State Innovation Model Annual Progress Report

May 2, 2016

Delaware aspires to be a national leader on each dimension of the Triple Aim: better health, improved health care quality and patient experience, and lower growth in per capita health care costs, in addition to improving provider satisfaction, our "plus one." In 2013, the Delaware Health Care Commission (HCC) convened stakeholders across the state – including consumers, providers, payers, community organizations, academic institutions, and state agencies – to work together to build a strategy to achieve these goals. That work culminated in Delaware's State Health Care Innovation Plan followed by the award of a four-year, $35 million State Innovation Model Testing Cooperative agreement from the Centers for Medicare and Medicaid Innovation (CMMI) to support the implementation of the plan. Combined with planned additional investments of nearly $100 million by purchasers, payers, and providers of care in Delaware, Cooperative Agreement funds are intended to support changes in health care delivery to create up to $1 billion in value over the next five to ten years.

Summary of Accomplishments and Milestones

In the first year of the State Innovation Model (SIM) Test Cooperative Agreement (February 2015 through January 2016), Delaware made significant progress in creating consensus around the plan for implementing the concepts originally envisioned by stakeholders and leaders around the state to produce a transformed health care system and help Delaware achieve the Triple Aim.

Delaware's Year 1 accomplishments are described below by component area.

Establishing Infrastructure/Stakeholder Engagement

Work that began in the Design phase continued in Year 1 of the Test phase as the Delaware Center for Health Innovation (DCHI), the non-profit organization established to lead the implementation of the state's SIM goals, continued to serve as a forum for stakeholder engagement and consensus building as well as a sustainable, long-term home for this work past the Cooperative Agreement award. More than 70 stakeholders, community leaders, and state officials serve either on the board of directors or on committees.

The DCHI has five standing committees – Healthy Neighborhoods, Clinical, Payment Model Monitoring, Workforce and Education and Patient & Consumer Advisory – as well as a Technical Advisory Group. The board and the majority of the committees met monthly throughout the year and all meetings were open to the public.

In addition, DCHI hosted two cross-committee meetings (in July and November), which allowed committee members and the general public to hear updates on all committees' work and provide input and feedback on highlighted topic areas. In all, more than 100 board, committee, and other stakeholder meetings ensured continued engagement, propelling the work at a rapid pace.

In addition to the Board and Committee structure, leaders of the Department of Health and Social Services (DHSS), DCHI and HCC actively engaged specific stakeholder groups to make progress towards Delaware's goals and ensure their continued commitment to the state's Innovation Plan, including:

- Meeting with the state's major payers both to align at a high-level on concepts and plans as well as to work out technical details such as data sharing and measure development. Alignment included principles of design for value-based payment as well as concrete agreement on measures to include on the Scorecard and the path to share data on those measures.
- Meeting with professional societies and trade associations, such as the Delaware Academy of Family Physicians, the Medical Society of Delaware, and the Delaware Healthcare Association.
- Meeting with provider systems, including all major health systems and Accountable Care Organizations (ACOs).
- Conducting targeted outreach to 21 practice sites testing the Common Scorecard—which includes approximately 120 providers—to gain critical feedback and input to the scorecard's development.

As an additional demonstration of stakeholder commitment to this work, DCHI received contributions from various stakeholders in Year 1 to allow the organization to hire an Executive Director in October 2015. DCHI will continue to seek additional funding commitments from stakeholders for staff and operating expenses, as these are not supported by the SIM Cooperative Agreement.

In an effort to continually engage a broad range of stakeholders, HCC engaged a PR/communications contractor to develop a comprehensive website for the Delaware Center for Health Innovation, www.dehealthinnovation.org, which houses general information on the DCHI, each committee, and publications as well as detailed information on initiatives such as Practice Transformation. The website evolved in the first year to be the go-to resource for information about health care innovation in Delaware and provides a mechanism for the public to submit questions or comments about the transformation.

DCHI also began work on developing an overall program dashboard to track how Delaware is progressing on overall outcomes and implementation of SIM initiatives. This dashboard intends to help the DCHI Board and Committees answer 3 questions: (1) Is DCHI achieving its goals? (2) Where are there opportunities to address specific needs or share best practices? (3) What programmatic decisions/changes should we consider?

The DCHI Board and Committees engaged in active discussions over the past year to ensure there was a focus on program outcomes and adequate representation of progress across each of the Committees. Topics of discussion included which measures to track, how to define those measures, and what the technical specifications are for tracking each measure. This year, DCHI will begin operationalizing the program dashboard (e.g., IT build, population of data, definition of refresh process) and facilitating discussions with stakeholders to verify information provided.

Patient and Consumer Advisory

Central to all of the work of the state's Innovation Plan is the patient. In order to give voice to the needs of patients and consumers, the DCHI created the Patient and Consumer Advisory Committee to provide a patient perspective in all of the initiatives within the Plan. The Patient and Consumer Committee provided significant input into the development of the DCHI website, a fact sheet/one-pager, and a draft consumer brochure to

ensure that the content was reflective of the consumer perspective and easily understood by a variety of audiences.

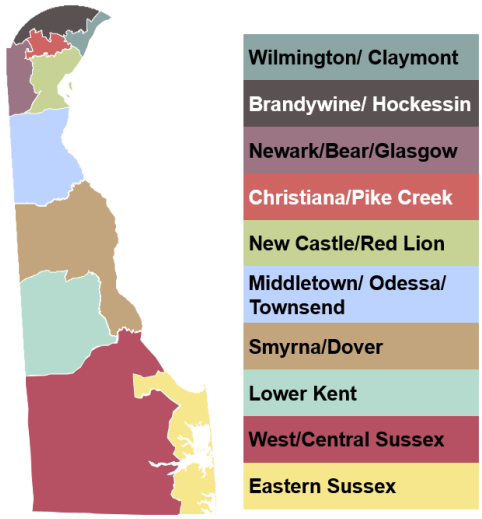
During the year, the Committee also researched patient engagement tools and initiatives from throughout the region in order to understand best practices in communicating with patients and consumers. These best practices will be summarized in a white paper planned for Year 2.

Healthy Neighborhoods/Population Health

The Healthy Neighborhoods Committee of DCHI is shaping the design and implementation of Delaware's population health strategy. Healthy Neighborhoods is Delaware's approach to supporting communities across the state to work together to develop locally-tailored solutions to some of the state's most pressing health needs. In Year 1, the committee reviewed data on Delaware's health needs to align on four priority themes: Healthy Lifestyles, Maternal and Child Health, Mental Health and Addiction, and Chronic Disease Prevention and Management. These themes will provide a structured approach for Neighborhoods to identify the challenges most pressing in their area and select locally-tailored projects or interventions to address these needs.

Another task of the committee was to create Neighborhood boundaries. The original Innovation Plan laid out broad characteristics of neighborhoods to include 50,000-100,000 people and have at least one multi-professional health care facility. The committee began with census data, identifying contiguous areas with the approximate population needed and adjusting the regions to reflect socioeconomic factors, health care patterns, commonly recognized community identifications, and feedback from stakeholders.

Final Healthy Neighborhoods Map:



The Committee also worked to define the operating model for the Healthy Neighborhoods approach by reviewing models of population health collaboratives from around the country and engaging in dialogue regarding possible organizational structure, governance and funding models. The result was the development of a consensus paper titled Healthy Neighborhoods Operating Model which outlines key elements:

- Each Neighborhood will be led by an inclusive, multi-stakeholder Council that will assess needs, identify gaps, and determine a strategy to be carried out at the local level;
- Neighborhoods will be supported by full-time staff focused on project management, community engagement, and technical support; and,

- Neighborhoods will partner with DCHI, state agencies, health systems, and donors on integrating with other statewide health care innovation efforts, data needs and funding.

The adoption of this consensus paper led to additional progress in defining the roll-out approach for scaling the model statewide. The committee established a timeline to launch the ten Healthy Neighborhoods across three "waves." Using population health data and in consultation with Delaware's Division of Public Health and stakeholders, a workgroup identified the three highest-need communities within the state for launch in Year 2 (2016). The committee developed and the DCHI board adopted the Healthy Neighborhood Rollout Approach consensus paper, which in addition to detailing the wave approach, lays out the process for setting up each Neighborhood, including local council formation, community planning, and program implementation.

Clinical/Delivery Transformation

Over the course of year 1, Delaware has seen significant adoption of value-based care delivery models by providers. By the end of year 1, Delaware had five Medicare Shared Savings Program (MSSP) ACOs, which includes participation by all of the acute-care adult hospital systems in the state.

The primary focus of the DCHI Clinical Committee is to accelerate adoption of these new models of care delivery and to support providers to transform the way care is delivered for their patients. Year 1 work focused on designing and launching various initiatives to enable that transformation.

During the design phase, HCC issued a Request for Information (RFI) on practice transformation. The responses received from that RFI were used by the committee and a working subgroup as input into the development of recommendations on practice transformation. The committee developed, and the board approved, a consensus paper on Primary Care Practice Transformation that describes the new capabilities required in primary care, recommends a funding model for practice transformation support through SIM Cooperative Agreement funds, and defines milestones practices should achieve through the process.

The committee's consensus paper was used to inform the development of a Request for Proposals released by the HCC to procure practice transformation vendors. The HCC selected and contracted with four vendors to conduct assessments, develop a curriculum for each practice based on needs, and complete semi-annual assessments against milestones for each practice site engaged in the initiative.

To support the vendors and encourage enrollment by practices across the state, the HCC employed a specific communications and outreach strategy with a cohesive, branded look. With input from the Clinical Committee, HCC and its communications contractor developed and executed a comprehensive education and outreach campaign with multiple components. The co-chair of the Clinical Committee and chair of the Health Care Commission, Dr. Nancy Fan, recorded a video that explained what practice transformation is and how it will benefit practices. The video was used in emails to over 600 clinicians and was included on a branded flash drive in a direct mail tube sent to over 500 PCP offices throughout the state. Brochures with general information and detailed inserts on value based payments and the four vendors were distributed to partners and made available for the vendors' use. A detailed section of the DCHI website was created to provide additional information and resources: http://www.dehealthinnovation.org/Health-Innovation/Committees/Clinical-Committee/Practice-Transformation In addition to the communications campaign, HCC and DCHI hosted several informational meetings with ACOs, CINs, professional societies, and primary care practices to encourage participation and promote education.

With the announcement of the selection of Health Partners Delmarva, LLC as one of the recipients of CMMI's Transforming Clinical Practices Initiative (TCPI) Award, leaders of HCC and DCHI reached out to the awardees in Delaware to ensure the rollout of SIM practice transformation was aligned with and complementary to the plan

for TCPI in the state. Leaders from both initiatives established and maintain regular communication and share enrollee data and best practices. TCPI leaders were also in attendance at two of the meetings hosted by HCC and DCHI for practices to learn about the transformation support opportunities in the state.

Throughout Year 1, the Clinical Committee led a consensus-based process for selecting the initial set of measures for Delaware's Common Provider Scorecard. Unlike payer scorecards currently available, the Common Scorecard will be a centralized place for providers to view their performance across their entire patient panel, regardless of payer. Originally envisioned as including a limited number of measures, robust discussion among the committee members resulted in 26 measures encompassing quality, utilization and total cost of care. The final list of measures is available at http://www.dehealthinnovation.org/Health-Innovation/Committees/Clinical-Committee/Common-Scorecard. Through additional working sessions and communication with the payers, the final Common Scorecard measure set is approximately 75% aligned with the measures that will be used by Delaware's payers in their pay-for-value payment models.

In addition to selecting the measures, the committee led the development of a plan to test and gather feedback on the Scorecard. Prior to a statewide rollout, a small group of providers volunteered to provide input on the measures, test data accuracy and diagnose any technical issues. The DCHI board conducted outreach to a diverse set of practices that varied by geography, primary care specialty, and practice size. DCHI hosted a webinar for interested providers and enrolled 21 sites – 120 providers – in the test. Throughout the testing phase, HCC's contractors provided one-on-one outreach to each practice site to collect feedback, determine measure relevance, and resolve providers' questions. This direct and intensive interaction was critical to finalizing the requirements for version 2.0 of the scorecard.

The Clinical Committee also reached consensus on care coordination in its paper Care Coordination as an Extension of Primary Care. This paper lays out a vision for care coordination as an extension of primary care, describes principles for funding care coordination and principles for provider eligibility, and recommends investments to support providers in adoption of care coordination.

Delaware's providers strongly believe that successfully coordinating care for high-risk individuals requires closer integration of primary care and behavioral health providers. The Clinical Committee formed a working group consisting of primary care and behavioral health stakeholders to develop a strategy for behavioral health integration with primary care. The working group discussions culminated in the development of a consensus paper: Integration of Behavioral Health and Primary Care. The paper makes the case for behavioral health and primary care integration in Delaware, articulates a vision for the integration, recommends models of support, and provides a timeline for implementation. With this paper as a roadmap, Delaware is ready to begin implementation in Year 2.

Payment Models

The goal of the DCHI Payment Model Monitoring Committee, comprised of payers, providers, and state leaders, is to ensure both the availability and successful adoption of value-based payment models across the state. In support of that goal and in order to identify areas where a common approach can support the acceleration and adoption of value based payment models, the committee examined several key topic areas including patient panel size and attribution methodology, practice transformation support models and participation requirements, the structure of care coordination support, and Total Cost of Care payment model design.

Through its work, the committee:

- Secured commitments from major Commercial and Medicaid payers to adapt alternative payment models for primary care to align more than 75% with v2.0 Common Scorecard measures.

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

In addition, Delaware Medicaid and State Employee Benefits programs worked to incorporate the core elements of Delaware's approach to outcomes-based payment into their payment models being adopted by the Medicaid MCOs and State Employee Benefits third party administrators.

Workforce and Education

Achieving the Triple Aim Plus One will depend on all of the health professions working in coordination and therefore involves retraining the current workforce and developing new training programs for the future workforce. The DCHI Workforce and Education Committee is leading this effort. The committee analyzed current and projected demographics of Delaware's population to understand the needs of the health care workforce. Using state and national data, the committee was able to understand the landscape and use that as the foundation for the future development of a Delaware-specific health workforce planning model.

The committee also worked toward consensus on recommendations to support curriculum development and implementation for providers to have the skills and capabilities necessary to coordinate care effectively. The Health Care Workforce Learning and Re-Learning Curriculum consensus paper recommends that a curriculum strengthen a core set of six competencies and also recommends the audience, core topics, and format/channels of the training, while encouraging alignment with practice transformation. This consensus paper was used by the HCC to inform the development of one component of an RFP to procure services for the development and implementation of a learning and re-learning curriculum.

The second component of the RFP released by the HCC in Year 1 was for the facilitation of a Health Professionals Education Consortium. The goal of the Consortium will be to provide a centralized framework for leadership, innovation, and the continuous incubation of new and/or enhanced programs. Specifically, the Consortium will foster the development of innovative and interdisciplinary primary care teaching programs that support team-based care and new service delivery models. A vendor or vendors will be selected for both the curriculum development and the establishment of the Consortium in Year 2.

Another priority area for the Workforce Committee was licensing and credentialing of health professionals. In the design phase, cumbersome licensing and credentialing processes were identified as a barrier to provider recruitment. In addition to committee discussions, DCHI conducted an online survey in order to fully understand these issues. Results of the survey as well as additional key informant interviews will inform a consensus paper on streamlining licensing and credentialing that is expected in Year 2.

Health Information Technology

A significant technology infrastructure is necessary in order to achieve the ambitious goals of Delaware's Innovation Plan. As part of the development of Delaware's Operational Plan, a requirement of the SIM

Cooperative Agreement, the SIM team met with various stakeholders in order to assess the current state of technology and understand stakeholder plans and priorities. This provided input into a comprehensive HIT roadmap, outlining the elements necessary to support statewide health transformation. Examples of roadmap elements include: establishing a multi-payer claims database, increasing clinical data submissions, providing consumer access to their health records, and expanding event notification.

The first component of Delaware's HIT strategy that will support health system transformation is the design and launch of the Common Scorecard. In conjunction with DCHI's Clinical Committee, the Technical Advisory Group (TAG) worked with major commercial and Medicaid payers to operationalize a pilot of the scorecard to 21 practice sites, representing approximately 120 providers. Technical aspects of this work included establishing common measure specifications applied by each payer to its own data, mapping provider NPIs to allow for linking of practice-level data across payers, creating standards for data transfer, establishing data sharing agreements among parties, and supporting the Delaware Health Information Network (DHIN) in operationalizing a common reporting platform using a third-party developer.

Payer participation in the scorecard has been critical and the TAG serves as the primary link between the state's payers and the developers to resolve issues in developing data feeds and finalizing specifications for attribution lists. Attribution lists will be used to provide practices with actionable information about which specific patients require attention.

The technical team also worked with the developer to build out the interface for the scorecard incorporating feedback from the test sites. This feedback informed the design requirements to support version 2.0 scorecard measures and functionality, which will launch statewide in Year 2. As part of the design for version 2.0 of the scorecard, we have developed detailed specifications for new functionality, including display of goals, statewide reporting, and incorporation of practice transformation milestones.

Leveraging State Authority

The design of Delaware's innovation initiative and the establishment of the DCHI as a separate non-profit organization to lead the implementation of the state's SIM goals illustrate the effort to create a movement that was not solely driven by state government. However, it is clear that state government can play a large role in catalyzing the efforts of the initiative by leveraging its regulatory and purchasing authorities, particularly through its Medicaid program and the State Employee Benefits Plan, which together cover approximately a third of Delawareans.

Delaware's Governor, Jack Markell, has been a staunch champion of expanding access to health care in the state and finding innovative ways to reduce costs and improve quality. His leadership was critical in Delaware's application for CMMI funding and the commitment of his team and the Executive Branch has been shown throughout Year 1. For example, Delaware's Division of Medicaid and Medical Assistance (DMMA) initiated contracts with Managed Care Organizations that require participation in SIM and introduction of new payment models that are consistent with the vision of the HCC and DCHI. In addition, the state's Office of Management and Budget (OMB), which administers the State Employee Benefits Plan, is represented on the DCHI board of directors and engaged in the Payment Committee, ensuring alignment in the goal of increasing value based payment models.

Delaware selected the State-Federal Partnership Model for its health insurance exchange and through that authority, can set state-specific standards for Qualified Health Plans (QHPs) participating on the state's exchange. In 2015, Delaware revised its QHP standards to include items directly aligned with the state's Innovation Plan, including the availability of pay for value and total cost of care models, funding for care

coordination, aligning measures tied to payment to the measures on the Common Scorecard, providing requested data in support of the Common Scorecard, and the submission of claims data to the HCC or its designee.

Increased fiscal pressures on the state's budget for FY 2016 brought increased scrutiny to the cost of health benefits for employees in Year 1. Independent of the SIM process, the Delaware General Assembly created a task force to study the state's health plan to identify areas for cost savings and efficiencies. DCHI leadership presented information on the SIM initiative to the task force, and in its final report, the task force specifically referenced the work of DCHI, with some of its recommendations reinforcing and aligning with those of SIM.

Summary of Challenges and Delays

In the first year, Delaware encountered some specific challenges and delays and has used these as learning opportunities to inform our plan and adjust course as needed.

One of the challenges Delaware faced was the rapidly evolving landscape of payment reform. Delaware worked to ensure alignment of new payment models being adopted across the state with Delaware's shared vision for value based payment and care delivery. During the year, there was significant activity among stakeholders around new payment models including all of Delaware's adult health systems initiating or enrolling into Medicare Shared Savings Programs. Several physician aggregators were also active, competing to enroll providers in their ACO models. While these developments represent positive movement towards value based payment models, they introduce complexity for providers and payers. HCC and DCHI worked closely and collaboratively with payers to build on existing innovations, meeting on a regular basis to discuss and encourage alignment in principle and timing.

The pace of roll-out of value based payment models from the state's payers was more moderate than the timeline set forward in the original Cooperative Agreement project narrative. Delaware had proposed that payers make alternative payment models available to providers in September 2015. However, payers have designed and will be offering a pay-for-value model to eligible providers statewide beginning in January 2017, with pilots occurring in 2016. The delays do not reflect significant differences in the approach to value based payments, but rather operational considerations and challenges faced by the payers during the design of the programs, such as integration of data systems, longer than expected time to analyze data to establish thresholds, and mobilization of staff.

Technological challenges were also encountered at various points during the year. The Common Scorecard was designed to be multi-payer so that practices could receive information across their entire patient panel. The varying approaches and priorities of different payers required careful attention to ensure continued engagement and alignment. Capturing scorecard data from claims information was a primary design decision in the first version of the scorecard. However, collecting and aggregating the data in a similar method across payers and grouping that information consistently into practices was not straightforward. Payers had different systems to gather and output data and different internal representations of practices and metrics. By actively engaging each party on a regular basis, the technical team was able to quickly identify and resolve issues, prevent miscommunication and minimize errors.

Another challenge related to the Scorecard was the implementation of data sharing agreements for patient attribution lists between the payers and the DHIN. Active conversations, including legal counsel, led to a successful resolution of the issue, but the length of time it took to ensure that all parties' concerns were addressed led to delays in the availability of attribution data, pushing that functionality of the Scorecard into Year 2.

Summary of Funding

CMMI awarded Delaware a four year Cooperative Agreement for up to $35 million, with specific restrictions on how the funding could be applied. Based on feedback from stakeholders, HCC developed a budget narrative as part of its original Cooperative Agreement application submission that estimated a total funding requirement of approximately $130 million over the four-year period, with contributions coming from multiple sources including payers, health systems, philanthropic organizations, other grant opportunities, and the CMMI SIM Cooperative Agreement. HCC developed its priorities for funding based on the following guiding principles:

- Focus Cooperative Agreement on start-up / one-time costs; find alternative sustainable funding for ongoing operational costs
- Preserve SIM Cooperative Agreement funds for uses with limited alternative options
- Leverage grants from foundations or other private sources wherever possible
- Leverage Medicaid to obtain a favorable federal match
- Establish that direct investments in delivery system should be funded by payers (or co-funded with providers)
- Request continued support (in-kind and monetary) from stakeholders to demonstrate commitment to CMMI
- Concentrate support from contractors in the first several years of the Cooperative Agreement to maintain pace, and taper that support as more local capacity is built to carry forward this work

HCC has continued to operate with these principles in mind. Recognizing the importance of this work to achieving the goals set forth in Delaware's State Health Care Innovation Plan, HCC conducted competitive procurement processes to select vendors and leveraged existing contractors to support Delaware's transformation work.

The following table summarizes spending by project area for the first year of the model test Cooperative Agreement. The project areas noted in the table align with the structure outlined in the Operational Plan for Year 2 and beyond. Cooperative Agreement funding available in Year 1 was $12,259,694. The total amount expended $8,287,865.12. A carryover request in the amount of $3,971,828.88 will be submitted to CMMI.

Year 1 (February 1, 2015 to January 31, 2016) Spending by Project Area:

	Total Expended
Population Health	$1,050,000
Delivery/Clinical	$2,361,029
Payment	$1,912,500
Health IT	$1,476,500
Workforce and Education	$383,475
Patient and Consumer	$372,475
Overall Management/ Establishing Infrastructure	$731,000
Travel	$886
Total	**$8,287,865**
Year 1 award	$12,259,694
Carryover request	**$3,971,829**

Summary of Sustainability Strategies

Throughout the development of the State Innovation Plan and the pre-implementation year of the Test Cooperative Agreement, Delaware has always kept an eye toward sustainability. First, the Delaware Center for Health Innovation was established as a non-profit entity with representatives from the public and private sectors to formalize and sustain the deep involvement of stakeholders in the implementation of the plan. The DCHI is privately funded through stakeholder contributions and in-kind services, and this model is critical to ensure the continuation of transformation activities as administration changes occur. A major milestone for DCHI was the hiring of its first staff member, Executive Director Julane Armbrister in the fall of 2015. Under Ms. Armbrister's leadership, DCHI applied for and received 501c3 status, established a physical office, engaged in fundraising conversations, and evaluated two grant opportunities. Plans for hiring additional staff in Year 2 are on track with the receipt of additional stakeholder contributions and commitments. A larger permanent staff will enable DCHI to move toward the vision of assuming the full direction of the Innovation Plan as Cooperative Agreement-funded contractor support tapers and eventually ends.

Beyond the critical work of establishing the infrastructure of DCHI, there are other initiatives that will ensure sustainability of this work beyond the Cooperative Agreement period, administration transitions, or other changes:

- Through SIM-funded Practice Transformation, Delaware is investing Cooperative Agreement dollars in preparing primary care providers to transition to value-based payment models. The success of the Practice Transformation program is critical to ensuring the readiness and willingness of providers to change the delivery system alongside the changes in the models of payment.
- Linking DHIN, HCC, and DCHI through bylaws and board membership will ensure that there is long-term interconnectivity throughout the health care policy, health IT, and stakeholder communities.
- The development and implementation of the HIT strategy included in Delaware's Operational Plan will put in place the technological structures necessary for long-term, sustainable change in the health care system.
- Healthy Neighborhoods is envisioned as a community-driven approach to population health. Developing the capacity and resources to drive changes from the grassroots level will create the buy-in necessary for sustainability.
- Educating strategic partners and leveraging existing aligned initiatives throughout the state will enable a broader reach and more significant impact toward goals.

Conclusion

In Year 1, Delaware continued its progress toward creating a plan to achieve the Triple Aim plus One by engaging a variety of stakeholders and pursuing a consensus-based approach. The active engagement of critical partners across the state has enabled Delaware to be well positioned to move into the implementation phase in Year 2.