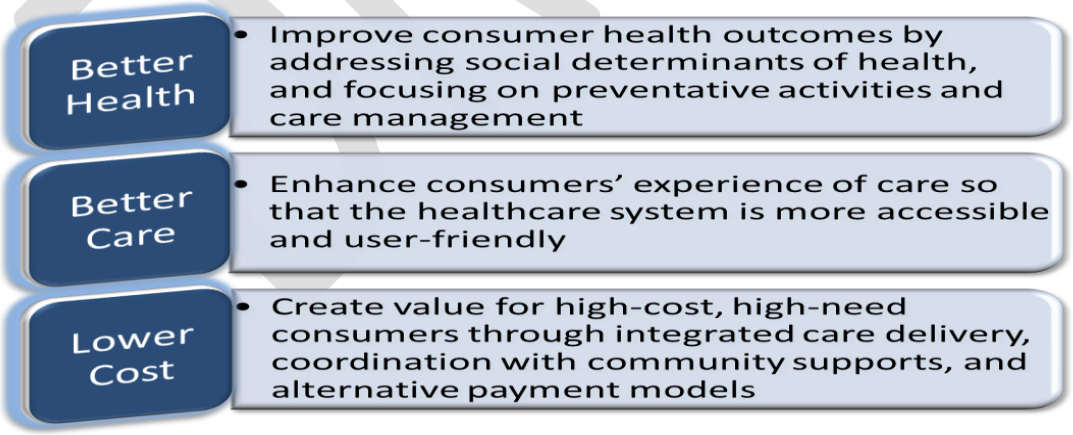
EXECUTIVE SUMMARY

The District of Columbia State Health Model Design grant from the Centers for Medicare and Medicaid Services sparked a bold commitment to **transform the District's current healthcare landscape into a more value-based care delivery and payment system**. This State Health Innovation Plan (SHIP) is the final deliverable of the year-long Model design work, which consisted of broad based stakeholder input on how to resolve the District's paradigm: expansive health insurance coverage, with limited achievement in key indicators of population health. Our work over the past year was oriented to accomplishing the Triple Aim[1] and the District's priority to remove barriers to socio-economic betterment. Poor health absolutely obstructs the pathway to the middleclass for many District residents—most of which reside in marginalized sections of our community (Wards 7 and 8) where there is an over-burden of chronic disease and poor social determinants of health. Current infrastructure, policies, and payment approaches within the District's landscape were explored to reach consensus on a transformation roadmap that is feasible, effective, and a sustainable approach to reducing the District's health disparities.

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 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.

Figure 1. District of Columbia's Transformation Goals Align with the Triple



[1]The 'Triple Aim' was developed by the Institute for Healthcare Improvement, and is a framework used by CMS to optimize health system performance. More information is available at http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

Within this framework, the District ambitiously intends to renovate its health care system to achieve five objectives in five years:

1. **Develop a continuous learning health system that supports more timely, efficient, and higher-value healthcare throughout the care continuum.**
2. **Better align overall health spending and re-invest savings towards prevention, housing and other social determinants of health.**
3. **Reduce inappropriate utilization of inpatient and emergency department service usage by 10 percent, or meet DC Health People 2020 benchmark goal.**
4. **Reduce preventable readmission rates by 10%, or meet DC Healthy People 2020 benchmark goal.**
5. **Significantly improve performance on selected health and wellness quality measures and reduce disparities.**

This SHIP describes the initiatives that will be implemented under three “Pillars” (Care Delivery Reform; Payment Reform; Community Linkages) that are essential in crafting and executing our vision for transformation, and the “Enablers” (State Holder Engagement; Health Information Technology, Workforce; Quality Improvement) that are critical to the viability of these Pillars. Short- and long-term efforts include building off of on-going efforts which include:

- integrating health services for Medicaid beneficiaries with severe mental illness through a Health Home model;
- tracking hospital acquired conditions among District hospitals and syncing Medicaid payment to actual costs of care;
- supporting care coordination at the community level through PPS rates that reflect the enabling services provided by our Federally Qualified Health Centers (FQHC);
- shared savings programs within commercial health insurers; and
- mini health information exchange groups that cluster data sharing within circles of providers.

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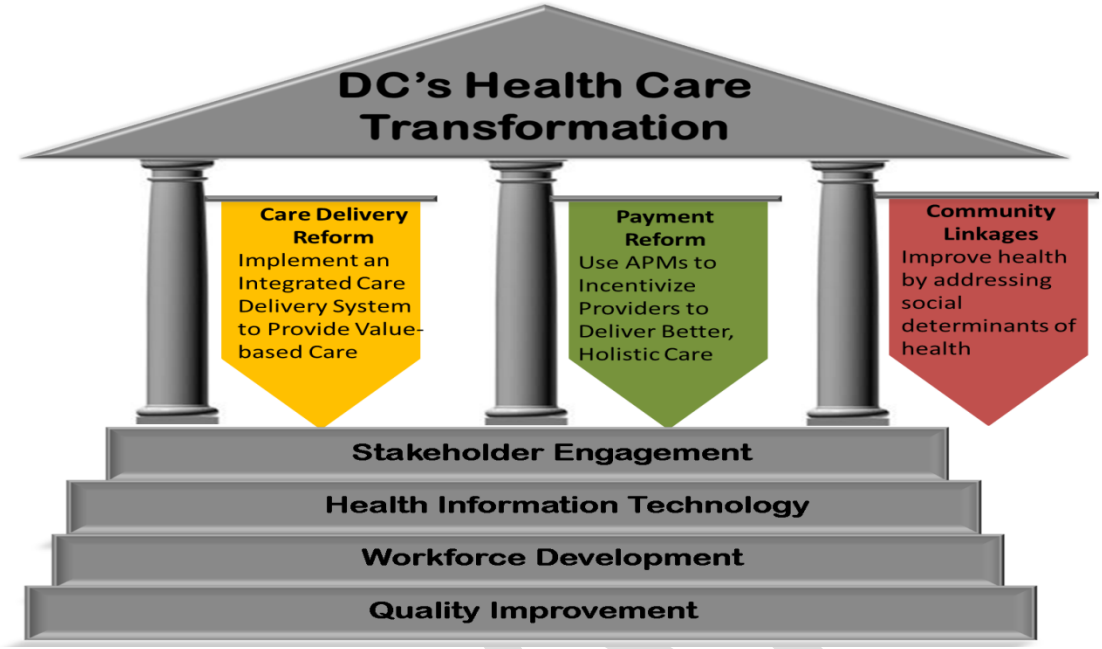
Figure 2. District of Columbia's Health Care Pillars and Enablers



We understand that the Pillars of our transformation plan are intedependent, and only successful through the deliberate use of our Enablers—each of which is bulleted below:

- **PILARS**
  - I. **CARE DELIVERY**: Implement an integrated care delivery system to provide value-based care
  - II. **PAYMENT REFORM**: Establish payment model innovations & realign incentives to pay for value-based care
  - III. **COMMUNITY LINKAGES**: Improve population health through the systematic integration of health and social needs
- **ENABLERS**
  - A. **STAKEHOLDER ENGAGEMENT**: Solicit and incorporate stakeholder input throughout the design and implmentation of health care transformation initiatives
  - B. **HEALTH INFORMATION EXCHANGE**: Develop overarching health information technology and exchange capabilities
  - C. **WORKFORCE DEVELOPMENT**: Support provider capacity deliver integrated care within alternative payment models

D. **QUALITY IMPROVEMENT**: Align reporting requirments across programs and track provider performance in improving health outcomes

We also know that while the Enablers catalyze our Pillars, they require dedicated focus and resources for their particular intracacies. Thus, throughout this document the descriptions of the Enablers are weaved throughout, in addition to set sections dedicated to each one.

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 and where attention throughout the Model Design year should focus. With more than forty-percent of District residents enrolled in either the state Medicaid program or our locally-funded insurance program [see Figure 3], called Alliance, many of the findings from our analysis were directly related to our Medicaid beneficiaries. Four key themes emerged as a result of the scan:

1. **Considerable healthcare disparities exist between racial and ethnic groups, geographic areas, and social-economic statuses in the District.** In particular, residents of Wards 7 and 8 disproportionately experience disparities with higher rates of chronic disease, lower incomes, and poorer health outcomes than the general population.
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 emergency department 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 statuses, disproportionately consisting of racial and ethnic minorities.
4. **A majority of Medicaid expenditures are attributed to a small percentage of Medicaid beneficiaries with exceedingly high costs in the fee-for-services population.** High spending is driven by in inefficient service utilization, poor maintenance of healthcare, and lack of coordination between sites of care among the District's residents.

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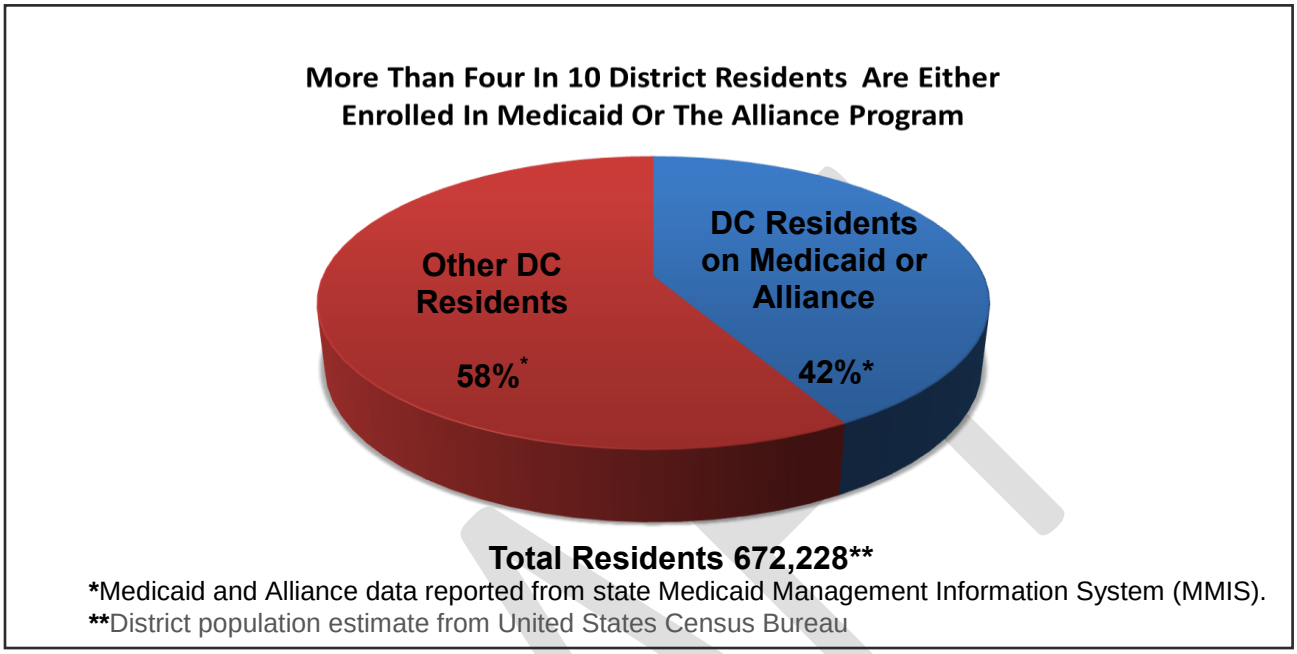
Figure 3. Percentage of Medicaid and Alliance Enrollment Amongst District Residents



***Medicaid and Alliance data reported from state Medicaid Management Information System (MMIS).
****District population estimate from United States Census Bureau

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 prevalent disparities noted above.

Developing OUR plan: Multiple communication methods used to collect stakeholder input

Over five hundred unique individuals were involved in the District's SIM Model Design planning efforts. We deployed a robust stakeholder engagement strategy throughout the year that included workgroups, health care consumer interviews, emailed weekly newsletters, a dedicated SIM webpage and social media. Input received from stakeholders drove the direction of our SIM efforts, and are incorporated into this document.

Our engagement activities were primarily organized around a SIM Advisory Committee and topic-specific SIM Workgroups. The Advisory Committee consisted of 'decision makers' in DC that have the authority and resources to implement the transformative initiatives envisioned---including those from local government agencies, the Mayor's office and Council, commercial and public health insurers, providers, and beneficiary advocates. From October 2015 to June 2016, the Advisory Committee met quarterly and provided guidance to the SIM Model Design

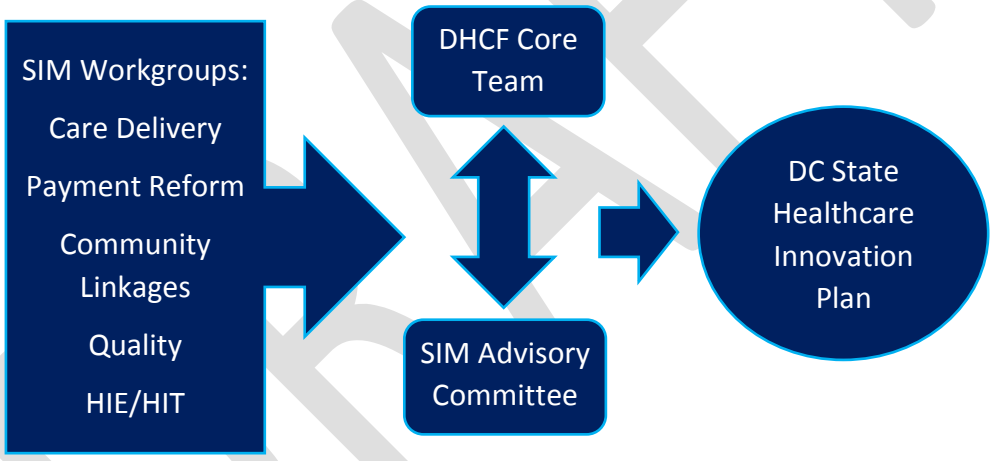
Core Team within the District's Department of Health Care Finance (DHCF), its partnering District government agencies, and the SIM Workgroups related to the planning and development our health care reform initiatives.

There were five SIM Workgroups, each dedicated to a specific topic, including:

- Care delivery
- Payment reform
- Community linkages
- Quality measurement
- Health information technology and exchange

Each SIM Workgroup was chaired by an Advisory Committee member and consisted of a wide range of payers, providers and consumers. The work dynamic and information flow between the workgroups, SIM Advisory Committee, and DHCF Core Team is depicted in Figure X.

Figure 4. Workgroup Recommendation Flowchart



In addition to the workgroups, the District talked with consumers to obtain feedback on their experience with our current healthcare system. We conducted over 100 in-person interviews at FQHCs, hospital emergency departments 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, emergency department utilization, access to social services, and overall satisfaction with the District's healthcare system. Upon analysis of the interview data several themes emerged:

- *Of individuals that went to the emergency department within the last year more than two times, 50 percent of them had a chronic health condition.* Respondents reported that disease management classes, pain management, medication management, and healthy living services would help them control their chronic condition and live independently.

- The majority of respondents receive the medication they needed but have trouble obtaining vision and dental care and understanding Medicaid coverage and denials.

- Over 75 percent of respondents used the emergency department in the past year. Most went to the emergency because of an emergency, but the second most common reason was because they could not see their primary care provider due to unavailability.

- Many respondents struggled to obtain essential social services they need. Housing and food security were identified as the greatest needs, but hardest to attain. Utilities, transportation and childcare were also reported as significant needs.

Many of the themes observed in the consumer interview data were also evident in the consumer focus group data. One consumer focus group was held with five DC Medicaid beneficiaries. Participants were selected from a list of high utilizers of the healthcare system or individuals recommended by the DC Office of the Ombudsman. Key focus group themes were:

- Several participants were confused by the benefits offered under Medicaid and were concerned about the availability of preventative medicine.

- Building a good relationship with their primary care provider and its office staff is important. This rapport greatly influences participants' choice to visit community-based providers before going to the emergency department.

- Participants want mental health services, but refusing to utilize these services because of the stigma associated with mental illness.

- The District's Ombudsman Office is effective in resolving healthcare access issues.

We used an interactive webpage that allowed individuals to provide comments related to the SIM Design process, planned health reform initiatives, and to sign up for Workgroups, and share. We also used social media, such as Twitter, to increase the public's awareness of our SIM activities.

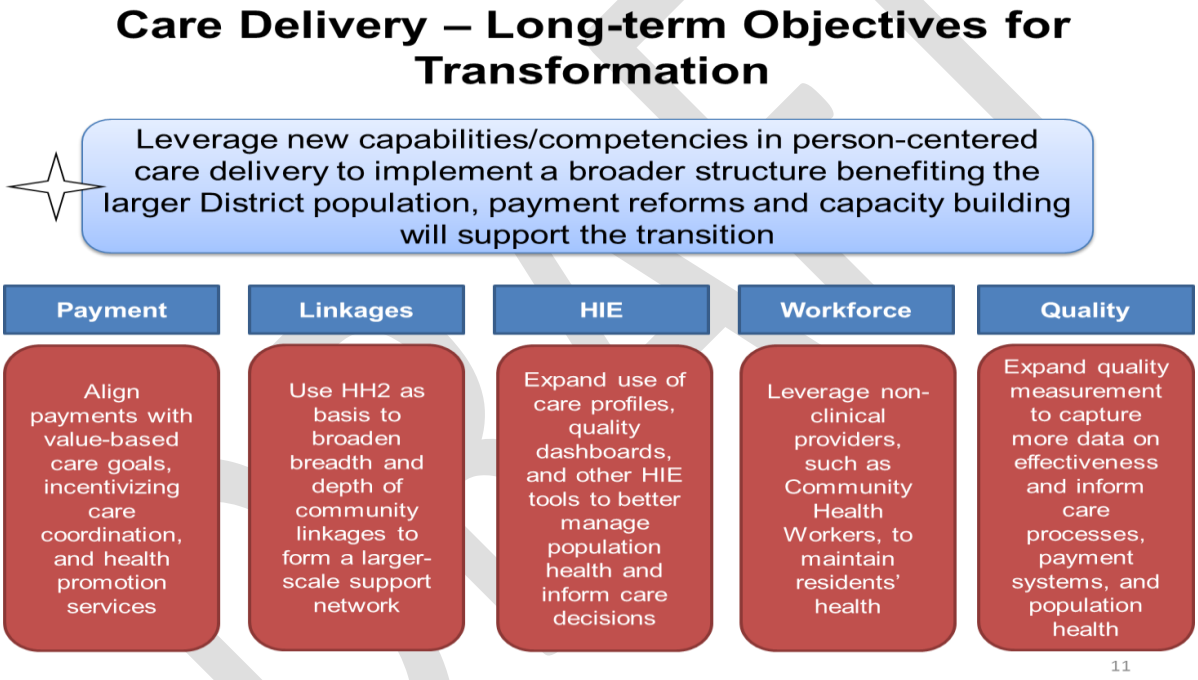
PILLAR I – IMPLEMENT AN INTEGRATED CARE DELIVERY SYSTEM TO PROVIDE VALUE-BASED CARE

Over-utilization and inappropriate utilization of hospital and emergency department services is prominent in the District, particularly for the treatment and/or management of chronic conditions. A main contributing factor to the inappropriate utilization of care 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 requisite capabilities for meaningful, patient-centered coordination.

We used lessons-learned from ongoing District initiatives and input from stakeholders to develop one of the first tangible products of the SIM planning process (Health Homes Two, described below), and to frame our long-term goal of spur providers' transition from fee-for-service (FFS) care delivery to integrated care delivery systems using an alternative payment model [see Figure 5].

Figure 5. Long-term Care Delivery Transformation Leverages Payment Models, Community Linkages and Enabling Activities



The short-term objective for transforming our care delivery system focuses on implementing a Medicaid Health Home benefit for high-need individuals with physical chronic health conditions that integrates an individuals' full array of medical, mental, and behavioral needs, and key social determinants of health. This model will create value for individuals beyond clinical care, by incorporating elements of value-based payment and strength-based, person-centered care care delivery. The long-term objective is to build off of the infrastructure and competencies advanced through the Health Homes model to accomplish systematic transition to more integrated and accountable care.

PILLAR II – ESTABLISH PAYMENT MODEL INNOVATIONS & REALIGNED INCENTIVES TO PAY FOR VALUE-BASED CARE

Alternative payment models are an integral part of a transformed care delivery system. They include incentive structures that enable providers to effectively and efficiently finance "whole person" care. In order to transition the District's health care 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: Care delivery and payment reform efforts must be complementary to successfully meet our goals of eliminating disparities and reducing inappropriate service utilization. Financial incentives must support these health system goals and facilitate a system of shared accountability. Additionally, efforts must leverage existing strategies and/or resources where possible.
2. Payment Transformation Should Be Incremental, Yet Purposeful: Healthcare transformation cannot happen overnight and will require support from all stakeholders to ultimately succeed. All potential reform options should remain on the table until they can be discussed in more detail. The District, however, should be bold, thoughtful, and strategic in its proposals.

Additionally, stakeholders agreed that payment models should be established in the District that tie provider reimbursement to patients' health outcomes, while enabling and incentivizing new care delivery approaches. These care delivery approaches include, but are not limited to:

- Paying for non-clinical services such as care management and coordination activities
- Addressing social determinants of health through community linkages
- Enhancing patient access via online tools and using HIE 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

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Based on the guiding principles recommended by providers, payers and other stakeholders, this SHIP will describe initiatives that promote three conditions:

1. Flexible Payment/Incentive Models – We plan to empower providers to use a wider range of tools to achieve high-quality outcomes, to increase their buy-in for care delivery and payment transformation.
2. Capacity Building Support – We will identify opportunities to support providers through quality improvement, technical assistance and education efforts to help all parties achieve their transformation goals.
3. Increased Provider Accountability – Over the next five years, we will gradually progress towards provider-level financial risk-sharing models--- permitting providers to take full responsibility for their patients. High-performing providers will share in the savings that result from high-quality care, while encouraging low-performing providers to alter their care delivery methods in ways that better address the needs of their patients.

Figure 6 below details the District's payment structure and implementation timeline to begin the transformation towards paying for value.

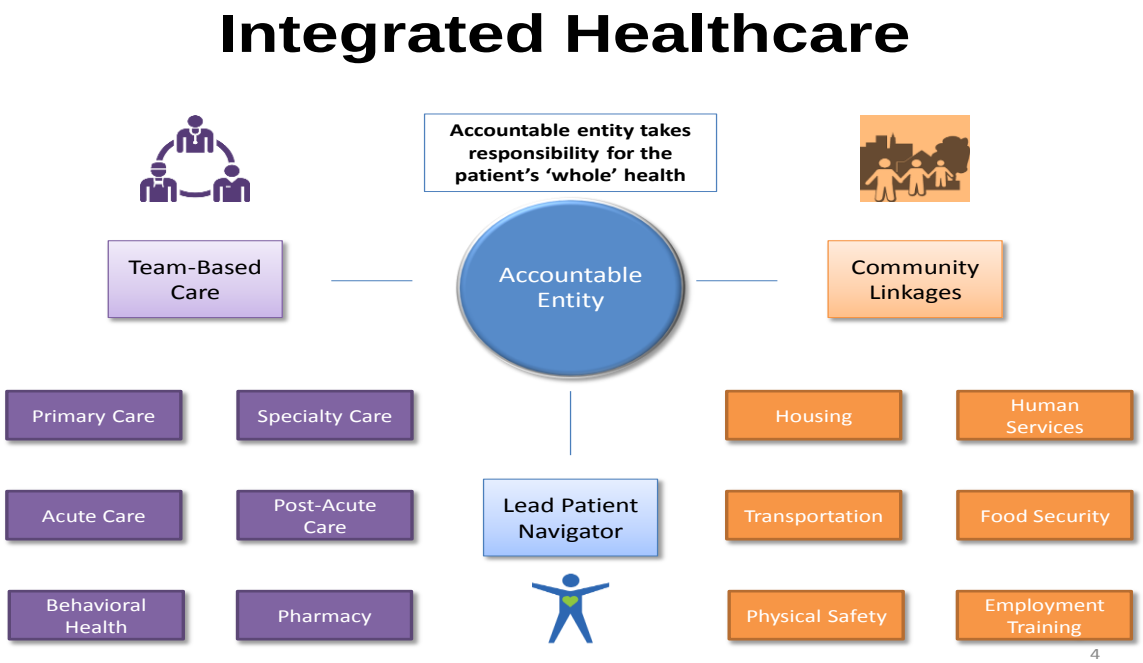
Figure 6. Five Year Plan to Move Toward Alternative District Payment Methods

	2017	2018	2019	2020	2021
Key Activities	• Baseline year	Year 1 of P4P payments	Menu of Payment Options (P4P, APMs)		
Base Payment	Enhanced FFS		• Enhanced FFS; or • APM (e.g. Shared Savings; Full-Risk)		
Supplemental Payment(s)	• Care Coordination Payments (HH1, HH2, EPD, DD, MCO) • P4P (e.g. bonuses and/or penalties related to readmission rates, preventable IP/ED use, hospital acquired conditions) • Other (e.g. partnership with Hospital ACO)				
Capacity Building	• Health Information Exchange (e.g. IAPD tools) • Health Home 1 and 2 (e.g. flexible PMPM dollars) • Accountable Health Communities (e.g. screening/referral resource) • Lump Sum Payment for APM/Capacity Building (see Medicare)				
Outcomes	Set baseline for LANE, Re-admissions, and IP measures	Set reduction targets (%)	• Reset baseline • Add measures based on data/priorities	Reset baseline	Reset baseline
Non-Traditional FFS Payments	• 0% APM • 30% tied to value	• 20% APM • 50% tied to value	• 30% APM • 70% tied to value	• 50% APM • 90% tied to value	

PILLAR III – IMPROVE POPULATION HEALTH THROUGH INTEGRATION OF COMMUNITY LINKAGES AND CARE REDESIGN

We envision an integrated health care delivery system where both health and social needs are incorporated (see Figure 7). However, a huge separation between the health service and social service arenas exists in the District. For the majority of residents, their health needs are delivered by doctors and nurses, are paid by public (i.e. Medicaid; Medicare) or private health insurers, and for the most part are regulated by two District government agencies (Department of Health Care Finance [Medicaid] and Department of Health). Within the social service realm, services are delivered by social workers and housing specialists, where payment is primarily locally-funded or from federal agencies (Substance Abuse and Mental Health Services Administration; US Housing and Urban Development), and regulated primarily by another District government agency (Department of Human Services). With the exception of one or two government agencies (e.g. Department of Behavioral Health) and categories of providers (e.g. community health worker) that operate in both arenas, systematic integration of a person's 'whole' needs is absent from our service delivery, payment or oversight perspectives.

Figure 7. District's Vision for an Integrated Health Care Landscape



Realizing this dilemma, support for establishing systems that link health and social services exists throughout the District. Our current Mayoral administration aims to end chronic homelessness among individuals and families by the end of 2017, and to ensure that by 2020, homelessness in the District will be a rare, brief, and non-recurring experience. The costs of

homelessness are far-reaching, with the substantial portion being attributed to health care expenses[2]. Living without permanent housing can be a health risk as evidenced in this population's frequent use of emergency rooms, medical and psychiatric inpatient hospital care, and nursing homes[3]. DC's Medicaid program is absorbing most of these costs, as nearly all District residents experiencing homelessness are now eligible for Medicaid enrollment. In our recent examination of chronically homeless DC Medicaid beneficiaries, we found that 42 percent sought care in the emergency room for non-immediate and non-emergent conditions. The reason for seeking emergency room services is most likely linked to social, instead of medical, needs.

In recent years, the District has implemented initiatives focused on integrating health and social services---

- **No Wrong Door:** Addresses access to long term services and supports (LTSS)
- **DC CrossConnect:** Provides unified case planning for families served by the District's Child and Family Services Agency, coordinating among multiple District agencies
- **Medicaid Health Homes program:** Commonly called Health Homes One, it uses care teams to integrate and improve care for beneficiaries with severe mental illness.

In addition to the existing **Permanent Supportive Housing (PSH)** program which provides housing assistance and case management for individuals and families experiencing chronic homelessness, these programs support a person-centered approach to service delivery by linking the health and social needs of individuals.

Despite the presence of such initiatives, significant gaps in linking individuals to relevant supports remain, including the lack of a data sharing and formal referral process between clinical and community providers. The SIM Advisory Board 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. These initiatives include:

1. Health Homes Model program – Commonly called Health Home Two, this initiative will be based in the primary care setting, and build off of National Committee for Quality Assurance's Patient-center Medicaid Home certification many of our primary providers either have or are working towards. Focused on beneficiaries with physical chronic conditions, and those with historical chronic homelessness, within Health Home Two,

[2] Homeward DC-District of Columbia Interagency Council on Homelessness Strategic Plan 2015-2020. Available at http://ich.dc.gov/sites/default/files/dc/sites/ich/page_content/attachments/ICH-StratPlan2.7-Web.pdf

[3] Corporation for Supportive Housing. Summary of Studies: Medicaid/Health Services Utilization and Costs. Available at http://pschousing.org/files/SH_cost-effectiveness_table.pdf

participating primary care providers will be accountable for coordinating their patients' full array of health and service needs.

2. Accountable Health Communities (ACH) – ACH 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.
3. Dynamic Patient Care Profile – The Patient Care Profile is a dashboard that draws on a variety of clinical and social services data systems to populate and share critical information beyond the health needs of the patient.
4. Improved Referral Process – An improved referral process would create a systematic referral process between clinical and community services.
5. Universal Needs Assessments – Creating universal needs assessments develops a common terminology and method of assessing individual and community health and health-related social needs.

ENABLER A – CONTINUOUS STAKEHOLDER ENGAGEMENT TO INFORM INNOVATIVE HEALTHCARE TRANSFORMATION INITIATIVES

The District has a history of actively engaging stakeholders in its health system reform initiatives; including outreach conducted during the creation of the 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 groups 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 the health care to a value-based system. Tangible tasks include:

1. Leveraging established boards and work groups: 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 (i.e., 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.
2. Renovating the DHCF Website: We intend the support ongoing discussions around the District's payment and delivery system reform initiative. To support this aim, DHCF's webpage will be redesigned to, among other things, serves as a clearinghouse for relevant emerging issues on payment reform and delivery system transformation. This website will use simple, clear and carefully translated materials for the general public's consumption. The webpage will also outline the goals, vision and progress of the District's SIM objectives.

3. Continuing to distribute the SIM Innovation Newsletter: We received positive feedback from stakeholders on our weekly SIM Innovation Newsletter, and intend to maintain its circulation. This newsletter provide information on emerging issues, funding opportunities, progress reports on implemented initiatives, and upcoming meetings related to payment and delivery system reform.

Insights from the consumer interviews and focus groups conducted throughout our SIM Model year support findings in the literature about the importance of consumer engagement in implementing programs that actually lead to improved health outcomes. We believe that consumers should be able to participate in health care reform discussions, and have the ability to provide timely and relevant feedback. In order to support consumers' participation in the District's transformation efforts—in a meaningful way, we will ensure that the initiatives bulleted above support the following principles.

- Health Literacy – In addition to the health literacy skills people need to navigate the healthcare system, share personal information with their health providers, and manage their health conditions, consumers need to learn about current health topics in a culturally-appropriate way.
- Empowerment – Informed and engaged consumers are at the center of effective health care systems and high quality patient-centered primary care. Providing patients with the tools and resources that reflect their individual values, perspectives and lifestyles can assist in reducing variation in services utilization across health service areas. The District will use patient surveys to obtain a better understanding of the population. Initiatives will be implemented that will to seek to expand access to care.
- Accountability – The District plans to implement strategies that will incentivize providers to assume more responsibility for the health outcomes of their patients. However, consumers must also assume accountability.

ENABLER B – OVERARCHING HEALTH INFORMATION TECHNOLOGY AND EXCHANGE CAPABILITIES

Effective use of data via health information technology (HIT) and exchanges (HIE) is fundamental for both the District's short- and long-term health reform efforts. To do so, 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 approach to sharing and using electronic health records, claims, public health and social services data, 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 and HIE tools among racial and ethnic minorities and less-wealthy individuals, there are also significant gaps in access to and use of HIT and HIE

among providers serving these populations. To address our existing HIE fragmentation, the District's HIE Policy Board and SIM HIE Workgroup refined a list of recommended initiatives that will bolster the District's HIE capabilities. Initial funding for these initiatives is supported by federal SIM Model Design funding, in addition to current and future approved Implementation Advance Planning Documents (IAPDs) from CMS. The five initiatives are:

1. Update the Current HIE Data Map to Reflect the District's Data Landscape – DHCF developed a comprehensive data map depicting existing HIE systems in use in the District, the storage centers and data flows of each major HIE system, and the degree of connectivity between systems. By documenting the existing data infrastructure, DHCF can more easily identify where gaps in accessing and transmitting data occur, and address them through updates to current infrastructure, designating new HIE entities, or commencing new HIE initiatives.
2. Create an District HIE Designation Process that Sets Thresholds and Standards for Participation – DHCF will establish a core set of HIE requirements and standards that must be met by HIE entities 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 three-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 1000 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 social service data bases.
4. Develop Dynamic Care Profile Tool that Aggregates 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 Ambulatory Connectivity, Electronic Clinical Quality Measurement Tools, Obstetrics/Prenatal Registries, and an Analytical Patient Population Dashboard – Funds will support providers in technically integrating HIE services into their practice and clinical workflows to aid in transformation to value-based care and payment models. 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

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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. Lastly, 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.

Each initiative aims to leverage existing HIE infrastructure and HIT initiatives to build bridges between current systems and improve functionality of District HIEs.

ENABLER C - Workforce Development and Investment Supporting Transformation Initiatives

A well-informed, properly-trained workforce is required to transform the District's healthcare landscape. It is particularly essential for implementing and sustaining the District's short- and long-term SIM health care reform initiatives, including those related to the proposed care delivery reforms and community linkages enhancements. In order to execute the initiatives put forth in this innovation plan, the District plans to build workforce and organizational capacity through investments in technical assistance and training. Enabling initiatives include:

1. Non-Clinical Providers Training – Non-clinical providers, such as community health workers, will be trained to operate in tandem with providers and care teams by contacting patients in the community and facilitating health promotion, health maintenance, and health management for at-risk populations.
2. Provider Education – Providers require education on how to deliver "whole person" care and address social determinants of health, in additional to clinical health issues.
3. HIT Promotion – Potential end users should be educated on how the use of HIT and HIE 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.
4. 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 Homes 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 HH2 and other workforce investments, will shape future investments for long-term care delivery and payment models, such as Accountable Health

Communities. The District's current investments in the healthcare and health-related workforce capacities will therefore have both immediate and long-term effects on the care delivery system.

ENABLER D – QUALITY IMPROVEMENT TO ASSESS PROVIDER PERFORMANCE AND HEALTH OUTCOMES

Fundamental to value-based payment systems is performance measurement. 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 across the District. Recognizing that implementing the right measures is critical to the success of a value-based payment system, we developed a strategy to implement provider-facing, standardized statewide measurement activities and evaluate the performance of its healthcare delivery system. The Quality Performance Improvement (QIP) plan is based on the stated objectives of the District's SHIP, and includes performance and process measures that reflect the key elements of a successful system transformation

The District's vision for the QIP is to significantly improve performance on selected outcome and quality measures, and to reduce health disparities. To do so, we will do the following:

1. Reach Consensus on a Core Measure Set Development – A core measure set will be developed to align with existing performance reporting initiatives. The measure set will be representative of the Districts current and future priority topic areas. Criterion for measure selection includes:
    a. Measures should be valid, reliable, and tested – Measures will be endorsed by the National Quality Forum (NQF);
    b. Measures must align with District priorities – Measures need to provide opportunity to improve health and measures that will influence the health care delivery system; and
    c. Measures should align with national measure sets and other measure sets commonly used in the District, whenever possible - Alignment across a set of quality measures is a foundational first step toward healthcare transformation, as it sends powerful market signals to providers as to how their performance will be measured for the quality of care they provide, regardless of the health insurance coverage of the patient. We have made a conscious decision to align with other performance initiatives and payers such as Medicare, CareFirst, DC Healthy People 2020, FQHC Uniform Data System Reporting. To minimize reporting burden, initial phases will rely on claims-based measures and available uniform survey results. As technology progresses, the District will transition to using electronic clinical quality measures

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2. Gain Multi-Payer Support – The District will obtain buy-in from other payers to ensure there is alignment across payers.
3. Launch an Electronic Quality Reporting Tool – An electronic clinical quality measurement (eCQM) tool and dashboard will be developed to give providers the ability to view measure data associated with their attributed patients, both on an individual and/or practice level. The District has explored the use of eCQMs to help providers ensure they are 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.
4. Population Health Surveillance – The District will leverage existing dashboards (i.e., DC Health People 2020) to monitor population health.

The District looks forward to sharing our SHIP with our federal partners at CMS, implementing this plan along with our many partnering stakeholders that dedicated long hours to creating this roadmap, and to ultimately furthering the transformation of the District's health care system to one that meets the goals of the Triple Aim: Better Health, Better Care and Lower Cost.

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