc reports on clinical measures related to meaningful use and other special projects

To aid in development of HIT initiatives, the DC HIE Policy Board was established by a series of Mayoral Orders, the last of which was on March 10, 2016. The Policy Board is responsible for advising the Mayor, the Director of DHCF, and sister agencies within the District on implementing a secure health information technology platform in line with the above goals. The HIE Policy Board helped develop the guiding principles used for the SIM initiatives, located in Appendix 11, to plan the five HIT SIM initiatives. The following sections contain a discussion of each of the five initiatives, and their prospective impact on the District's HIT landscape. Table 8 below shows how these five initiatives intersect with each of the Pillars to build system capacities.

Table 8. HIT Development Necessary to Support the Pillars

Pillar	HIT Initiatives
Pillar I – Care Delivery Reform	• Data Mapping • HIE Designation • Patient Care Profile • Ambulatory Connectivity, eCQM Tool, Obstetrics/Prenatal Registry, and Analytical Patient Population Dashboard
Pillar II – Payment Model Reform	• Data Mapping • HIE Designation • eCQM Tool, Ambulatory Connectivity, and Analytical Patient Population Dashboard • Data Warehouse
Pillar III - Community Linkages	• Data Mapping • HIE Designation • Patient Care Profile

The Pillars of care delivery reform, payment model reform, and community linkages are dependent on each of the Enablers to catalyze system transformation. HITs role in achieving such transformation is evident through the five initial SIM initiatives described in this section. These initiatives are aimed at enhancing care delivery, payment, and community linkages and enabling the District to achieve reduced health disparities, improved patient outcomes, and cost savings.

Initiative One: Update the HIE Data Map to Reflect our Data Landscape

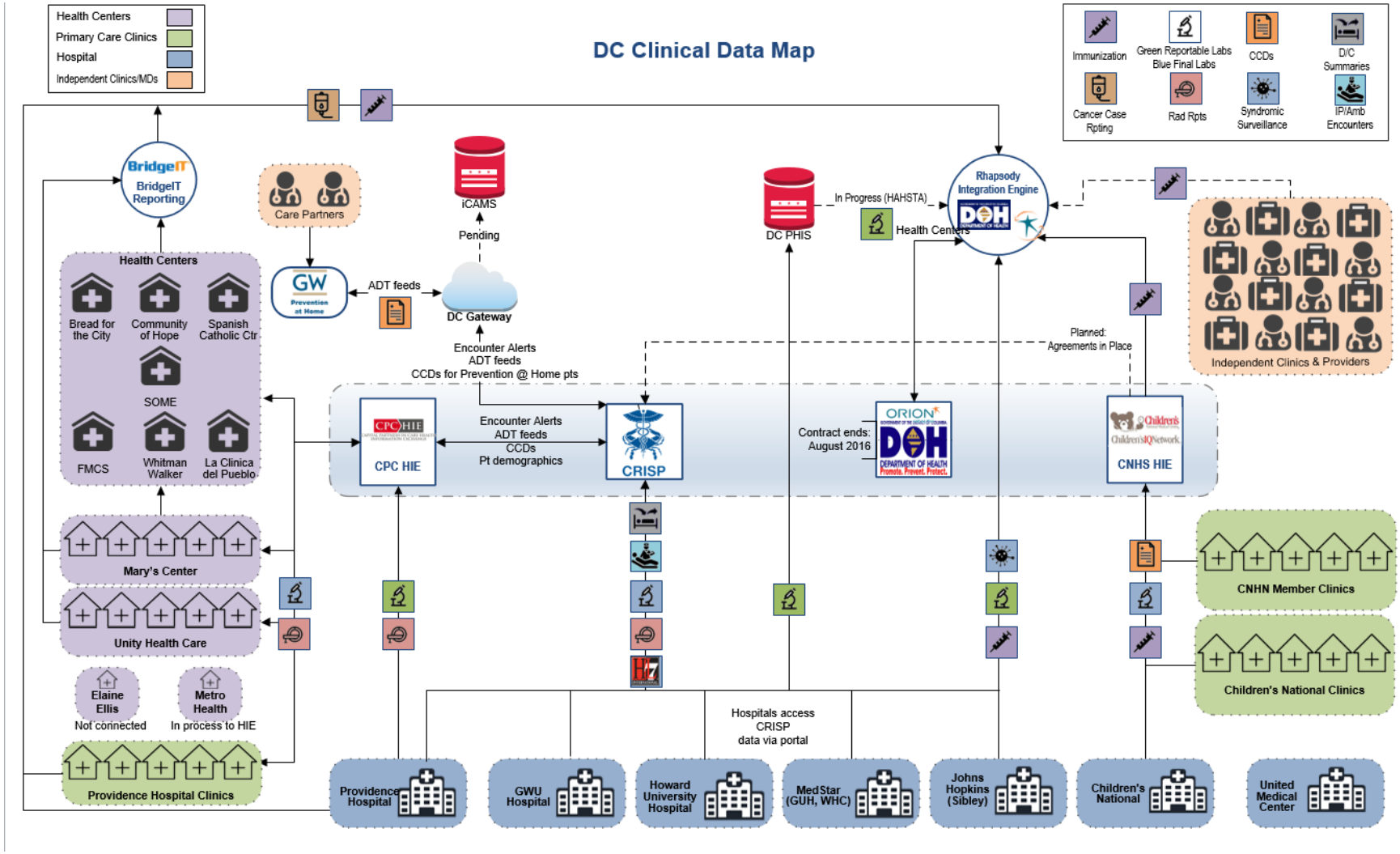
The goal of the data mapping initiative was to define the landscape of connectivity in the District, using results to identify and craft solutions to address points of access to HIE are absent or underdeveloped. This included sharing model practices and coordinating technical assistance to bridge gaps in HIE connectivity.

We developed this comprehensive data map to capture existing District HIEs, which includes smaller-scale HIE pathways that cluster data between and among circles of providers and systems. The data map also illustrates the storage centers and data flows of each HIE system and the degree of connectivity between them. Documenting the existing data infrastructure allows us to more easily identify gaps in data access and transmission, and address these gaps through updates to current infrastructure, designating new HIE entities, and/or commencing new HIE initiatives.

The data map was constructed by collecting information through numerous stakeholder interviewers (both internal and external to District government) to obtain information about the data they collect electronically, with whom the data is shared, challenges in sharing data, and gaps in who can share data. Interviews were held with the following District stakeholders:

- DC Department of Health Care Finance
- DC Department of Health
- DC Department of Human Services
- DC Department of Behavioral Health
- HIEs/Health Information Organizations, Children's IQ Network
- DC PCA and community organizations
- VA/DOD
- Hospitals

Figure 14. The District's HIE Data Map



Prior to the data mapping initiative, we identified major 'point of access' barriers as part of the HIE Roadmap where caregivers and providers have limited, if any, HIT connectivity capacities:

- **Behavioral health sites of care:** These provider types are excluded from participating in the Meaningful Use program. As such, they lack financial incentives and supportive resources to adopt EHRs and implement HIE capabilities, creating access barriers.[xl]
- **Ambulatory sites of care:** The foundation for value-based, quality-driven care models uses data to track implementation progress, quality, costs, and outcomes. Smaller ambulatory providers may not possess the financial or technological resources and skills to transform their practices into such models.
- **Pharmacy and pharmacy benefit managers (PBMs):** These providers house their own clinical pharmacy data and do not communicate well with other provider systems. Thus, pharmacy data is often siloed, preventing care coordination and integration.
- **Non-clinical sites of care (social and community services and supports):** These sites of care are outside the traditional clinical spectrum of care delivery and are not afforded technical assistance or financial resources to store data or construct data exchanges. However, data collected at these sites of care greatly impact individuals' social determinants of health and can help inform care plans, aid in care coordination, and frame a picture of 'whole person' health.

Lack of connectivity for these sites results in gaps in care and hinders aggregation of 'whole person' patient data. Without HIT capturing and sharing data on service provision, there is a risk that essential information regarding an individual's health status, service utilization, provider history, and care plan will be lost.[xli] Such missing information can put individuals at risk for inappropriate treatment and can contribute to poor health outcomes.

For care sites where HIE connectivity exists in some capacity, there may be significant limitations as to the breadth and depth of connectivity.[xlii] Data is often siloed by site of care, condition, or service category, and data systems cannot or do note communicate with each other to transmit data. Issues regarding interoperability, security, and trust arise between disparate data systems, while solutions to such gaps are expensive to implement. For these gaps, current HIT infrastructure can be leveraged and expanded to bolster connectivity, while initiatives described below pave the way for a more connected, interoperable, and secure information system for healthcare.

Transformation Initiatives Supporting SIM HIT Expansion

We used the information gathered through the data mapping process and during HIE Workgroup and Policy Board meetings, to help plan and design the next four HIT initiatives. These initiatives will help address data gaps and facilitate the redesign of our care delivery and payment system, underpinning it with a comprehensive data infrastructure that is accessible, interoperable, secure, and cost-effective.

Initiative Two: Create an HIE Designation Process that Sets Thresholds and Standards for Participation

We are developing a designation process that will be used to sanction District HIE entities. This process will facilitate future initiatives, including those mentioned in the SHIP. HIEs currently operating in the District have different capabilities, functionality, and levels of access, and there is no standard definition of what it means to be an HIE. This all creates a disjointed and unstandardized HIE landscape. To address these issues, we identified three main objectives for designation:

- Standardize the minimum capacities and functionality of HIEs operating in the District
- Set clear requirements for business and technical operations, including specific standards for privacy and security protocols
- Encourage interoperability of HIEs so that information can flow freely and securely between sites of care

We have identified six key categories of requirements for the HIE designation:

1. Accreditation and certification
2. Business operations
3. Performance and monitoring
4. Policies and procedures
5. Security and encryption
6. Technical

The exact process for evaluating HIEs is still under discussion but would, at a minimum, require HIEs to meet specific thresholds and milestones in each of the six requirement categories. However, such designation requirements must be incorporated into a new District legislation and regulation before being implemented. Once these have been promulgated, we will begin to designate eligible HIEs to operate in the District and to support the scope of HIT tools and capacities needed to enhance care delivery, payment, and community linkages.

Designated entities will be able to capture and transmit data between disparate sites of care. This would enable providers to receive, review, and amend real-time updates to patient care plans and Patient Care Profiles (discussed later). Enhanced connectivity will also allow providers to view health information at the population level, enabling population health management for an entire patient panel.

Initiative Three: Build a Data Warehouse to Store, Process, and Analyze Medicaid Claims

The DHCF Medicaid Data Warehouse (MDW) is a 3-year project designed to improve access to DHCF's Medicaid Management Information System (MMIS) claims data for business analytics. Data analytics is limited in the current system because of the types of data elements available through Medicaid claims, which are only housed for four years within the system. When completed, the new warehouse is expected to house over 10 years of claims data and over 1,000 CMS-required data variables, with easy-to-use front-end interfaces for sharing reports and dashboards. The data warehouse represents an essential step in integrating disparate data sources to inform population health monitoring and care delivery in the District.

Analytics. The data warehouse can be used to stratify and analyze the claims data housed within the warehouse for purposes of population health monitoring, such as:

- Tracking cost and utilization data trends
- Enabling rapid-cycle evaluation of provider performance and enrollee health outcomes

To enable population health monitoring, the data warehouse will hold a set of core specialized reports that prioritize reporting and feedback on certain initiatives. These core reports will be expanded as the warehouse is developed and stakeholder use agreements are put in place. Additionally, the warehouse will subscribe, process and publish data reports to end users and external partners. This will help engage stakeholders and encourage buy-in among end users. The data warehouse will be designed to facilitate a variety of end use cases:

Reports Offered through the New Data Warehouse

Using various business intelligence tools and web applications, end users and business partners will be able to access stored data in various formats, including:

- Excel spreadsheets
- SAS data files
- PDF files
- Predesigned reports and dashboards
- CSV files
- Custom flat file data extracts

Over time more advanced functionality will be established to produce 837 and 835 data extracts for exchange with providers and business partners.

DHCF employees, program managers and executives will have access to the data in the forms most appropriate for managing program operations, analyzing trends, and informing population health improvement activities.

Executive staff, program managers and staff will have access to executive information and decision support systems through which the data will be accessed with regular authenticated log in.

We are also in the process of establishing a robust data governance process that will enable us to share relevant data with a wider audience, such as providers, health systems, health centers, insurers, and other industry actors.

While the warehouse currently only houses data from Case Net, the District's sole case management system, merged with MMIS claims data, the objective is for it to include other data sources from private entities and government agencies as the model develops. We have initiated the first stage of standing up the data warehouse, which is slated to go-live in September of 2016, and are taking over some of our former vendor's processing functions within the warehouse.

Access. Access to the warehouse is restricted to operational and executive staff due to the housing of personal health information (PHI) and other sensitive health information. Approved staff will use the warehouse to improve initiative program operations, mine data for population health monitoring, and track costs and utilization of services.

We envision a flexible longer-term process in which access to the warehouse and its data stores are determined by evaluating requests from external parties. Depending on the complexity of requests and demonstrated need for data types, parties can either be given access to the entire warehouse or to specific portions of data within the warehouse. We also envision creating public-use data sets for stakeholders to use without submitting formal access requests. We hope to use these data sets to foster buy-in, demonstrating to stakeholders how data can help with business operations and health managements. Expansion of warehouse capabilities and inputs is depicted in Appendix 12. As more stakeholders engage with the data warehouse, we will build out additional tools to incorporate data sets and requests from other sources to inform feedback loops for improving operational and provider performance.

Initiative Four: Develop Dynamic Patient Care Profiles that Pulls Patient Specific Data to Aid in Care Coordination

Funds from CMS requested through the IAPD will be used to develop an on-demand document called the Patient Care Profile. This tool is designed to provide a practitioner or their care team a high-level summary of a particular patient that is quickly accessible at the point of care. Many providers and practices struggle to access a more complete story of their patients' health and utilization patterns within the healthcare system. Information in this story is crucial to managing current conditions, as well as preventing or mitigating future health issues.

We want to empower clinicians and their teams to access and turn critical patient data into meaningful information for patient care. We worked with providers and other key stakeholders to determine which data elements are the highest priority to include in this tool. The Patient Care Profile will provide users information not traditionally included in other clinical documents, including information on individual housing status, risk stratification, and patient attribution to designated entities (e.g., Managed Care Organizations, Health Home providers, etc.). By connecting additional data around social determinants of health, providers can receive a more holistic view of their patient and provide more proactive, rather than reactive, care management.

The Patient Care Profile will be accessible to providers and hospitals, along with their associated care teams, and will be generated from a combination of selected data sources accessed through a series of Application Programming Interfaces (APIs). As part of the initial

phase of this work, all Medicaid eligible hospitals, in addition to providers associated with Federally Qualified Health Centers (FQHCs), Medicaid Managed Care Organizations (MCOs), or designated Health Home entities, will be given access to this tool through a hyper-secure, web-based portal system. Subsequent phases will expand access to a broader set of District-wide providers and work to enable specific EHRs to call the Patient Care Profile directly from within their own systems. Table 9 presents a complete list of care profile data sources.

Table 9. Summary of Care Profile Data Sources

Source	Data System(s)	Connection Status	Data Type(s)
DC Department of Health Care Finance	Medicaid Management Information System (MMIS)/Medicaid Claims Data Warehouse	***NEW*** (Develop as part of IAPD)	Attributed Entities, Diagnosed Chronic Conditions, Immunization Data, Medicaid Claims History, Patient Demographics, Risk Stratification, and Medication(s)
DC Department of Human Services	Homeless Management Information System (HMIS)	***NEW*** (Develop as part of IAPD)	Housing Status
CRISP	ENS and Query Portal Systems	***CURRENTLY AVAILABLE*** (Incorporate as part of IAPD)	Care Plan/Management Info, Hospital/Ambulatory Utilization, and Patient Demographics

Through this tool, Providers and hospitals can update and/or verify the accuracy of the data captured within their own EHR systems before transmitting their summary of care documents to another provider. This is particularly important for providers and hospitals working to develop care plans for their patients with complex conditions who may be seeing multiple providers.

Initiative Five: Expand HIE Functionality to Include Ambulatory Connectivity, Electronic Clinical Quality Measurement Tools, Obstetrics/Prenatal Registries, and an Analytical Patient Population Dashboard

Our current data infrastructure suffers from fragmentation, data duplication, and discontinuity. We want to improve the free flow of patient data and create a connected clinical care ecosystem. This initiative expands connectivity to previously unconnected or siloed providers, enhancing HIT capabilities and building a more comprehensive data infrastructure to support population health monitoring.

Ambulatory Connectivity

The gaps identified earlier in this section specifically identify ambulatory providers having limited HIT capacity, including EHR adoption and HIE connectivity. Many ambulatory providers do not yet have the connectivity, tools, and skills to succeed in population-based quality and value-based health payment models. Using IAPD funds, we will support resources to directly engage with Medicaid ambulatory providers and assist them in on-boarding HIE services and activities. Specific activities include:

- Help support providers in meeting the HIT Meaningful Use requirements for EHR Adoption
- Assessment of the data quality of the outbound C-CDA[xliii]
- Use of the District's HIE services, such as the encounter notification service (ENS)
- Integration of the Electronic Clinical Quality Measurement (eCQM) dashboard, analytical population dashboard, and care profile into clinical workflows and EHR technology

C-CDA: Consolidated-Clinical Document Architecture

A set of template standards, codes, frameworks, and markup language representing a unified implementation guide for the most common electronic clinical documents. Arranging the building blocks contained within a C-CDA according to clinical needs produces clinical documents, such as discharge summaries and Operation Notes, among others.

Funds will support ambulatory providers in technically integrating HIE services into their practice workflows. Technical assistance, data workforce augmentation, and education to providers aids in the transformation of practices and will help providers achieve Meaningful Use. We plan to conduct both a peer learning collaborative focused on implementation and workflow design activities, and in-practice ('boots on the ground') implementation activities. These efforts will allow practices to take advantage of shared tools available through our HIE partners.

This initiative will help establish appropriate data connectivity, validate information shared bi-directionally, support the development of community-wide partnerships for coordination, and measure progress. Additionally, model practice guidelines and practical experiences of our most successful users will inform optimal use of HIT services for ambulatory providers.

Electronic Clinical Quality Measurement Tools and Dashboards

Electronic clinical quality measures (eCQM) help providers in delivering effective, safe, and timely care to their patients. CQM reporting is a requirement for many Federal and state programs, particularly those associated with pay-for-performance (P4P) models. Funds requested through the IAPD will be used for implementation of a practice- and population-level eCQM dashboard for providers and hospitals.

Specifically, inbound continuity of care documents (CCDs), which summarize current and past patient care information, will be routed from practices through an eCQM tool to support the calculations for Meaningful Use and other Federal and state programs' reporting requirements. Medicaid providers and hospitals will also have the option to rout their CCDs through this eCQM

system to help facilitate measure calculations, while outreach teams will work with practices to ensure conformance to CCD specifications and safeguard against inaccurate calculations.

A customizable dashboard will be generated for Medicaid providers and hospitals by loading Medicaid claims data into an existing eCQM reporting tool. Providers and hospitals will be given access to the eCQM dashboard through a web-based portal, which will enable them to view their own measures on both individual- and practice-levels.

eCQM: Electronic Clinical Quality Measurement

A dashboard that uses data from electronic health records and other health information technology systems to measure healthcare quality. Health Quality Measures Format (HQMF), developed by HL7, are electronic specifications used to document eCQM clinical content. eCQMs capture core measures in six domains: care coordination, clinical quality of care, population health, safety, person-centered experience and outcomes, and efficiency and cost reduction.

This eCQM tool and dashboard will help ease the provider burden when having to meet the specific quality reporting requirements laid out by Meaningful Use and other Federal and state programs. Streamlined reporting and access to quality data can help providers make care-decisions regarding service effectiveness and care planning. This platform can also prepare providers for instituting outcomes-based alternative payment models and risk assumption by enabling clear reporting of quality data which can be tied to provider payments.

Obstetrics / Prenatal Specialized Registry

Specialized Registries allow providers to better track and engage subpopulations by improving care coordination between providers and hospitals, enabling each to capture the psychosocial issues affecting the population. Funds requested through the IAPD will be used to help address a major public health issue in the District – prenatal care – by creating and leveraging benefits of Specialized Registries to support provider care decisions for those in the registry.

A **prenatal registry** will allow DOH and DHCF to have the necessary tools to examine the potential factors that may be driving the increased rate of infant mortality in the District. Using this registry, DHCF and DOH can then more easily track enrollment in the District's various pregnancy programs and determine which programs still have available capacity. Lastly Medicaid EPs will be able to use this registry to help meet the MU requirements around public health reporting.

In an effort to improve perinatal outcomes, Medicaid requires providers to complete a paper-based prenatal risk assessment form for all pregnant Medicaid individuals. These assessments are currently completed at low rates, primarily due to its cumbersome paper-based process. Additionally, we have a difficult time tracking and analyzing the results of these assessments since the data is not currently captured or stored electronically. This Specialized Registry will promote the collection and analysis of healthcare data of pregnant women, promote research, and potentially implement enhanced provider feedback mechanisms that facilitate better care delivery and management of high-risk patient populations.

Analytical Patient Population Dashboard for Population Health Monitoring

Providers' ability to manage the health of their entire patient population is crucial to moving towards risk assumption and outcomes-based payment models. Providers must be able to identify high-cost patients and patients at risk of developing costly and harmful conditions (e.g., diabetes and heart failure). Providers must also be able to recognize patients who are, or could become, patients who do not follow instructions or care protocols. To support development of these capabilities, IAPD funds will be used to implement a patient population dashboard.

> The dashboard will provide DHCF the ability to tailor views for their internal staff and Medicaid providers that align with associated program requirement. The initial phase of this work will be targeted towards all Medicaid eligible hospitals, in addition to providers associated with Federally Qualified Health Centers (FQHCs), Medicaid Managed Care Organizations (MCOs), or designated Health Home entities. Subsequent phases will expand access to a broader set of District-wide providers.

New dashboard capabilities will be developed at both the general population- and also patient-levels. This allows providers to analyze their panel's health outcomes, service utilization, and costs of care. Providers, in addition to approved District personnel, will access this dashboard through the same secure web-portal system proposed for the eCQM tool. The proposed analytical patient population dashboard will:

- Combine Medicaid claims data with real-time ambulatory connectivity and the hospital connections already in place; providers and hospitals can then enhance their insight into their patients' health beyond the individual medical record they have access to currently
- Enhance providers' abilities to identify the specific challenges restricting patients from achieving their optimal health and to isolate and pursue those individuals that are currently experiencing gaps in care

This population health management tool will help provide a proactive and cost-effective way for providers to reduce spending, encourage healthy behaviors, and streamline provider workflows. Increasing access to analyses and data will make it easier for stakeholders throughout the healthcare system to make more informed healthcare decisions.

Initiatives on the Radar

While the above initiatives help achieve our SIM goals of improving outcomes, enhancing experiences of care, and creating value in the healthcare system, future initiatives will compound SIM efforts to build a truly comprehensive and sustainable HIT infrastructure. Initiatives 'on the radar' include:

- Developing a formal sustainability plan for the District's HIE infrastructure
- Expanding data warehouse functionality to stakeholders and integrating external sources
- Exploring new technologies including telemedicine and remote patient monitoring to gather clinical data from patients outside of traditional care settings

- Establishing an All Payer Claims Database (APCD) to facilitate an increased understanding of healthcare cost, quality, and utilization in the District across all payers

The next Enabler we discuss is Developing Workforce Capacity. This Enabler is focused on building the necessary capacity in the workforce and the District healthcare system to allow for the payment and care delivery reforms discussed in our strategy.

Enabler C – Developing Workforce Capacity

The success of our SIM reform vision and goals across the three Pillars depends heavily on the readiness of our workforce. Our workforce must meet the various needs stemming from care delivery and payment reform efforts and increased community linkages. We plan to enhance our workforce and organizational capacity through:

- Investing in technical assistance and training for clinical providers, care extenders, and social service providers
- Augmenting communication and collaboration pathways between and among clinical and health-related social services
- Using payment transformation to promote a more holistic, longitudinal, and value-based approach to population health

While the District is home to a wide range of healthcare providers and allied health professionals, many of these providers are geographically concentrated in specific areas of the city. This makes it more difficult for residents outside of those areas to seek appropriate forms of care. Residents in Wards 7 and 8 in particular have limited access to hospitals and primary care providers, driving their high rates of inappropriate utilization and ED visits. Appendix 13 provides detailed maps of primary care and specialty providers accepting Medicaid enrollees, compared to the Medicaid enrollee population in each Ward. Compounding these disparities, our current workforce does not include a large capacity of non-clinical providers who may participate in interdisciplinary care teams and are vital in bridging gaps in care for such medically underserved areas.

Non-clinical providers and **care extenders** assist residents in locating appropriate clinical service providers, adhering to their care plans, and addressing the social determinants affecting health. This enables proper patient utilization of care services and longer-term maintenance of quality health outcomes outside of clinical settings, key goals of our SIM effort that drive improve population health.

As we move towards value-based care delivery and payment models, we will need a workforce with new skills and capabilities that match the needs of providers implementing such initiatives. Key components of these initiatives, such as collaboration with community providers and treating the ‘whole person’ will require training to develop these capacities in existing providers, as well as training new providers. We will focus our workforce development efforts on increasing the capacities of our current workforce and training new entrants to the workforce, such as community health workers and other non-clinical providers. Such technical assistance will foster the skills required to implement and sustain ongoing health reform initiatives:

- Both clinical and non-clinical providers will need to build skills and competencies specific to providing person-centered, value-based care

- Providers may need to be redeployed in non-traditional roles to provide better care across the continuum
- Providers may need to assume different or an expanded set of responsibilities that foster provider accountability for the patient panel
- All providers across the continuum of care will need technical skills required to fully leverage practice-extending health information technologies, and facilitate quality monitoring and improvement

The District's projected workforce needs will differ depending on the Health Home 2 acuity group. Groups 1, 2, and 3 all have different staff member requirements and staffing ratios for their respective care teams, as detailed in Appendix 5. We will continue to bolster our workforce development initiatives to achieve proper staffing of the Health Home 2 care teams, in addition to relevant support staff for provider practices, hospitals, non-clinical providers, and government agencies. Examples of workforce development areas necessary to support each of our SIM Pillars are included in Table 10 below:

Table 10. Workforce Development Necessary to Support the Pillars

Pillar	Capacity Building	Training
Pillar I – Care Delivery Reform	▪ Health home providers ▪ Wrap-around service providers (community health workers) ▪ Other non-clinical providers	▪ Collaborating with non-clinical providers ▪ Health home ▪ HIT ▪ Whole person care planning
Pillar II – Payment Model Transformation	▪ Technical support for staff (changes to work flow, organizational leadership, HIT, quality and, performance measurement and improvement, program requirements)	▪ Quality monitoring ▪ HIT ▪ Value-Based payment ▪ Data Analytics
Pillar III – Community Linkages	▪ Wrap-around service providers (community health workers) ▪ Other non-clinical providers	▪ Collaborating with non-clinical providers ▪ 'Whole person' care planning

We will leverage current workforce development initiatives underway to train additional workers to operate in this redesigned healthcare landscape. These initiatives will also provide us with insight into how to structure our SIM-specific workforce development initiatives to better align capabilities with SIM goals. Table 11 below includes a high-level overview of initiatives.

Table 11. Current District Workforce Development Initiatives

Workforce Enhancing Initiative	Description
Career and Technical Education (CTE)	Office of the State Superintendent of Education's Division of Postsecondary and Career Education (PCE) funds multiple Local Education Agencies (LEAs) and individual schools to develop and offer career and technical education (CTE) programs of study in high wage and high demand career sectors, such as healthcare. PCE has also funded fourteen Career Academies, supported by core industry advisory boards made up of local businesses. This also supports several initiatives of UDC-Community College's, including a portion of the student support teams, the dual-enrollment program, and the co-requisite remediation initiative.
Career Pathways Task Force and Innovation Fund	A multi-stakeholder Career Pathways Task Force is responsible for developing a city-wide strategy for the development and implementation of career pathways programs for adult learners. Based on the Task Force's efforts and findings, the DC Council passed legislation establishing a Career Pathways Innovation fund to provide grants to design, pilot, and scale best practices in the implementation of adult career pathways and improve District performance on workforce outcomes. Innovation fund spending will address workforce system alignment and access to career pathways, and will be coordinated with programming at other agencies.
Workforce Intermediary Program	A sector-based workforce development initiative that brings together multiple stakeholders in key industries with significant employment growth and importance to the local economy. The program promotes a shared understanding of industries' workforce needs, advances training that meets those needs, coordinates services for job seekers, and helps employers find qualified job candidates. The Workforce Intermediary is currently active in the hospitality and construction sectors, and may expand into additional high-growth sectors, including healthcare, based on the work of the Career Pathways Task Force. Partner agencies and organizations with existing workforce and education programs in each sector participate in advisory groups, and the program helps connect them to employment opportunities.
Partner Engagement with Educational Institutions	Efforts to strengthen the connection between the Department of Employment Services (DOES) and University of the District of Columbia-Community College (UDC-CC). The workforce investment council (WIC) will solidify the addition of UDC-CC classes and programs to the District's Eligible Training Provider List (ETPL). UDC-CC's Division of Workforce Development and Lifelong Learning (WDLL) is currently serving as the primary training partner for the DC Career Connections Program, which will provide education, training, workforce development and work experience for approximately 400 District youth. The WIC will engage colleges and universities whose offerings align with the in-demand sectors and occupations data. WDLL also works closely

Workforce Enhancing Initiative	Description
	with DOES' Business Services Group (BSG) to connect trained District residents to jobs. District residents receive training and career counseling from WDLL and the BSG then works with completers and employers to place District residents.
Partner Engagement with Other Educational and Training Providers	The WIC's ETPL includes a number of CBO and for-profit training providers, employers, and organized labor, to foster apprenticeship instruction providers. It also provides a number of non-federally funded training options outside of the ETPL that are accessible through other agency programming. The District plans to better coordinate these training resources and ensure that jobseekers have access to high quality providers with clear links to employer needs by improving provider evaluation processes and expanding available options. We will help facilitate customized training options that are directly linked to employer needs, help facilitate partnerships between employers and training providers, and utilize advisory committees to ensure that training providers are linked to feedback.

The workforce development opportunities discussed above offer key areas for potential partnerships to build the workforce to meet SIM needs. Leveraging their resources, tools, and development pathways, we will invest in opportunities to provide ongoing training to the current healthcare and health-related workforce. As we implement changes necessary to reform the current care delivery system, we will consider lessons learned and model practices from past and ongoing development and training opportunities to effectively and efficiently move current workforce capacities towards our goals. Examples of recent workforce trainings specific to meeting SIM goals include:

Person-Centered Planning

- A major emphasis of the District's planning activities and initiatives, such as the No Wrong Door program, is optimizing informed choice and promoting person-centered thinking and planning among District agency staff and providers.
- The DC Office of Disability Rights (ODR) and Department on Disability Services (DDS) delivered a joint training on disability and the Americans with Disabilities Act to staff at the District's Aging and Disability Resource Center (ADRC). This training provided a framework for working and communicating with people with disabilities, serving as a foundation for doing person-centered planning and informed consent.

Community Integration

- DHCF will develop a Community of Practice for DC Medicaid case managers focused on supporting and facilitating greater individualized community exploration and integration. The Community of Practice will allow for multi-directional training and information sharing: from District government to case managers; from case managers to District government; and amongst case managers.

Housing Support

- DHCF staff and its agency and community partners participated in the first Medicaid Innovation Accelerator Program (IAP) webinar on housing tenancy. This was the first in a series of webinars under the Supporting Housing Tenancy track of the IAP. During the webinar, participants learned about tenancy support services, current providers and funding sources, and Medicaid authorities that may cover tenancy support services.

Innovation

- Events and announcements through the SIM Innovation Update Weekly Newsletter on TA and educational opportunities, such as webinars on value-based payment readiness for PCPs, FQHCs, and other providers

Value-Based Payment

- The National Academy of State Health Policy's (NASHP) Value-Based Payment Reform Academy helps selected states to develop and implement value-based alternative payment methodologies (APMs) for federally qualified health centers (FQHCs) that support their goals for transforming how care is paid for and delivered.

These trainings provide a foundation upon which we can build to better educate providers and key staff members on the elements of transformation. More technical concepts, such as value-based payments and use of HIT, will require in-depth education for providers, care teams, and non-clinical care partners. To the extent possible, we will work with community partners, educational institutions, non-governmental organization, and thought leaders to create and present such information to key SIM stakeholders. This will be an ongoing and iterative process since we anticipate that our workforce needs will change as our roadmap to comprehensive healthcare reform evolves. Part of this evolution includes the continuous assessment of our workforce needs, education, and future capacities. As we identify new areas in which to enhance our reform efforts, we will consider our workforce capacity, identify opportunities to develop additional workforce capacities, and cultivate and implement trainings for our current workforce to organically develop new skillsets.

This approach will enable us to meet our goal of building bridges of communication between specialists, primary care providers and community supports to develop capacities of the entire healthcare workforce. This will allow providers to learn of, ready themselves for, and implement care delivery and payment model reforms with minimal burden and maximum effect on improving the quality and reducing the costs of care. We are considering many approaches to enhancing our current workforce. Enabling strategies for workforce capacity development include:

- **Provider education and training:** Providers and patients can benefit from education and training on how to deliver person-centered care and address social determinants of health in a team-based setting. Additional education will help providers to successfully make the shift towards using value-based alternative payment models and drive care delivery transformation. We will work with workforce investment boards to create training programs and career ladders.
- **Engaging providers through technical assistance efforts:** We are identifying technical assistance and training to offer providers to prepare them for the implementation of new initiatives. Trainings and education may provide an overview of topics relevant to SIM initiatives (e.g., value-based purchasing) or may train providers on new skills required for participation. Training and technical assistance methods under consideration include:
  - Partner with local universities to provide workforce training and capacity building; particularly community health workers
  - Advanced courses in HIT, including HIE
  - Grants to support start-up costs to implement new initiatives
- **Training non-clinical providers and new workforce entrants:** Non-clinical providers and wrap-around service providers, such as community health workers, may need to be trained to operate in tandem with clinical providers and care teams. They may contact patients in the community and facilitate health promotion, maintenance, and

management for at-risk populations. Additionally providers will need to be flexible with regard to providing care outside of their practice area and practice in a more interdisciplinary way (e.g., including behavioral health as part of physical health visits). Our goal is to increase the number of non-clinical and interdisciplinary provider and new entrants by partnering with institutions and leveraging existing workforce development initiatives.

- **HIT adoption:** Providers may be educated on how the use of HIT tools can enhance provider decision-making, track quality and performance, offer expanded access to care information for patients, and modernize billing and documentation practices. This will create a more complete and accessible data picture of patient and population health.
- **Learning collaborative development:** Learning collaboratives may be created to share model practices among providers, systems, community supports, and government agencies. This will enhance continuous learning efforts and build overall system capacities, fostering patient-centered partnerships among disparate stakeholders.

Specific investments will be targeted towards our initiatives, such as Health Home 2, for which providers will be trained and assisted in establishing care teams and instituting new cultures of care. By building workforce capacities for specific initiatives, the District can test and adjust its commitments to developing the workforce so that it meets program needs and SIM goals. Lessons learned from Health Home 2 and other workforce investments, will shape future investments for long-term care delivery and payment models on our radar, such as Accountable Health Communities. Our current investments in the healthcare and health-related workforces' capacities will therefore have both immediate and long-term effects on the care delivery system.

The next Enabler we discuss is Quality Performance Improvement. This Enabler is focused on measuring and reporting progress to monitor and improve care. Performance measurement provides needed data to payers, providers, and patients.

Enabler D – Quality Performance Improvement

In coordination with the other Enablers -- HIT, stakeholder engagement, and workforce development -- we have developed a robust plan for quality performance improvement (QPI) to advance the SIM efforts. Our QPI goal is to improve health outcomes and reduce health disparities which requires measuring both process outcomes (e.g., provide recommended screenings) and health outcomes (e.g., decreased morbidity and mortality). Tracking quality measures will allow us to measure avoided costs associated with process failures, errors, and poor outcomes. To reach our goal we must first establish streamlined and reliable measures and reporting processes.

> Our vision is to significantly improve performance on selected health and wellness outcome quality measures and reduce disparities.

Fundamental to value-based payment systems are performance measures that can assess the extent to which providers are achieving the Triple Aim goals. Currently, the District does not have a standardized data collection or performance reporting system. Measures are reported to different oversight bodies including state and federal governments in various forms. The fragmentation makes it difficult to measure population health changes across the District. Agencies will need to coordinate to ensure the QPI plan is effectively integrated into their work plans. For example, DHCF plans to update their Medicaid quality strategy to align with the QPI. Once implemented, the QPI strategy will allow the District to see a complete picture of its residents' health and evaluate the performance of the healthcare delivery system.

We will continually work to improve the quality of healthcare delivered by programs administered by the District. We will do this by:

- Utilizing continuous quality improvement principles for performance measurement
- Utilizing population health dashboards with which beneficiaries and providers can monitor health progress. A population health management dashboard can also be used to profile risk, identify the prevalence of health conditions by provider or site, and evaluate provider and practice performance

Performance measurement is essential for the District's initiatives aimed at improving the quality, efficiency, and overall value of healthcare. P4P arrangements and other value-based arrangements provide financial incentives to hospitals, physicians, and other healthcare providers to carry out such improvements and achieve optimal outcomes for patients. The District will be able to track quality measures used in P4P. The QPI plan will also include tracking and measuring of the Health Home 2 core measures. These include the CMS Health Home Core Measures and three District-specific measures, 30-day all cause readmissions, hospital admissions with a chronic disease diagnosis, and the rate of inpatient hospital utilization.

The QPI plan is a targeted strategy that measures outcomes of specific healthcare transformation and reform initiatives. We will use performance measurement to promote Districtwide transformation and population health improvement. Our approach aligns with CMS' view that the development and use of quality measures is essential to maintain or improve the quality of care and patient experience.

Currently, we do not have a standardized data collection or performance reporting system. Measures are reported in various forms and are in silos that make it difficult or impossible to measure population health changes across the District. As Peter Drucker, the business and management expert, famously said, '**If you can't measure it, you can't improve it.'**

Therefore a key component of our healthcare transformation efforts is developing a QPI strategy to implement provider-facing, standardized statewide measurement activities that we will use to evaluate the performance of the healthcare delivery system and progress of the reform initiatives.

The QPI plan will address the reporting challenges outlined below:

- **Siloed Environment:** There are several reporting initiatives, but no standardized collection of measures or District-wide performance monitoring system.
- **Duplication of Efforts:** Frequently, payers focus on similar quality topics but may utilize different measures (e.g., different readmission measures). Perhaps even more administratively complex and burdensome to providers is the fact that different payers may have different specifications for very similar measures (e.g., multiple specifications for diabetes control).
- **Lack of Standardized Collection:** Lack of standardized data collection means that comparisons across time for the same provider or comparisons between providers are difficult or not possible.

Addressing these challenges will require that we collaboratively develop a common set of measures with a streamlined reporting capability. Quality measure alignment across payers is a critical success factor for each initiative meaning we cannot measure the progress and success of value-based payment reforms without a core set of measures that is collected frequently, timely, and accurately. To overcome the challenges the Workgroup developed core focus areas for QPI:

- Promote coordinated and streamline quality reporting across all District payers
- Promote agreement on a shared set of measures and identify measures to evaluate improved outcomes for specific populations
- Develop options to promote a quality reporting data infrastructure and identify quality report infrastructure needs for providers
- Develop strategies for quality improvement

Our QPI plan will support the three Pillars in the SHIP. Table 12, below, shows key initiatives within each Pillar and describes how improved QPI processes will enable success in each Pillar.

Table 12. Illustration of How QPI Initiatives Support the Pillars

Pillar	Quality Performance Improvement Initiatives
Pillar I – Care Delivery Reform	▪ Ability to measure and monitor CMS core health home measures ▪ Measures to evaluate outcomes for specific populations ▪ Providers will be able to view their own measures at individual and practice level ▪ Promote more coordinated and streamlined quality reporting
Pillar II – Payment Model Transformation	▪ Ability to align with other District initiatives such as CareFirst PCMH ▪ Develop performance measures for P4P to move towards value-based payment ▪ Providers will measure and report on QPI measures and have dashboards available to help them manage their patient population ▪ Ability to monitor population health measures, including DC Healthy People 2020 that align with District priorities and initiatives
Pillar III – Community Linkages	▪ Access to population surveillance dashboard to identify patients in need of additional care coordination ▪ Ability to measure the need for community linkages and the effectiveness of enhanced community linkages

Current Reporting Landscape

As discussed above the District does not have a mechanism to conduct District-wide measurement making it challenging to get a complete picture of the health of its residents or evaluate the performance of the District's healthcare delivery system. To enable future reform, it is important to understand our current reporting landscape, which includes:

- **CMS Medicaid Adult and Pediatric Core Measure Set:** CMS established the Adult and Pediatric Core Measure Sets (CMS Core Measures or CMS Core Measure Set) to standardize the measurement of healthcare quality across state Medicaid programs, assist states in collecting and reporting on the measures, and facilitate use of the measures for quality improvement. While reporting is voluntary for states, the District reported on 14 of 26 adult measures and 17 of 22 pediatric measures In FFY2014.
- **Electronic Clinical Quality Measures (eCQM):** CMS developed electronic clinical quality measurement (eCQM) requirements as part of the Medicare and Medicaid EHR incentive program. Eligible Professionals and Eligible Hospitals are required to report on

the eCQMs. Medicare professionals, group practices and hospitals may be involved in other Medicare reporting and quality initiatives.

- **Federally Qualified Health Centers (FQHC) Uniform Data System:** The Uniform Data System (UDS) is a standardized Federal reporting system that provides consistent information about health centers. The UDS is used to measure and improve health center performance and operations and to identify trends over time. UDS data is also used to compare individual health center performance with national data to review differences between the U.S population at large and those individuals and families who rely on the healthcare safety net for primary care. The UDS measures reflect many of the CMS Core Measures and efforts to align the measures continue.
- **CareFirst BlueCross BlueShield Patient-Centered Medical Home (PCMH):**[xliv] CareFirst's PCMH program is designed to provide primary care providers with a more complete view of their patients' needs and of the services they receive from other providers so that they can better manage their individual risks, improve health and produce better outcomes. The program requires greater provider-patient engagement and it compensates providers for that engagement. CareFirst plans to better align their measures with the CMS Core Measure Set.
- **District of Columbia managed care quarterly performance reporting:** DHCF evaluates MCO performance across a number of domains including financial condition, administrative performance, care management outcomes, utilization trends, and the related medical care spending. The MCOs also report on the adults and pediatric core set of measures.
- **DC Healthy People 2020:** DC Healthy People 2020 (DC HP2020) strives to identify local health improvement priorities, provide relevant and measurable objectives and goals, and engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge. DC HP2020 forms an integral part of the Community Health Improvement Process, using the Community Health Needs Assessment to set health goals and priorities and, along with stakeholders, determine community health objectives and targets. DC HP2020 is the District's only public-facing performance monitoring of key population health outcomes.

Short-term Goal: Quality Performance Improvement Plan

Our QPI plan includes many short-term initiatives.

Consensus building on core measure set development. Alignment across a set of quality measures is a foundational step towards healthcare transformation. Measure alignment will send a powerful signal to providers on how their performance is measured for the quality of care they provide, regardless of the health insurance coverage of the patient. We developed an initial

set of core measures as part of the SIM Design process but will continue to refine this measure set to further align with existing performance reporting initiatives (which included input from stakeholders that also participated in the DC Healthy People 2020 development process) as other measure sets are changed and updated. The measure set will continue to be representative of the District's current and future priority areas. The criteria for measure selection under the SIM Design process and in the future includes the following guidelines:

- Measures should align with national measure sets and other measure sets commonly used in the District, whenever possible. We have made a conscious decision to align with other performance initiatives and payers such as the CMS Core Measure Set, CareFirst, DC Healthy People 2020, and the FQHC Uniform Data System
- Measures should be valid, reliable, and tested
- Measures will be endorsed by the National Quality Forum (NQF)
- Measures must align with District priorities. The priorities were identified with common themes across various initiatives and the results of the environmental scan
  - We will align measures and measure outcomes for the key themes identified in the environmental scan. For example, rising number of Hispanics with HIV, heart disease in African American population
- Measures need to provide opportunity to improve health and will influence the healthcare delivery system
- To minimize reporting burden, initial phases will rely on claims-based measures and available uniform survey results

We conducted an inventory of the existing community health needs assessments (CHNA) such as the FY 2014-16 DC Healthy Community Collaborative Community Health Improvement plan, Other CHNA, Center for Medicare and Medicaid Innovation (CMMI), and Center for Disease Control (CDC) Racial and Ethnic Approaches to Community Health (REACH) as well as DC Healthy People 2020. We then identified common themes across the various assessments. These themes are outlined in Appendix 16. These common domains or themes are discussed below and in Appendix 16.

Gain multi-payer support. The District will obtain buy-in from other payers (e.g., commercial payers) to promote measure alignment. As part of a successful QPI, healthcare quality measurement must continuously evolve to reflect transformation priorities and meet stakeholder expectations. It is critical that we develop measure sets that they be meaningful to patients, consumers, and physicians, while reducing variability in measure selection, collection burden, and cost. Therefore, our goal is to establish broadly agreed upon core measure sets that could be harmonized across payers.

Launch electronic quality reporting tool. CMS developed electronic clinical quality measurement (eCQM) requirements as part of the EHR incentive program. The District is developing and implementing a practice- and population-level eCQM dashboard for Eligible Professionals (EP)

and Eligible Hospitals (EH) that can be expanded to support other providers. We are exploring using the eCQM dashboard to allow providers to measure and report on QPI measures. A customizable dashboard will be generated for Medicaid EPs and EHs by loading Medicaid claims and clinical data into an existing eCQM reporting tool and dashboard. EPs and EHs will be given access to the eCQM dashboard through a web-based portal, which will enable them to view their own measures, both on an individual and/or practice level. As technology progresses, the District will rely more on eCQMs.

Population surveillance dashboard. The District will leverage existing population health measures identified in the DC Healthy People 2020 Framework to monitor population health which will require the development of a provider-facing dashboard. Providers will need this dashboard to help effectively manage their patient populations. This includes their ability to identify high-cost patients and/or patients at high risk of developing costly and harmful conditions, such as diabetes and heart failure. Providers must also be able to increase their capacity to recognize patients that have become or are at an increased risk of becoming non-adherent. The dashboard will be available to DHCF to review progress towards milestones. Providers will have access to both the population health dashboard and to the eCQM dashboard through the same web-based portal.

Selected SIM Measures

There is no shortage of measures or conditions from which the District could choose for the QPI plan. The District has identified priority conditions for healthcare quality measurement and improvement that align with the Pillars and short-term and long-term goals.

Population measures. We reviewed several other initiatives, such as the DC Healthy Community Collaborative, Centers for Medicare &and Medicaid Innovation (CMMI) grant programs, DC Healthy People 2020, CDC Racial and Ethnic Approaches (REACH), and the CMS Core Set of Adult and Pediatric measures for Medicare and Medicaid, and the ACA Section 2703 Health Home measures.. We identified top eight conditions and clinical outcomes that were addressed across all initiatives:

- Asthma
- Behavioral Health
- Cancer
- Cardiovascular
- Care Coordination
- Child Health
- Diabetes
- Maternal and Infant Health
- Oral Health

- Prevention
- Sexual Health

Appendix 16 provides detail description on the common themes and the importance of these themes in the context of District residents. Appendix 17 also outlines the core measures that were agreed upon through our stakeholder engagement process. The stakeholders identified top 35 measures to be included as core measures (Appendix 17). Fourteen additional measures will be considered later and the core measure set will continue to evolve. Figure 15 below illustrates summarized version of the core measures that were identified for population health.

Figure 15: Proposed Core Measure Set

Initiatives on the Radar

The District's short and long-term initiatives will strategically position the District to enhance our capabilities to meet the federal requirements and align with industry trends. The following initiatives are currently under discussion:

- *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)*: The goal of MACRA is to evolve from the fee-for-service (FFS) incentive structure and volume of services provided towards the provision of higher quality and value service with greater patient-centered focus. We envision the District's capabilities to evolve such that we transition

from current FFS structure to an integrated value-based care delivery and payment system. The purpose of the CMS Quality Measure Development Plan (MDP) is to meet the requirements of the statute and serve as a strategic framework for the future of clinician quality measure development to support Medicare Merit-based Incentive Payment System (MIPS) and Medicare alternative payment models (APMs).

- *Core Quality Measure Collaborative*:[xlv] CMS and America's Health Insurance Plans (AHIP), as part of a broad collaborative of healthcare system participants, is releasing seven sets of clinical quality measures that support multi-payer alignment, for the first time, on core measures for physician quality programs. The core measure sets are intended to promote alignment of quality measures for the practitioner community (e.g., physician) or group practice level accountability and are in the following areas:
  - Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMH), and Primary Care
  - Cardiology
  - Gastroenterology
  - HIV and Hepatitis C
  - Medical Oncology
  - Obstetrics and Gynecology
  - Orthopedics

The collaborative promotes alignment and harmonization of measure use and collection across payers in both the public and private sectors. CMS is already using measures from each of the core sets. Using the notice and public comment rule-making process, CMS also intends to implement new core measures across applicable Medicare quality programs as appropriate, while eliminating redundant measures that are not part of the core set. Commercial health plans are rolling out the core measures as part of their contract cycle.

The Quality Performance Improvement is the last Enabler in our strategy. This concludes our discussion of the Pillars and Enablers. The following section is the District's plan to evaluate and monitor the overall SIM efforts that includes the short and long-term initiatives across all Pillars. The evaluation and monitoring plan is followed by the operational plan and financial analysis.

Evaluation and Monitoring

The District's QPI plan articulates our vision and strategy for measuring performance related to the short and long-term reform initiatives described in the SHIP. The QPI measures the performance of the health system including improvements in care and outcomes. Conversely, the evaluation and monitoring plan described in this section articulates both the process of the SIM reform initiatives being implemented and the outcomes of initiatives. It is an evaluation of our performance in achieving the goals described in the SHIP. This plan will help us achieve the short-term and long-term initiatives and also provides the input needed to change strategies in the event we are not initially successful. This plan also describes how we will evaluate short-term initiatives, namely Health Homes, as well as our plans for evaluating long-term initiatives.

For the Health Home evaluation, the District will contract with an independent evaluator to assess the effect on cost and quality of care of the Health Home programs (e.g., the impact of new services such as comprehensive care management, care coordination, transitional services, and linkages).

We will develop a set of metrics to measure progress across the transformation effort to measure the overall impact on each element of the triple aim and our operational and process goals. The goal of the evaluation plan is to review and measure the impact of SIM initiatives and:

- Assess effectiveness of policy and regulatory levers
- Examine which program characteristics, implementation approaches or adaptations, and contextual factors are associated with better outcomes and reductions in costs
- Identify which integration and payment models have the most promise for improving care, improving health, and lowering costs in different settings and geographic locations

Evaluation Plan for Short-term Initiatives: Health Homes

We will contract with a vendor to develop and conduct an evaluation that will assess the implementation process and impact of the Health Homes initiative (described in detail in Pillar I and Appendix 5). Many of the evaluation criteria will come from the federal Health Home program requirements but we will also include evaluation questions specific to challenges and opportunities presented in the District.

The evaluator will examine the following:

- Structure of models selected to deliver services
- Progress on outcomes, including clinical, quality, costs, and patient experience measures

Variations in Health Home structures will also be evaluated, for example, assessing how various designs and operational structures impact care delivery and outcomes. This will provide insight about the processes and staffing models necessary to become and sustain a Health Home. Specific research questions for each of these areas are listed below in Table 12.

In general, structural and process research questions will be primarily addressed by a contractor using information collected during site visits, focus groups, interviews or other methods, as well as data collected by the District.

The contract period for the evaluation vendor will be one base year and four option years. The base year includes revision of the evaluation design as needed in light of this review, an analysis plan, collection of additional data, and baseline data analysis. The subsequent option years will be a continuation of data collection and data analysis and a final evaluation report in the fourth option year.

Table 13. Research Questions for Evaluation of Health Home Program

SIM Component	Evaluation Questions
Health Home (Outcome Questions)	▪ Were there clinical improvements in chronic disease management? (e.g., did A1C levels increase or decrease; did blood pressure decrease or stabilize over time; etc.) ▪ Do health homes reduce unnecessary hospital admissions, ED visits, or admissions to skilled nursing facilities among people with chronic illnesses? ▪ Does cost-effectiveness differ based on the structure of a Health Home? ▪ Do health homes reduce the total costs of care? Does primary care and behavioral health service spending increase? ▪ Do health homes improve chronic disease management and care coordination, including care coordination when individuals transition between levels of care and providers? ▪ Do beneficiaries report improved access to family supports and social services? ▪ Do health homes improve the experience with care for beneficiaries, caregivers and family members, and providers? ▪ Do health homes deliver patient-centered care? ▪ Are beneficiaries and/or their caregivers able to participate more effectively in decisions concerning their care? ▪ Are beneficiaries better able to self-manage their conditions or more likely to engage in healthy behaviors?
Health Home (Structural Questions)	▪ What is the relationship between health homes and other physical, mental, or social service providers?

SIM Component	Evaluation Questions
	▪ What staffing models have health home providers adopted to meet the requirements of being a health home? ▪ Have health information systems been changed to facilitate health home implementation? ▪ What challenges do providers face? ▪ Are there common features among the high-performing health home providers? ▪ How do participating health homes use the enhanced PMPM payment?

Many of the questions above will be addressed early in the Health Home implementation, the latter period of the evaluation for Health Home will focus on sustainability, particularly after the federal resources phase out. Additional research questions to consider for Health Home during program years four and five include:

- Is there consistent churning in and out of Health Homes? If so, why?
- How much does it cost to implement and sustain the various features of a Health Home?
- What types of providers are best suited to become a Health Home?

Evaluating Other SIM Initiatives

In addition to evaluating the Health Home initiatives, there are other initiatives that we are pursuing related to payment reform, HIT, community linkages, and workforce development. Table 13 below provides examples of research questions that we may use to evaluate these initiatives.

Table 14. Research Questions for Evaluation of SIM Efforts

SIM Component	Evaluation Questions
Payment Reform	▪ What proportion of primary care and behavioral health practices and beneficiaries participated in SIM alternative payment models? ▪ Do alternative payment models result in lower healthcare costs? ▪ Is there variation by practice type?
Community Linkages	▪ Number of collaborations between clinical and health-related social services enabled by the Health Home model, Accountable Health Communities, health information technology, and an updated referral process. ▪ Measure linkages within interdisciplinary team of clinical and health-related social services, the District to address SDOH and improve health outcomes and health status.

SIM Component	Evaluation Questions
Improving Population Health	▪ To what extent do the population health measures change over time?
HIT	▪ Progress in comprehensive data map ▪ To what extent set standards created for HIEs in the District are related to interoperability, privacy, etc. ▪ Progress on District's centralized warehouse ▪ Progress on tools and initiatives that bolster HIT usefulness ▪ Progress on Patient Care Profile ▪ Progress on eCQM Tool and Dashboard ▪ Have health information systems been changed to facilitate health home implementation?
Workforce Development	▪ To what extent a well-developed and well-trained workforce is developed to implement and sustain short- and long-term transformation initiatives, especially for care delivery reform and enhancing community linkages. ▪ What methods are established for building the workforce capacity through: technical assistance and training; investing in non-clinical communication and collaboration between clinical and health-related social services; incentivizing a holistic approach to care though payment reform? ▪ What staffing models have health home providers adopted to meet the requirements of being a health home?
Stakeholder Engagement	▪ How satisfied were stakeholders with their level of participation in the planning and implementation of SIM? ▪ To what extent were stakeholders across the state engaged in the SIM?

Evaluating and Monitoring Population Health

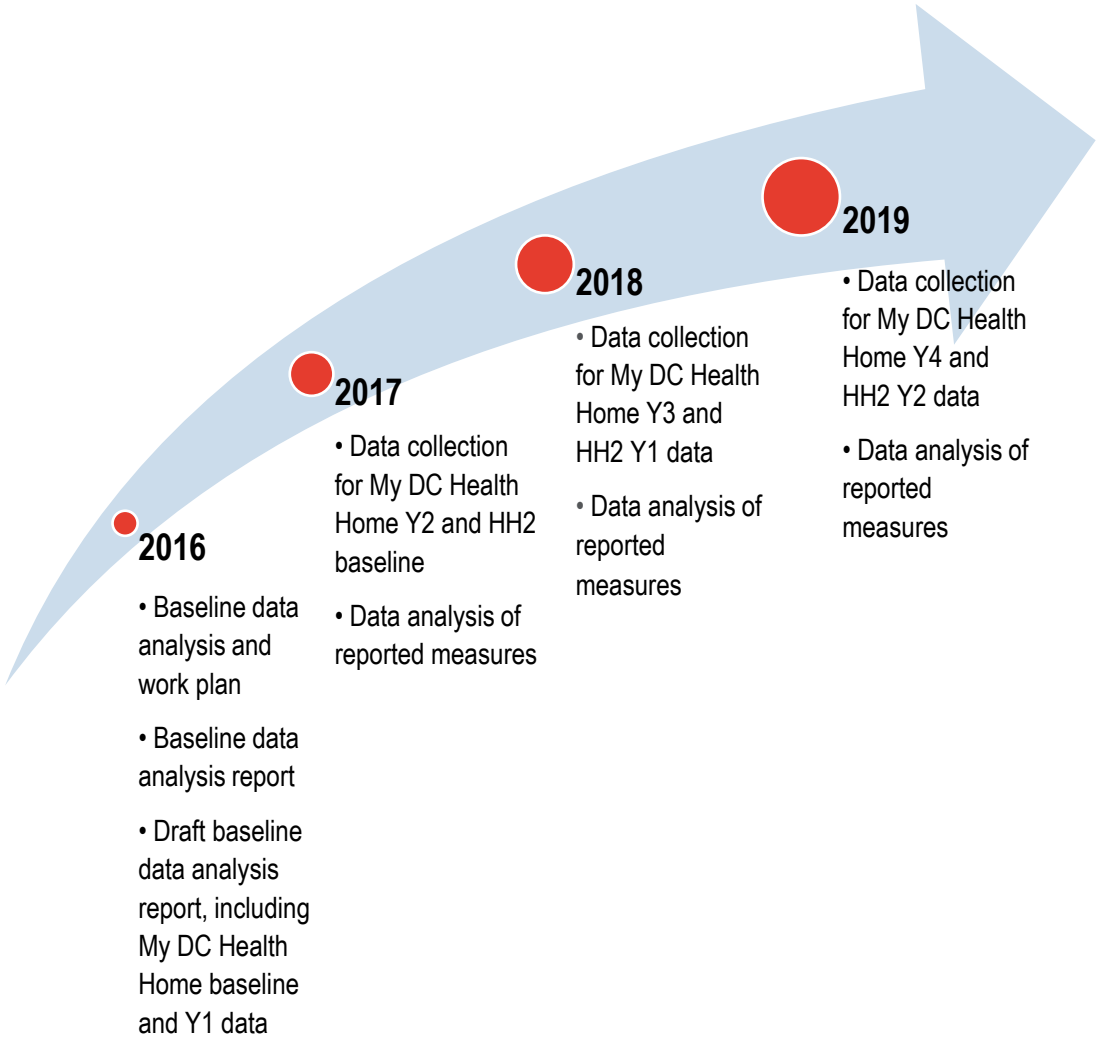
Much of the DC Healthy People 2020 framework will serve for monitoring key population health outcomes over time. Equally important is the collective evaluation and recommendation of evidence-based strategies to best impact the objectives and their use as a guide for individuals and organizations seeking to improve the health and well-being of District residents.

The evaluation and monitoring plan will link efforts to track progress against the population health goals. The goals will be developed for the domains discussed earlier. Once we begin reporting we will develop a baseline for the measures and then set thresholds or goal for the specific measure.

Evaluation and Monitoring Overall Timeline

The timeline to prepare for, launch, and further evolve the performance measurement and evaluation approach for both the Health Home model and SIM initiatives is outlined below.

Figure 16. SIM Evaluation and Monitoring Timeline



The following section outlines the District's operational plan that describes our future governance structure, how we leverage various policy levers, and our roadmap with detailed milestones for our transformation efforts.

Operational Plan

Our operational plan establishes the specific steps needed to implement the short and long-term initiatives. This describes what the District needs to do, the order of the steps needed to accomplish those tasks and the personnel and tools needed to meet the SIM goals. Our plan is to continue to update the operational plan on a regular basis to verify that we are is sticking to the outlined steps. This section of the operational plan includes our:

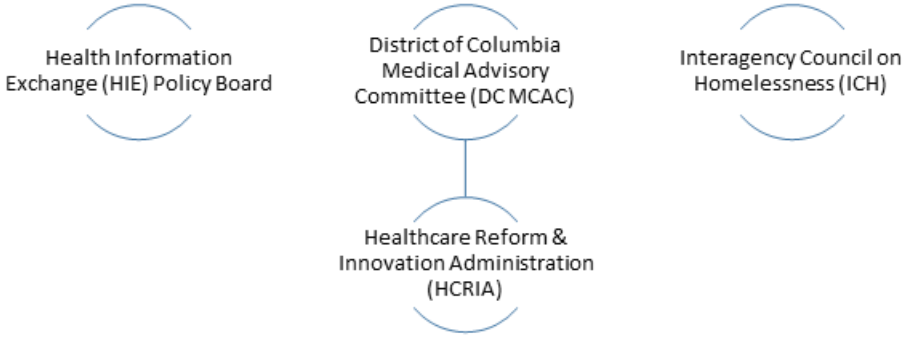
- Proposed future governance structure
- Policy levers to achieve reform
- Transformation roadmap with milestones from years one through five of the SIM plan

Proposed Future Governance Structure

A formal governance structure moving forward is important for several reasons. It not only gives internal and external stakeholders confidence in our activities, but also promotes continued stakeholder engagement and participation in the District's reform initiatives.

Proposed Future Governance Structure

Figure 17. Governance Structure



District of Columbia Medical Care Advisory Committee (DC MCAC). The DC MCAC is a forum for key participants and stakeholders in the Medicaid program, including consumers, advocates, providers and District officials to review the program's operations and offer advice for improvements directly to DHCF.

The Director and Deputy Director of DHCF chair the committee. There is at least one board certified physician and other representatives of health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care. The current representation structure contains:

- Physicians and direct service provider representatives
- Advocacy organizations and trade associations
- Medicaid consumers and interested citizens not receiving Medicaid benefits
- Government support
- Staff support

The DC MCAC Executive Committee seeks to promote meaningful participation of community members, advocates, and Medicaid beneficiaries in the advisory, educational, and advocacy work of the MCAC body. The four key recommendations for the structure and function of MCAC to impact the policies and programs of the District's healthcare system are:

- MCAC will give guidance on the development and assessment of priorities, goals, and performance objectives for each of the most patient-facing DHCF divisions including HCRIA
- MCAC will review and formally move on substantive State Plan Amendments (SPAs), waivers, and regulations
- MCAC will have themed meetings throughout the year and standing items that address issues that beneficiaries face. Themed meetings could include DHCF provider performance, managed care oversight and accountability, eligibility and enrollment, and barriers to services such as transportation and neighborhood
- MCAC will revise the member list and increase MCAC member accountability

Healthcare Reform and Innovation Administration (HCRIA). DHCF has four staff who constitute the core SIM team and will work towards the implementation of the SIM Design initiatives. The DC MCAC will guide the work of the SIM team.

HIE Policy Board. The purpose of the Board will be to advise the HCRIA and other District agencies, regarding the implementation of secure, protected health information benefitting District stakeholders in accordance with DHCF HIE Action Plan. The Board consists of 21 members, including seven District government representatives appointed by the Mayor.

- The board will make recommendations based on development of policies essential to broad implementation of secure, protected health information exchange benefiting District stakeholders
- Make recommendations to HCRIA regarding improving HIE operations including vision, mission, geographic scope and functional scope

- Make recommendations on establishing the roles, responsibilities, and relationships between parties to organize and oversee activities among stakeholders

Interagency Council on Homelessness (ICH). The purpose of ICH is facilitating interagency, cabinet-level leadership in planning, policymaking, and program development, provider monitoring, and budgeting of the continuum of care of the homeless services. The ICH will:

- Provide leadership in developing strategies and policies that guide implementation of the District's policies and programs for meeting the needs of the individuals and families who are homeless and are at a risk of being homeless

Policy Levers to Achieve Reform

The District has a variety of tools at its disposal to enable and empower healthcare transformation through model design, Medicaid care delivery and payment reform, regulation, and legislation. The SIM Design process has brought together a diverse group of policymakers, regulators, association leaders, payers, providers, and consumers to examine the role of the District in healthcare, identify policy requirements needed to support transformation, and take steps to build the foundation for successful implementation.

Table 15. Illustration of how Policy Levers are leveraged for Pillars

Pillar	Policy Levers
Pillar I – Care Delivery Reform	▪ Affordable Care Act initiatives ▪ Home Health State Plan Amendment ▪ Section 1115 waivers ▪ Implementation Advance Planning Document (IAPD) ▪ Innovator Accelerator Program guidance and technical assistance ▪ Comprehensive Primary Care (CPC)
Pillar II – Payment Model Transformation	▪ Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) ▪ Innovator Accelerator Program guidance and technical assistance ▪ Section 1115 Waivers ▪ Implementation Advance Planning Document (IAPD) ▪ Bundled Payments for Care Improvement (BPCI)
Pillar III – Community Linkages	▪ Section 1115 Waivers ▪ Implementation Advance Planning Document (IAPD) ▪ Comprehensive Primary Care (CPC)

Specifically, the design process included representatives from Department of Health, Department of Human Services, Department of Behavioral Health, Department of Disability Services, Department of Health Care Finance, Council Members, and others. There are several specific offices or Boards that are involved in healthcare, representing a significant opportunity to enable change. This approach to policy design increases the likelihood the District can institutionalize the vision for transformation.

These offices serve a variety of functions, including that of regulator, licensor, funder, and provider of services, and collectively represent the array of ways transformation can be supported by the government.

The District has already utilized some of the policy levers to lay the groundwork for the transformation efforts. Table 14 above and the discussion below illustrate how the various policy levers are leveraged to drive the three Pillars.

- **Health Home State Plan option:** Under the Affordable Care Act (Section 2703), the Health Home State Plan Option allows states to design health homes to specifically provide comprehensive care coordination and disease management for Medicaid beneficiaries with chronic conditions.

  On January 1, 2016, DHCF launched a new benefit for Medicaid beneficiaries with mental healthcare needs, called My DC Health Home, that will help coordinate a person's full array of health and social service needs—including primary and hospital health services; mental healthcare, substance abuse care and long-term care services and supports. My DC Health Homes are community-based mental health providers, as known as Core Services Agencies, which have hired nurses, primary care doctors and others with social and health-related backgrounds, to create Care Teams.

- **Section 1115 demonstrations or waivers:** Section 1115 waivers allow states more flexibility with their Medicaid and CHIP programs so long as these waivers are budget neutral, or do not cost more than what the federal government would have otherwise paid. CMS has approved a number of Delivery System Reform Incentive Payment waivers that allow states funding flexibility to cover populations, services, and other costs. A Section 1115 waiver may help the District to pursue initiatives that are limited without a waiver due to regulatory flexibility or funding.

- **Additional SIM funding:** There has been some indication from CMS that there will be another round of SIM funding grants to promote planning, design, implementation and testing of state innovation models. Our planning efforts would benefit greatly from an additional round of SIM funding.

- **Medicaid Innovation Accelerator Program:** CMS launched the Medicaid Innovation Accelerator Program (IAP) in July 2014 with the goal of improving health and healthcare for Medicaid beneficiaries by supporting states' efforts to accelerate new payment and service delivery reforms. The District will leverage federal tools and resources to advance Medicaid-specific delivery system reform. We will utilize the lessons and best

practices shared by CMS to accelerate Medicaid-focused innovations to transform healthcare.

- **Implementation Advance Planning Document (IAPD):** To address existing fragmentations in HIE connectivity, the District's HIE Policy Board and SIM HIE Workgroup refined a list of recommended initiatives that would bolster the District's HIE capabilities. The SIM grant is being used to create a cohesive plan for implementing and sustaining these initiatives. Initial funding for these initiatives is supported by the SIM grant and by prior approval of an Implementation Advance Planning Document (IAPD) update for additional Federal Financial Participation (FFP) using funds already approved in the original HIT-only IAPD on December 17, 2015.

- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): T**he District will continue its work with the payment reform Workgroup in order to continue the discussion regarding payment reform in the District. We will align our future initiatives with goals and objectives to MACRA.

- **Center for Medicare and Medicaid Innovation (CMMI):** We will leverage CMMI's Comprehensive Primary Care (CPC) initiative designed to strengthen primary care. CPC offers population-based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five comprehensive primary care functions.

  The other CMMI initiative is Bundled Payments for Care Improvement (BPCI) initiative. This initiative links payments for the multiple services beneficiaries receive during an episode of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare.

Health System Transformation Roadmap and Milestones

The District's roadmap outlines the milestones the District must strive to meet to transform care delivery and payment models in accordance with its five aims. Within the next five years (2017 – 2021), we will achieve five aims--- two of which specifically align to the District's Healthy People 2020 framework goals for reductions in inappropriate ER use and hospital readmissions:

1. 100% of DC residents enrolled in Medicaid with a qualifying chronic health condition will have access to a care coordination entity, that is primarily responsible for all aspects of care, by 2018
2. 15% reduction from baseline in non-emergent ED visits for all District residents by 2020
3. 10% reduction from baseline in preventable hospital readmission rates for all District residents by 2020, 15% reduction from baseline for residents enrolled in Medicaid by 2020

4. Develop and implement a plan to reinvest savings achieved through system redesign to promote prevention and health equity, using a comprehensive approach not solely focused on healthcare by 2021
5. 85% of Medicaid payments will be linked to quality and 50% payments will be tied to an APM by 2021

Table 16. Transformation Roadmap and Milestones by Pillar and Enabler

Year	Pillar I - Care Delivery Reform	Pillar II - Payment Model Reform	Pillar III - Community Linkages	Enabler A – Stakeholder Engagement	Enabler B - HIT	Enabler C - Workforce Capacity Development	Enabler D - Performance Improvement and Evaluation
Year 1	▪ Designate and stand-up HH2 Providers in Tiers 1 and 2 ▪ Stand-up HH2 Tier 3 in alignment with DOH procurement timelines ▪ TA to providers on team-based care, HIT, community linkages, and patient education Set baselines for LANE, readmissions and IP measures	▪ Start providing PMPM payments to HH2 providers ▪ 0% of payments are via APMs and 30% of payments tied to value ▪ TA to providers on delivering outcomes-based VBP Renegotiate MCO contracts with view towards incorporating APMs	▪ Enroll PSH providers to become HH providers ▪ Member engagement in the enrollment process ▪ Work with DCPCA-led network of clinical, community, and social providers to build a health network to identify and address the social determinants of health for DC Medicare and	▪ Work with providers to develop TA training ▪ Include providers on data collection technique and performance measures ▪ Work with community and providers to conduct outreach, education and support to increase EHR adoption ▪ Collaborate with community on patient	▪ Complete data map and identify areas of opportunity for increased connectivity ▪ Start designation for prospective HIEs ▪ Go-live of data warehouse infrastructure and provisional access to key actors Gain IAPD approval for development and integration of ambulatory HIT connectivity, Dynamic Care Profiles, OB registry and	▪ Develop learning collab-oratives and deliver TA to providers on team-based care, payment model and delivery reform, HIT, community linkages, and patient education ▪ Provide TA training on HIE interfaces ▪ Identify workforce capacity gaps Develop training programs for non-clinical health staff such as Community Health Workers	▪ Performance evaluation baseline data analysis and work plan and report ▪ Performance evaluation draft baseline data analysis report to include Health Home w/ SMI Baseline and Y1 ▪ Gain IAPD approval for development and integration of eCQM and analytical patient population dashboard

			Medicaid beneficiaries ▪ Use HIT to strengthen community linkages and improve care coordination	engagement strategies Collaborate with HIE and Homelessness boards	integration of eCQM and analytical patient population dashboard		
Year 2	▪ Set percentage outcomes reduction targets ▪ Expand and refine HH2 processes using lessons learned from year 1 ▪ HH2 providers start receiving P4P payments Continue TA to providers to build capacities and	▪ Develop payment strategy to tie payments to outcomes reduction targets ▪ Implement year 1 of P4P payments ▪ 20% of payments are via APMs and 50% of payments tied to value Continue TA to providers on delivering outcomes-based	▪ Implement DCPCA-led strategies to build network that consistently and systematically identifies and addresses the social determinants of health for DC Medicare and Medicaid beneficiaries. ▪ Health home clinical providers begin collaborating with Permanent Supportive	▪ Collaborate with public health to assess community health needs ▪ Collaborate with DCPCA to identify and address social determinants of health ▪ Collaborate with community on increasing patient engagement Collaborate with HIE and Homelessness boards	▪ Implement policies, standard operating procedures, and technology requirements for use and security of HIT services ▪ Conduct outreach, education, and technical assistance to increase adoption and use of HIT ▪ Use HIT quality reporting mechanisms to	▪ Continue to provide TA to build workforce capacity ▪ Continue to assist providers with the implementation of the HH program and practice transformation	▪ Performance evaluation data collection for SMI Health Home Year 2 and chronic conditions health home baseline ▪ Performance evaluation data analysis

	encourage P4P adoption	VBP and assuming risk	Housing (PSH) providers. ▪ Engage new partners, both clinical delivery and community social services. ▪ Clinical delivery site service support that includes site-level technical assistance to address screening, referral, and navigation integration into staffing plans and process workflows ▪ Implement enhanced referral and needs assessment plan Member engagement in		inform P4P payments ▪ Continue data warehouse construction and expansion of use access Implement work plans and financing for IAPD HIT initiatives		

			the care planning process				
Year 3	▪ Reset the baseline for outcomes measures ▪ Add measures based on data and priorities ▪ HH2 providers receive P4P and start assuming risk for patient populations Continue TA to providers to build capacities and encourage P4P adoption	▪ Introduce menu of APM options for providers to start assuming risk / shared savings ▪ Identify model practices for providers looking to assume risk ▪ Continue TA to providers on delivering outcomes-based VBP and assuming risk 30% of payments are via APMs and 70% of payments tied to value	▪ Refine enhanced referral process and needs assessment ▪ Enroll sufficient HH2 teams to coordinate care for 25,000 eligible beneficiaries Assess implementation of AHC strategies	▪ Collaborate with community on increasing patient engagement Collaborate with HIE and Homelessness boards	▪ Conduct outreach, education, and technical assistance to increase adoption and use of HIT ▪ Continue data warehouse construction and expansion of use access ▪ Implement IAPD initiatives and test use among providers Use HIT to improve care coordination	Continue to provide TA to build workforce capacity	▪ Performance evaluation data collection for SMI Health Home Year 3 and chronic conditions Health Home Year 1 ▪ Performance evaluation data analysis ▪ Use HIT quality reporting mechanisms to inform risk-based APMs
Years 4 and 5	▪ Reset the baseline for	▪ Transition providers to risk-bearing APMs	▪ Provide seamless care	Provide performance feedback, establish new reporting	▪ Conduct outreach, education, and technical	Continue to provide TA to build workforce capacity	▪ Performance evaluation data collection for SMI Health Home

	outcomes measures ▪ HH2 providers receive P4P and start assuming risk for patient populations ▪ Broader care delivery system integration through APC/ACO models Continue TA to providers to build capacities and encourage risk assumption	and shared savings models ▪ Continue TA to providers on delivering outcomes-based VBP and assuming risk 50% of payments are via APMs and 85% of payments tied to value	coordination and health promotion ▪ Provide comprehensive care management services ▪ Provide comprehensive transitional care, including appropriate follow-up	requirements with stakeholders	assistance to increase adoption and use of HIT ▪ Continue data warehouse construction and expansion of use access Implement IAPD initiatives		Year 4 and chronic conditions Health Home Year 2

Financial Plan

This section summarizes the financial analysis of the major reform component of the SHIP – the Health Home 2 initiative. The analysis reviews the viability of the potential savings and investment costs of this initiative and describes the strategies for cost reductions.

Our short-term goal is to implement the Health Home 2 to coordinate, and ultimately integrate care for high-need residents with chronic physical health conditions (including HIV/AIDS) and social needs that impact health, such as homelessness. By transitioning to a Health Home model of care, there is an opportunity to eliminate expenses through proactive care and care coordination. As discussed in the environmental scan the District has one of the Nation's highest healthcare coverage rates. However, disparities continue to exist between health outcomes of many residents. Racial and ethnic groups have significantly poorer health outcomes in key geographic and socio-economic areas. For example, Diabetes rates in Wards 7 and 8 are nearly twice the national average.

We are pursuing Health Home 2 to make care more efficient and effective for the targeted population. Below are some specific challenges that the District will address through the Health Home 2 initiative. Addressing these challenges will not only promote decreased health disparities and improved health outcomes but also improve care coordination and the efficiency of care to realize financial savings.

- **System fragmentation:** The District is a microcosm of the national disjoined healthcare system where residents navigate between unconnected sites of care contribution to poor health outcomes. For example, residents with multiple health and social needs may have four or more siloed agencies providing care management. Fragmentation in care delivery is particularly challenging for individuals with multiple chronic physical health conditions who use the most services. HHs will allow for continual treatment and management to improve patient health outcomes and reduce costs.
- **Service utilization:** Too often, individuals use the ED for primary care and they are not linked to community-based care after hospital discharge. This leads to hospital readmissions. For example, the District's ED utilization rate is almost twice the national rate at 746 ED visits per 1,000, versus 423 nationally. HHs will provide the level of care coordination required to reduce ED visits. The Health Home model brings us closer to our goal of reducing inappropriate utilization of inpatient and ED by 10%.
- **Medicaid spending:** The majority of Medicaid expenditures are from a very small percentage of Medicaid beneficiaries with exceedingly high costs for the fee-for-services (FFS) population. 5% of Medicaid beneficiaries account for 60% of Medicaid spending in the District, including costs for long-term services and supports. Since the Health Home model provides targeted care to the top 5% population, we expect a drop in overall cost of care for this population.

The District will use the Health Home model to bridge one of the most significant barriers to integrated physical and behavioral healthcare, care coordination, and communication across

providers. Our goal is to improve outcomes and reduce and contain costs through increased monitoring and care coordination, improved care quality, and reduced hospital, skilled nursing facility, and ED use.

Strategies for Cost Reduction

Cost savings resulting from improved health status and reduced utilization are expected to, at a minimum, cover the costs of the Health Home 2 program and we anticipate savings in excess of Health Home 2 costs.

The Districts Health Home model will change how healthcare services are delivered with a strong focus on primary and preventive care and more effective care management. Strategies that will support cost-containment include but are not limited to:

- **Whole-person care:** Health Home 2 will address physical and behavioral healthcare, as well as social services and supports to treat the 'whole person' and move towards clinical integration. Coordination and monitoring across both physical and behavioral health needs can help to manage and improve such individuals' health. Health Home will bridge the gaps in the fragmented care delivery system by shifting the focus away from treating individual acute episodes to a more comprehensive, coordinated way of treating 'whole person' needs. Health Home 2 will allow providers to take the extra time to communicate with the other providers patients' may go to such as specialists, hospitals, or home health aides. This results in coordinated care and patients avoid duplicated tests or conflicting advice. This reduction in duplicate tests and visits will result in cost savings.
- **Needs assessment for care planning:** The information gathered in assessments, screenings can also help managed care organizations, and payers to stratify individuals into different risk categories, understand their utilization patterns, and further pursue high-need individuals for specific services that may improve their health. Risk stratification of high cost patients with appropriate handoffs and care coordination, promote person/family-centered care, better outcomes, and lower costs.
- **Care coordination:** We will use care management and coordination partnerships to cover gaps in care. Using care coordinators in integrated care teams facilitates the development and use of care plans and increases patient adherence to care plans. Care coordinators create links between providers and sites of care so that information can flow without being lost during care transitions (e.g., when patients move from inpatient hospital to outpatient care, unnecessary emergency care to primary care). The reduced emergency care will result in cost savings.
- **Health information technology (HIT):** HIT allows data aggregation and sharing with care team members to address care gaps. HIT will create Patient Care Profiles, a snapshot of an individual's medical history, recent utilization trends, care plans that are available at the point of care. Patient Care Profiles help fill information gaps and improve provider decision-making and patient outcomes. A study by the RAND Corporation

indicates the largest savings come from reduced hospital stays (a result of increased safety and better scheduling and coordination), reduced nurses' administrative time, and more efficient drug utilization.

Please see Pillar I and Appendix 5 for more information about the Health Home 2 program.

Financial Model Assumptions

Provider Payments:

- Health Home 2 providers on a per-member-per-month (PMPM) basis, triggered by the delivery of one of the six Health Home 2 services. Based on the results of the risk assessment, we will group members by risk
- $46 PMPM for group one enrollees (enrollees with two or more chronic conditions).
- $137 PMPM for group two enrollees (enrollees with two or more chronic conditions and a higher likelihood of future hospital utilization based on a risk assessment)
- Estimated enrollment is 17,000 enrollees for group one and 5,000 in group two

Savings Methodology and other Assumptions:

We used the return on investment forecasting calculator for health homes and medical homes by Center for Healthcare Strategies (CHCS). This is a web-based tool to help identify the cost-savings potential of new care delivery models such as HHs. Detailed assumptions about the Health Home 2 initiative were included in the mode for the following model specifications and variables:

- Target population characteristics such as size, risk stratification, and expected enrollment rate
- Timeframe for forecast period and ramp-up
- Average annual baseline costs for target population, by service category
- Trend (expected growth in healthcare costs)
- Anticipated changes in utilization patterns.
  - We include the expected change in beneficiary's utilization for each of the years. We then compare the change to trended baseline costs for each forecast year.
- Estimated program costs
- Discount rate – this is the organizational cost of capital to calculate the return on investment

The model then forecasts potential savings. We discuss the utilization changes and savings below.

Expected Total Cost Savings and Return on Investment

The District is in the process of estimating the expected five year savings for the proposed Health Home program and the three and five year projected return on investment.

Table 17. Estimated Utilization Changes Associated with Health Home 2 Metrics

Metric	Baseline	Utilization Decrease (Increase)
30-day all-cause readmission rate (%)	In progress	In progress
ED visits per 1,000 eligibles	In progress	In progress
Acute inpatient admissions per 1,000 eligibles	In progress	In progress
Average monthly physician office visits per 1,000 eligibles	In progress	In progress
Average monthly post-acute SNF admissions per 1,000 members	In progress	In progress
Home Health visits per 1,000 eligibles	In progress	In progress
Average monthly impatient psychiatric admission per 1,000 members	In progress	In progress

Table 18. Estimated PMPM Cost Savings for each Category of Service

Category of Service	Medicaid PMPM Savings
Inpatient	In progress
Emergency Department (ED)	In progress
Outpatient	In progress
Office-Based Care (Professional)	In progress
Laboratory	In progress
Pharmacy	In progress
Long Term Care	In progress
Home/Community Based Services	In progress
Mental Health Services	In progress
Substance Abuse Services	In progress

We will continue to revise our financial model as we pursue additional initiatives that will generate savings.

Glossary

Term	Definition or Description
Access	Access to a service, a provider or an institution, thus defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their need
Accountable Care Organization (ACO)	A network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending. At the heart of each patient's care is a primary care physician.
Accountable Health Communities (AHC)	Addresses a critical gap between clinical care and community services in the current healthcare delivery system by testing whether systematically identifying and addressing the health-related social needs of beneficiaries' impacts total healthcare costs, improves health, and quality of care.
Acute Care	A pattern of healthcare in which a patient is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Acute care is usually given in a hospital by specialized personnel using complex and sophisticated technical equipment and materials. Unlike chronic care, acute care is often necessary for only a short time.
Admission, Discharge, and Transfer (ADT)	A software application used by healthcare facilities to track patients from the point of arrival at a hospital until departure by transfer, discharge, or death.
Adoption	To acquire, purchase, or secure access to certified EHR technology
Advance Planning Document (APD)	Type of document required by CMS for states to receive access to federal funds for certain programs or investments including the EHR Incentive Program
Affordable Care Act (ACA)	A federal statute signed into law by President Barack Obama on March 23, 2010. Under the act, hospitals and primary physicians would transform their practices financially, technologically, and clinically to drive better health outcomes, lower costs, and improve their methods of distribution and accessibility.
All Payers Claim Database (APCD)	Large-scale databases that systematically collect medical claims, pharmacy claims, dental claims (typically, but not always), and eligibility and provider files from private and public payers.
Alternate Payment Model (APM)	The Patient Protection Affordable Care Act (PPACA) created a number of new payment models that move away from paying healthcare providers for quantity of care (fee-for-service) towards quality of care they provide to patients.

Term	Definition or Description
America's Health Insurance Plans (AHIP)	America's Health Insurance Plans (AHIP) is the national trade association representing the health insurance community. AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable healthcare coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.
Application Programming Interfaces (APIs)	A set of routines, protocols, and tools for building software applications and for accessing a Web-based software application or Web tool. An API specifies how software components should interact and APIs are used when programming graphical user interface (GUI) components. A software company releases its API to the public so that other software developers can design products that are powered by its service.
Behavioral Health	A branch of interdisciplinary health which focuses on the reciprocal relationship between the holistic view of human behavior and the well-being of the body as a whole entity.
Benchmark	A process of comparing and measuring practices, processes, philosophies, policies and performance against high-performing, high-quality areas
Capital Partners in Care	Capital Partners in Care was created to improve care for high-utilizing chronically ill Medicaid recipients in the D.C. area, including those who rely on ED visits for primary healthcare. The project uses a city-wide database, care teams, and tele-health to improve communication with patients, develop care plans, and personally manage care as these patients gradually transition into receiving care through patient-centered medical homes.
Care Coordination	The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services.
Care Delivery	A system in which the patient experiences the close attention and care coordination of a primary caregiver within each discipline
Career and Technical Education (CTE)	Provides students of all ages with the academic and technical skills, knowledge and training necessary to succeed in future careers and to become lifelong learners. In total, about 12.5 million high school and college students are enrolled in CTE across the nation.
Case Management	A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes

Term	Definition or Description
Centers for Medicare and Medicaid Services (CMS)	The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality healthcare
Children's National Health System (CNHS)	Formerly DC Children's Hospital is the only exclusive provider of pediatric care in the Washington, D.C., area and the only freestanding children's hospital
Chronic Condition(s)	A human health condition or disease that is persistent or otherwise long-lasting in its effects or a disease that comes with time.
Chronically Ill	A situation where a person is unable to perform at least two activities of daily living such as eating, toileting, transferring, bathing and dressing, or requires considerable supervision to protect from crisis relating to health and safety due to severe impairment concerning mind, or having a level of disability similar to that determined by the Secretary of Health and Human Services.
Clinical Document Architecture (CDA)	Is a base standard which provides a common architecture, coding, semantic framework, and markup language for the creation of electronic clinical documents
Clinical quality measures (CQM)	Tools that help measure and track the quality of healthcare services provided by eligible professionals, eligible hospitals and critical access hospitals (CAHs) within our healthcare system. These measures use data associated with providers' ability to deliver high-quality care or relate to long term goals for quality healthcare
Community Linkage(s)	Partnerships with organizations in the surrounding community such as local hospitals to offer health-related programs and services to employees when the employer does not have the capacity or expertise to do so or provide support for healthy lifestyles to employees when not at the workplace.
Consolidated-Clinical Document Architecture (C-CDA)	Provides a methodology for all types of medical documents. It is based on the HL7 Reference Information Model (RIM), but is flexible enough to accommodate user-defined fields (typical HL7), and can store complete documents, binary data, and multimedia as well in its body. It's been approved by ANSI in 2010. CDA introduces the concept of incremental semantic interoperability, which allows tracking of relationships between elements of care.
Dashboard	A dashboard is a screen that consolidates critical performance metrics all in one place, making it easy for users to stay constantly updated on the information most important to their business
DC Department of Health (DOH)	The Mission of the Department of Health is to promote and protect the health, safety and quality of life of residents, visitors and those doing business in the District of Columbia.

Term	Definition or Description
DC Department of Health Care Finance (DHCF)	The DHCF, formerly the Medical Assistance Administration under the Department of Health, is the District of Columbia's state Medicaid agency.
DC HIE Policy Board	Established by Mayor's Order 2012-96 (Board Appointments); Mayor's Order 2012-110 (Board Appointments) on February 15, 2012. The purpose of the Board is to advise the Mayor, the Director of the DHCF, and other District agencies, regarding the implementation of secure, protected health information benefitting District stakeholders in accordance with DHCF HIE Action Plan.
DC Primary Care Association (DCPCA)	A non-profit health equity and advocacy organization dedicated to improving the health of DC's vulnerable residents by ensuring access to high quality primary healthcare, regardless of an ability to pay
Department of Employment Services (DOES)	The Department of Employment Services provides comprehensive employment services to ensure a competitive workforce, full employment, life-long learning, economic stability and the highest quality of life for all District residents.
EHR Interoperability	The ability of different information technology systems and software applications to communicate, exchange data, and use the information that has been exchanged.
Electronic Clinical Quality Measurement (eCQM)	Standardized performance measures specified in the accepted standard health quality measure format (HQMF) and uses the Quality Data Model (QDM) and value sets vetted through the National Library of Medicine's Value Set Authority Center (VSAC).
Electronic Health Record (EHR)	Information system utilized primarily to capture an individual's health data, along with the health services offered by a provider (doctor, hospital, laboratory, pharmacy, etc.).
Eligible Hospital(s)	A hospital that can claim and receive financial incentives for the acquisition and utilization of an EHR system.
Eligible Professional(s)	A health professional that can claim and receive financial incentives for the acquisition and operation of an EHR system.
Eligible Training Provider List (ETPL)	Established in compliance with the Workforce Investment Act (WIA) of 1998 and amended by the Workforce Innovation and Opportunity Act (WIOA) of 2014 to provide customer-focused employment training resources for adults and dislocated workers.
Emergency Department (ED)	Also known as an accident and emergency department (A&E), emergency room (ER) or casualty department, is a medical treatment facility specializing in emergency medicine, the acute care of patients who present without prior appointment; either by their own means or by that of an ambulance.

Term	Definition or Description
Encounter Notification Service (ENS)	Designed to provide real time notifications for care coordination and quality improvement purposes when patients are admitted, discharged, or transferred to, from or within a hospital.
Federal Financial Participation (FFP)	The percentage of the total cost of a program that the federal government commits to or is obligated by law to cover; for example, per the ARRA the federal government can cover 90% of the costs incurred by states/territories to establish and administer the Medicaid EHR Incentive Program.
Federally Qualified Health Centers (FQHCs)	Include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors
Fee-for-Service (FFS)	A payment model where services are unbundled and paid for separately. In healthcare, it gives an incentive for physicians to provide more treatments because payment is dependent on the quantity of care, rather than quality of care.
Health Disparities	Healthy People 2020 defines a health disparity as a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion
Health Equity	Healthy People 2020 describes health equity as the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.
Health Home(s)	The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 of the Social Security Act. CMS expects states health home providers to operate under a 'whole-person' philosophy. Health Home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.
Health Information Exchange (HIE)	Exchange of health information by electronic means. ARRA contains many incentives to promote HIE and, concomitantly, the meaningful use of EHRs

Term	Definition or Description
Health Information Technology (HIT)	Information technology applied to health and healthcare. It supports health information management across computerized systems and the secure exchange of health information between consumers, providers, payers, and quality monitors.
Healthy People 2020	Healthy People provides a framework for prevention for communities in the U.S. Healthy People 2020 is a comprehensive set of key disease prevention and health promotion objectives. The health objectives and targets allow communities to assess their health status and build an agenda for community health improvement.
High-risk	A higher-than-expected risk for developing a particular disease, which may be defined on a measurable parameter–e.g., an inherited genetic defect, physical attribute, lifestyle, habit, socioeconomic and/or educational feature, as well as environment
Homeless	An individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing
Homeless Management Information System (HMIS)	A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each Continuum of Care is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.
Homelessness	Homelessness is a temporary condition that people fall into when they cannot afford to pay for a place to live, or when their current home is unsafe or unstable. Other factors, such as job loss, physical and mental disability, various hardships—including personal, and drug addiction can accelerate people's slide into poverty, and for some, eventual homelessness, especially in the absence of proper social services.
HSC Health System	A nonprofit healthcare organization committed to serving people with complex healthcare needs and eliminating barriers to health services. The System combines the resources of a health plan, pediatric specialty hospital, home health agency and parent foundation to offer a comprehensive approach to caring, serving and empowering people with disabilities.
Implementation Advance Planning Document (IAPD)	One of the two types of APD that CMS requires of states/territories in order to obtain access to certain federal funds. Once CMS approves an IAPD, a state/territory can receive federal funds to implement and manage certain programs.
Long-Term Post-Acute Care (LTPAC)	A broad range of providers that include: home and community-based services; nursing homes; assisted living; long-term acute care hospitals; rehabilitation and post-acute care facilities; PACE programs; hospice;

Term	Definition or Description
	chronic disease and co-morbidity management; medication therapy management and senior pharmacists; wellness providers; and others. What distinguishes this sector is its focus on coordination of supportive services and care, restoring and maintaining health, wellness and functional abilities, and a particular, almost programmatic, focus on the particular needs and goals of each of its consumers and their families.
Long-term service and supports (LTSS)	Assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) provided to older people and other adults with disabilities that cannot perform these activities on their own due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time, typically 90 days or more.
Low-risk	A lower-than-expected risk for developing a particular disease, which may be defined on a measurable parameter–e.g., an inherited genetic defect, physical attribute, lifestyle, habit, socioeconomic and/or educational feature, as well as environment
Meaningful Use	Using certified electronic health record (EHR) technology to: Improve quality, safety, efficiency, and reduce health disparities. Engage patients and family. Improve care coordination, and population and public health. Maintain privacy and security of patient health information.
Medicaid	Public healthcare program that assists low-income families or individuals in paying for long-term medical and custodial care costs. Medicaid is a joint program, funded primarily by the federal government and run at the state level, where coverage may vary.
Medicaid Data Warehouse (MDW)	Offer better management and manipulation of healthcare claims information while meeting all Health Insurance Portability and Accountability (HIPAA), including 5010, and Health Information Technology for Economic and Clinical Health Act (HITECH) requirements.
Medicaid Managed Care Organizations (MCOs)	Managed Care is a healthcare delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services
Medicaid Management Information System (MMIS)	An integrated group of procedures and computer processing operations (subsystems) developed at the general design level to meet principal objectives. For Title XIX purposes, systems mechanization and mechanized claims processing and information retrieval systems is identified in section 1903(a)(3) of the Act and defined in regulation at 42 CFR 433.111.

Term	Definition or Description
Medical Care Advisory Committee (MCAC)	A forum for key participants and stakeholders in the Medicaid program, including consumers, advocates, providers and DC officials to review the program's operations and offer advice for improvements directly to the DHCF.
Medicare	Is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)	The act repeals the sustainable growth rate (SGR) formula for calculating updates to Medicare payment rates to physicians and establishes an alternative set of annual updates. In addition, MACRA introduces a new merit-based incentive payment system and puts in place processes for developing, evaluating, and adopting alternative payment models (APMs). The act also extends funding that was otherwise set to expire at the end of FY2015. These extensions include funding for the state Children's Health Insurance Program (CHIP) and for the Community Health Centers Fund (CHCF) for two additional years, through FY2017.
Medicare and Medicaid EHR Incentive Program	Beginning in 2011, the Electronic Health Records (EHR) Incentive Programs were developed to encourage eligible professionals and eligible hospitals to adopt, implement, upgrade (AIU), and demonstrate meaningful use of certified EHR technology
Memoranda of Understanding (MOU)	A formal agreement between two or more parties. Companies and organizations can use MOUs to establish official partnerships. MOUs are not legally binding but they carry a degree of seriousness and mutual respect, stronger than a gentlemen's agreement
National Committee for Quality Assurance (NCQA)	A private, 501(c)(3) not-for-profit organization dedicated to improving healthcare quality.
National Quality Forum (NQF)	A nonprofit organization based in Washington, D.C. that is dedicated to improving the quality of healthcare in the United States. To that end, the NQF embodies a three part mission to set goals for performance improvement, to endorse standards for measuring and reporting on performance and to promote educational and outreach programs.
No Wrong Door (NWD)	A collaborative effort of the U.S. Administration for Community Living (ACL), the Centers for Medicare & Medicaid Services (CMS), and the Veterans Health Administration (VHA), to support state efforts to streamline access to LTSS options for all populations and all payers. The state Medicaid agency is a critical partner and player within the NWD System conducting activities such as outreach, referral, assessment, functional and financial eligibility and even final determination which are all activities that are part of a state's NWD System.

Term	Definition or Description
Ombudsman	An official appointed to investigate individuals' complaints against maladministration, especially that of public authorities
Patient Centered Medical Home (PCMH)	Provides healthcare that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.
Patient Outcome(s)	Outcomes from medical care that are important to patients.
Pay-for-performance (P4P)	Refers to healthcare payment systems that offer providers financial incentives for realizing, improving on, or surpassing their performance targets for certain quality and cost measures. Payments are based on measures divided into three buckets: structure, process, and outcome measures.
Payment Reform	Refers to a range of healthcare payment models/methods that use payment to promote or leverage greater value for patients, purchasers, payers, and providers. Plan members. Health plan's enrollees or plan participants.
Payment System	A system used to settle financial transactions through the transfer of monetary value, and includes the institutions, instruments, people, rules, procedures, standards, and technologies that make such an exchange possible.
Per Member, Per Month (PMPM)	Refers to a fixed, capitated monthly payment made to providers to cover the total cost of care for a given patient. In Health Home 2, PMPM rates are triggered for high acuity patients when providers document in iCAMS at least two comprehensive care management (CCM) services and at least two other Health Home 2 encounters, with at least one being face-to-face and no duration requirement (low acuity individuals require one CCM service and one other Health Home service with no face-to-face requirement to trigger a PMPM payment
Permanent Supportive Housing (PSH)	Provides permanent housing and supportive services to chronically homeless individuals and families with histories of homelessness to ensure housing stabilization, maximum levels of self-sufficiency and an overall better quality of life.
Person Centered Planning	A set of approaches designed to assist someone to plan their life and supports. [1] It is used most often as a life planning model to enable individuals with disabilities or otherwise requiring support to increase their personal self-determination and improve their own independence.

Term	Definition or Description
Personal Health Information (PHI)	Also referred to as protected health information, generally refers to demographic information, medical history, test and laboratory results, insurance information and other data that a healthcare professional collects to identify an individual and determine appropriate care.
Pillar(s)	A person or thing regarded as reliably providing essential support. In the District's SHIP the three Pillars provide the main components and structure for reform efforts.
Point of Access	A station that transmits and receives data. An access point connects users to other users within the network and also can serve as the point of interconnection between the WLAN and a fixed wire network.
Post-Acute Care	Rehabilitation or palliative services that beneficiaries receive after, or in some cases instead of, a stay in an acute care hospital. Depending on the intensity of care the patient requires, treatment may include a stay in a facility, ongoing outpatient therapy, or care provided at home.
Postsecondary and Career Education (PCE)	Supports programs that improve the overall postsecondary enrollment, graduation, certificate completion, and employment rates for youth and adults in the District of Columbia. Through financial and programmatic support, PCE creates opportunities for District of Columbia youth and adults to attend postsecondary institutions and earn certifications and/or college degrees. PCE also assists residents in obtaining adult literacy proficiency, acquiring a GED, or another similar credential.
Primary Care	Healthcare at a basic rather than specialized level for people making an initial approach to a doctor or nurse for treatment.
Primary Care Provider (PCP)	A healthcare practitioner who sees people that have common medical problems.
Provider(s)	A doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner. A healthcare provider also is any provider from whom the University or the employee's group health plan will accept medical certification to substantiate a claim for benefits.
Quality Improvement	A formal approach to the analysis of performance and systematic efforts to improve it.
Quality Measurement	A structure or process of care that has a demonstrated relationship to positive health outcomes and are under the control of the healthcare system
Referral(s)	A written order from the primary care provider for the patient to see a specialist or receive certain medical services

Term	Definition or Description
Residential Empowerment Adolescent Community Home (REACH)	A community-based residential facility for committed and detained youth ages 13 to18 who are in the custody of and referred by the DC Department of Youth Rehabilitation Services. REACH provides youth involved in the juvenile justice system with a highly structured, service-enriched, homelike environment as an alternative to institutionalization.
Silo Data	A separate database or set of data files that are not part of an organization's enterprise-wide data administration.
Skilled Nursing	Care given or supervised by registered nurses. Nurses provide direct care; manage, observe, and evaluate a patient's care; and teach the patient and his or her family caregiver.
Social Determinants of Health	The structural determinants and conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to healthcare
Social Services	Government services provided for the benefit of the community, such as education, medical care, and housing.
Stakeholder	A person who has an interest in or investment in something and who is impacted by and cares about the outcome
State Innovation Model (SIM)	A proposal that describes a state's strategy to use all of the levers available to it to transform its healthcare delivery system through multi-payer payment reform and other state-led initiatives. Round One Model Design Awards.
State Plan Amendments (SPAs)	An agreement between a state and the Federal government describing how that state administers its Medicaid and CHIP programs. It gives an assurance that a state will abide by Federal rules and may claim Federal matching funds for its program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state.
Section 1115 Demonstrations (or waivers)	Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as: ▪ Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible ▪ Providing services not typically covered by Medicaid

Term	Definition or Description
	▪ Using innovative service delivery systems that improve care, increase efficiency, and reduce costs
Uniform Data System (UDS)	The Uniform Data System (UDS) is a standardized reporting system that provides consistent information about health centers
Value Based Care Delivery	A framework for restructuring healthcare systems around the globe with the overarching goal of value for patients—not access, cost containment, convenience, or customer service.
Value-Based Purchasing	Centers for Medicare & Medicaid Services (CMS) initiative that rewards acute-care hospitals with incentive payments for the quality of care they provide to Medicare beneficiaries.
Veteran's Health Administration (VHA)	A component of the United States Department of Veterans Affairs (VA) led by the Under Secretary of Veterans Affairs for Health[3] that implements the medical assistance program of the VA through the administration and operation of numerous VA Medical Centers (VAMC), Outpatient Clinics (OPC), Community Based Outpatient Clinics (CBOC), and VA Community Living Centers (VA Nursing Home) Programs.
Workforce Investment Council (WIC)	The WIC serves as both the state and local area workforce investment board under the Workforce Investment Act and is responsible for advising the Mayor, Council, and the District government on the development, implementation, and continuous improvement of an integrated and effective workforce investment system.

[i] Preceding and during DC's SIM Design grant activities, stakeholder were collaborating around steps to improve health in the District as part of the development of DC Healthy People 2020.

[ii] Triple Aim. Retrieved from:

http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx

[iii] Healthy People 2020 Retrieved from: (http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/FINAL%20DC%20HP2020%20Framework%20Report%205-23-16.pdf

iv District of Columbia Interagency Council on Homelessness. (2015). Homeward DC- District of Columbia Interagency Council on Homelessness strategic plan 2015-2020.Retrieved from http://ich.dc.gov/sites/default/files/dc/sites/ich/page_content/attachments/ICH-StratPlan2.7-Web.pdf

v Corporation for Supportive Housing. (2009). Summary of Studies: Medicaid/Health services utilization and costs. Retrieved from http://pschousing.org/files/SH_cost-effectiveness_table.pdf

[vi]Center for Housing Policy. (2015, April). The Impacts of Affordable housing on Health: A Research Summary. Retrieved from http://www2.nhc.org/HSGandHealthLitRev_2015_final.pdf.

[vii] Moses, K. and Davis, R. (2015, July 22). Housing is a Prescription for Better Health. Retrieved from http://healthaffairs.org/blog/2015/07/22/housing-is-a-prescription-for-better-health/.

[viii] Robert Wood Johnson Foundation. (2011, May) Housing and Health. Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70451.

ix Centers for Medicare & Medicaid Services. (2016, February 16). Core measures. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html

x The Kaiser Family Foundation State Health Facts. Data Source: Kaiser Family Foundation estimates based on the Census Bureau's March 2015 Current Population Survey (CPS: Annual Social and Economic Supplements).Retrieved from http://kff.org/other/state-indicator/total-population/.

xi Centers for Disease Control and Prevention. (2015, September 10). CDC health disparities and inequality report. Retrieved from http://www.cdc.gov/minorityhealth/CHDIReport.html#Intro

xii Medicaid Management Information System (2015, August).

xiii Centers for Disease Control and Prevention. (2010, October). Establishing a holistic framework to reduce inequities in HIV, viral hepatitis, STDs, and tuberculosis in the United States. Retrieved from http://www.cdc.gov/socialdeterminants/docs/SDH-White-Paper-2010.pdf

xiv McCarthy, D., Radley, D.C., & Hayes, S.L. (2015, December). Aiming higher: results from a scorecard on state health system performance. Retrieved from http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/2015_scorecard_v5.pdf

xv Centers for Medicare & Medicaid Services. (2015, December 29). FQHC advanced primary care practice demonstration. Retrieved from https://innovation.cms.gov/initiatives/FQHCs/

xvi Patient-Centered Primary Care Collaborative. (2015, July). CareFirst patient-centered medical home – DC. Retrieved from https://www.pcpcc.org/initiative/carefirst-patient-centered-medical-home-dc

xvii Children's National Health System. (2014, July 24). Children's National and hospital partners receive Healthcare Innovation Award Grant. Retrieved from http://childrensnational.org/news-and-events/childrens-newsroom/2014/childrens-national-and-hospital-partners-receive-health-care-innovation-award-grant

xviii Centers for Disease Control and Prevention. (2015, September 1). REACH 2014 Awardees. Retrieved from http://www.cdc.gov/nccdphp/dch/programs/reach/current_programs/reach.html

xix George Washington University. (2014, September 5). Researchers at George Washington University receive $23.8 million grant to test an innovative model to improve HIV prevention and care. Retrieved from http://publichealth.gwu.edu/content/researchers-receive-23-million-hiv-prevention

xx Centers for Medicare & Medicaid Services. (2016, June 1). Healthcare Innovation Awards: District of Columbia. Retrieved from https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/District-of-Columbia.html

xxi SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). Integrated care models. Retrieved from http://www.integration.samhsa.gov/integrated-care-models/list

xxii Agency for Healthcare Research and Quality. (2014, June). Chapter 2: What is care coordination? Retrieved from http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html

xxiii SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). (2013, July). Financing and policy considerations for Medicaid Health Homes for individuals with behavioral health conditions. Retrieved from http://www.integration.samhsa.gov/integrated-care-models/Health_Homes_Financing_and_Policy_Considerations.pdf

xxiv U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. (2014, July). A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/77121/PSHprimer.pdf.

xxv Centers for Medicare & Medicaid Services. (2016). Quality Payment Program: Delivery system reform, Medicare payment reform, & MACRA. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

xxvi Department of Health Care Finance. (2016). Health Homes for persons with severe mental illness. Retrieved from http://dhcf.dc.gov/page/health-homes-persons-severe-mental-illness

xxvii Patient-Centered Primary Care Collaborative. (2015, August). CareFirst patient-centered medical home – Maryland. Retrieved from https://www.pcpcc.org/initiative/carefirst-patient-centered-medical-home-dc https://www.pcpcc.org/initiative/carefirst-patient-centered-medical-home-maryland

xxviii Casart, A.J. (2016, February 4). Letter to Joseph Moser. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-appr-emerg-copay-protocol.pdf

xxix District of Columbia, Department of Health. (2015, June). Annual Health Report: Behavioral Risk Factor Surveillance System. Retrieved from http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2013%20Final%20BRFSS%20Annual%20Report%207%2029%2015.pdf.

xxx World Health Organization. (2016). Social determinants of health. Retrieved from http://www.who.int/social_determinants/en/

xxxi Miriam's Kitchen. (2016). Housing services. Retrieved from https://miriamskitchen.org/programs/housing-services/

xxxii American Psychological Association. (2016). Healthcare reform: integrated healthcare. Retrieved from http://www.apa.org/about/gr/issues/health-care/integrated.aspx

xxxiii Robert Wood Johnson Foundation. (2010, November 22). Interdisciplinary collaboration improves safety, quality of care, experts say. Retrieved from http://www.rwjf.org/en/library/articles-and-news/2010/11/interdisciplinary-collaboration-improves-safety-quality-of-care-.html

xxxiv U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). National action plan to improve health literacy. Retrieved from http://health.gov/communication/hlactionplan/pdf/Health_Literacy_Action_Plan.pdf

xxxv Patel, V., Barker, W., Siminerio, E. (2016, February). Disparities in individuals' access and use of health information technology in 2014. Retrieved from http://dashboard.healthit.gov/evaluations/data-briefs/disparities-individuals-access-use-health-information-technology.php

xxxvi Office of the National Coordinator for Health Information Technology. (2016, February). Office-based physician health IT adoption, Health IT Dashboard. Retrieved from http://dashboard.healthit.gov/dashboards/physician-health-it-adoption.php

xxxvii Office of the National Coordinator for Health Information Technology. (2016, February). Office-based physician health IT adoption, Health IT Dashboard. Retrieved from http://dashboard.healthit.gov/dashboards/physician-health-it-adoption.php

xxxviii Office of the National Coordinator for Health Information Technology. (2016, February). Office-based physician health IT adoption, Health IT Dashboard. Retrieved from http://dashboard.healthit.gov/dashboards/physician-health-it-adoption.php

xxxix Office of the National Coordinator for Health Information Technology. (2016, March). Office-based physicians that have demonstrated Meaningful Use through the Medicare EHR Incentive Program, Health IT Dashboard. Retrieved from dashboard.healthit.gov/dashboards/physicians-medicare-meaningful-use.php

xl SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). (2014, September). The current state of sharing behavioral health information in health information exchanges. Retrieved from http://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf

xli SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). (2014, September). The current state of sharing behavioral health information in health information exchanges. Retrieved from http://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf

xlii SAMHSA-HRSA Center for Integrated Health Solutions (CIHS). (2014, September). The current state of sharing behavioral health information in health information exchanges. Retrieved from http://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf

xliii Office of the National Coordinator for Health Information Technology. (2013, April 5). Implementing Consolidated-Clinical Document Architecture (C-CDA) for Meaningful Use stage 2. Retrieved from https://www.healthit.gov/sites/default/files/c-cda_and_meaningfulusecertification.pdf

xliv Patient-Centered Primary Care Collaborative. (2015, July). CareFirst patient-centered medical home – DC. Retrieved from https://www.pcpcc.org/initiative/carefirst-patient-centered-medical-home-dc

xlv Centers for Medicare & Medicaid Services. (2016, February 16). Core measures. Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html