Board Meeting

March 8th, 2017
Agenda

- Call to Order
  - Board Business
  - Recap and Status Update
  - Executive Director Update
  - Public Comment
  - Executive Session
Agenda

- Call to Order
- **Board Business**
  - Recap and Status Update
  - Executive Director Update
  - Public Comment
  - Executive Session
Board Business

1. Vote on Board members
2. Introductions
3. Conflict of Interest Statement
4. Review change in by-laws
5. Approve February meeting minutes
Welcome: DHSS Secretary Dr. Kara Walker

- Dr. Walker joins DHSS after serving as the Deputy Chief Science Officer at the Patient-Centered Outcomes Research Institute, a nonprofit, nongovernmental organization in Washington that is authorized by Congress to improve evidence available to help patients, caregivers, employers, insurers, and policymakers make informed healthcare decisions.

- A Caravel Academy high school graduate, Dr. Walker earned her medical degree from Jefferson Medical College and graduated from the University of Delaware’s chemical engineering program. She has taught Family and Community Medicine at the University of California, San Francisco, and advocated for health equity and for access to quality healthcare in minority and underserved populations.
Welcome: Nick Moriello

- Mr. Moriello serves as President of Health Insurance Associates (HIA) in Newark. Under his leadership, HIA has grown to one of the largest independent health insurance agencies in the tri-state area (DE, PA, MD).

- Mr. Moriello is one of the more respected health insurance advisors in his field. His technical expertise in health insurance, along with his ability of conveying complex insurance topics into everyday common language, is what draws agents & clients to him at HIA.

- He also serves on the Delaware State Chamber of Commerce Board of Governors, the Delaware State Chamber of Commerce Health Care Committee, and the Delaware Department of Insurance’s Life and Health Content Development team for licensing.
Welcome: Cindy Bo

- Ms. Cindy Bo has worked in healthcare strategy for over 20 years, ranging across the provider, payer and life sciences sectors with expertise in strategic planning, business development, mergers and acquisitions, and finance transformation.

- Ms. Bo is the Chief Strategy & Business Development Officer for Nemours Children’s Health System, Alfred I. duPont Hospital for Children. At Nemours, she manages the strategies and business development processes in support of new growth and integration opportunities for both the hospital and practice in the Delaware Valley.

- Ms. Bo has earned her MBA, with high distinction and honors, from Columbia Business School and her BS, summa cum laude, from Binghamton University School of Management.
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Summary of February DCHI Board meeting

- Update on SIM OP Health Information Technology (HIT) goals for the current grant year
- Discussed TAG’s structure moving forward and the need to refocus to broadly monitor HIT activity in the State
- Update on the rollout of Healthy Neighborhoods’ Wilmington/Claymont local council
- Update on Strategic Plan implementation for Q1
- Approved consensus paper on developing a framework for sustainable workforce capacity assessments
- Discussed Patient and Consumer Advisory Committee’s new structure
# DCHI 2017 Goals & Metrics

<table>
<thead>
<tr>
<th>Critical path metrics</th>
<th>Supporting innovations metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Common Scorecard accessible to PCPs statewide</td>
<td>1. Behavioral health integration testing program implemented</td>
</tr>
<tr>
<td>2. 50% providers participating in practice transformation</td>
<td>2. Health care workforce and education initiatives executed</td>
</tr>
<tr>
<td>3. 40% of Delawareans attributed to PCPs in value-based payment models</td>
<td>3. Enhanced provider engagement</td>
</tr>
<tr>
<td>4. 3 Healthy Neighborhoods launched</td>
<td>4. Transformation efforts aligned with regulatory changes/investments made by providers and payers</td>
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## Operational sustainability metrics

1. Long-range sustainability options established
2. Implement 2017 strategic imperatives
3. Broaden stakeholder engagement base
## DCHI 2017 Goals & Metrics: Critical path

### Metrics

<table>
<thead>
<tr>
<th>Initiative Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Common Scorecard accessible to PCPs statewide</strong></td>
<td>▪ Clinical Committee discussed the Scorecard’s potential for shaping policy and strategy across the State</td>
</tr>
<tr>
<td>- Exploring uses for population health and VBP</td>
<td>▪ Discussed integration with Practice Transformation support</td>
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<tr>
<td></td>
<td>▪ Board will continue to discuss appropriate path forward</td>
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<tr>
<td><strong>50% providers participating in practice transformation</strong></td>
<td>▪ ~37% PCPs enrolled¹</td>
</tr>
<tr>
<td>- Preparing providers to participate in new models of care and reimbursement</td>
<td>▪ Vendor measurement tools revised to identify practice-level progress towards milestones</td>
</tr>
<tr>
<td></td>
<td>▪ Practices achieving operational milestones</td>
</tr>
<tr>
<td></td>
<td>▪ Challenges include staffing resources, BHI, and lack of IT capabilities</td>
</tr>
<tr>
<td><strong>40% of Delawareans attributed to PCPs in value-based payment models by end of 2017</strong></td>
<td>▪ ~30% Delawareans in value-based payment models; payers continue to enroll practices</td>
</tr>
<tr>
<td>- Improving access to affordable, enhanced care delivery</td>
<td>▪ Payment Committee is gathering information on innovative payment models in other states to inform transformation in Delaware</td>
</tr>
<tr>
<td><strong>3 Healthy Neighborhoods launched</strong></td>
<td>▪ 100% staffed meeting 2017 goals</td>
</tr>
<tr>
<td>- Integrating clinical and community-based services/practices to identify and address priority needs of high risk populations, especially social determinants of health</td>
<td>▪ HN Sub-committees operational</td>
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<tr>
<td></td>
<td>▪ 2017-2018 budget outlined</td>
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<tr>
<td></td>
<td>▪ Wilmington/Claymont HN- Lead Council and Task Forces development under way</td>
</tr>
<tr>
<td></td>
<td>▪ Dover/Smyrna HN- Lead Council co-chair identified</td>
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<tr>
<td></td>
<td>▪ Sussex- SCHC relocated to Georgetown. Countywide M/CH plan in partnership with state.</td>
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<tr>
<td></td>
<td>▪ Statewide alignment on data and funding</td>
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</tbody>
</table>

¹ December 2016 PT vendor report indicated 101 sites and 347 DOs, MDs, NPs, PAs; does not include TCPI participants
## DCHI 2017 Goals & Metrics: Supporting innovations

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Initiative Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health integration testing program implemented</td>
<td>Enhancing integration and improving care for high cost and high need patients</td>
<td>▪ Accepting expressions of interest from PC and BH practices</td>
</tr>
<tr>
<td>Health care workforce initiatives executed</td>
<td>Building workforce capacity, ensuring an adequate workforce to meet the needs of the State</td>
<td>▪ In the process of interviewing candidates for BHI Program Manager position</td>
</tr>
<tr>
<td>Enhanced provider engagement</td>
<td>Ensuring capacity of providers to practice and thrive in changing environment</td>
<td>▪ Developing BHI business case tool to estimate potential profit/loss generated through BHI</td>
</tr>
<tr>
<td>Transformation efforts aligned with regulatory changes &amp; investments made by payers and providers</td>
<td>Continuing to monitor and encourage payment reform models that support SIM goals; exploring alignment with DPR on licensing and credentialing</td>
<td>▪ First in-person training session conducted on 2/16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Licensing &amp; Credentialing: deep dive research on similar approaches in other states to guide reform efforts in DE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Community Health Worker Sub-Committee continues to meet monthly</td>
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<tr>
<td></td>
<td></td>
<td>▪ Clinical Committee discussed potential outreach strategies including regional focus groups with providers to enhance awareness of and familiarity with the Scorecard, Practice Transformation, and BHI.</td>
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<tr>
<td></td>
<td></td>
<td>▪ Planning to integrate PT &amp; Workforce training programs; refresh PT &amp; Workforce training curricula to include information on helping providers succeed in new payment models</td>
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<tr>
<td></td>
<td></td>
<td>▪ Clinical Committee is working to expand outreach to independent primary care and behavioral health providers</td>
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<tr>
<td></td>
<td></td>
<td>▪ Explore licensing and credentialing recommendations</td>
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DCHI 2017 Goals & Metrics: Operational sustainability

### Metrics

1. **Long-range sustainability options established**

   - Transitioning away from intense consulting support
   - Expanding stakeholder support
   - Building in-house capacity for grant development (program support)
   - Budget to support initiatives through 2017 confirmed

2. **Implement 2017 strategic imperatives**

   - **Portfolio focus:** Healthy Neighborhoods transitioned from a visionary and planning role to a governance role with new supporting structure and will explore feasibility of original roll out goals
   - **Policy Focus:** DCHI engaging with new administration to enhance awareness of DCHI and its role in the SIM initiative, and to explore alignment of DCHI’s support with administration’s vision for path forward
   - **Stakeholder Engagement:** New DCHI website launched, targeting new stakeholder audiences, nurturing stakeholder engagement and converting stakeholders to advocates for the transformation effort
   - **Sustainability:** Stakeholder investment and support has been broaden for 2017

3. **Broaden stakeholder engagement base**

   - Implementing communication plan to foster awareness about SIM, DCHI and value added to transformation effort—new website provides points of engagement for stakeholders
   - 2017 outreach plan includes targeted communications with strategic stakeholders
Recall: 12 strategic imperatives from DCHI Strategic Plan

1. Maintain a broad portfolio of initiatives as necessary to realize the goals on which DCHI was founded, but evolve that portfolio in response to changes in the landscape.

2. Establish and sustain a strong implementation role for most initiatives that extends well through launch, but generally look to other organizations for ongoing operations.

3. Identify where policy solutions are necessary to support innovation and work with policymakers as necessary to bring those solutions to fruition.

4. Ensure that adoption of value-based payment for primary care supports our goals for transformation, while fostering other models to transform the full continuum of care.

5. Work with the next administration to leverage the State of Delaware’s purchasing authority to foster provider risk sharing as a critical enabler of quality & affordability.

6. Align DCHI-led delivery system transformation efforts with regulatory changes and investments being made by payers and providers to achieve similar goals.

7. Evolve our approach toward multi-payer alignment of quality measurement and reporting, to ensure impact and long-term sustainability.

8. Accelerate the rollout of Healthy Neighborhoods by streamlining the proposed operating model and establishing priorities based on identified community needs.

9. Adopt a systematic approach to communicating with stakeholders regarding DCHI’s efforts and how they dovetail with the efforts of other organizations and individuals.

10. Affirm our commitment to be transparent in our decisions and use of resources while creating channels to manage sensitive information and challenging discussions.

11. Continue to fund DCHI operations through stakeholder contributions, but augment this with grant funding for design and implementation of specific initiatives.

12. Continue staff hiring plan; rely on contractors for time-limited projects that require surge capacity and/or specialized expertise.

Four themes emerged from these 12 strategic imperatives:

- **DCHI portfolio** (1, 4, 7, 8)
- **Policy focus** (3, 5, 6)
- **Stakeholder engagement** (9, 10)
- **Sustainability** (2, 11, 12)

We will develop tactical plans against each of these themes.
### Strategic Plan implementation: actions for Q1 and beyond

<table>
<thead>
<tr>
<th>Themes</th>
<th>Q1 Path Forward</th>
<th>Status Update</th>
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</table>
| **DCHI Portfolio**<br>Ensure the availability and implementation of appropriate range of programs/tools and interventions to effect innovation and change | - Reassess/confirm path forward for each DCHI initiative  
- Identify significant state/federal changes and assess impact/opportunity  
- Align strategic plan with CMMI Operational Plan  
- Build consensus for new approaches to advance initiatives where needed | - Each Committee has confirmed core elements of 2017 initiatives  
- Board engaged in quarterly sessions for environmental updates on topics such as payment reform to assess gaps/opportunities for areas of focus  
- Healthy Neighborhoods transitioned to operational governance structure |
| **Policy Focus**<br>Leverage opportunities at federal and state level to drive payment reform | - Engage with new administration  
- Identify federal/state vehicles that would accelerate support and adoption of reform initiatives | - Appropriate stakeholders included in Payment Model Monitoring Committee’s recent webinars  
- Engaging new administration to enhance awareness of and alignment between initiatives |
| **Stakeholder Engagement**<br>Expand stakeholder support and engagement to effect change and buy-in for health care transformation | - Launch DCHI communications plan  
- Develop schedule for outreach to key stakeholders for updates and confirmation of alignment of goals  
- Share DCHI broadly | - TAPP Network redesigning the DCHI website to drive branding, stakeholder engagement, and to enhance communications and outreach; developing collateral materials to enhance stakeholder awareness of various initiatives  
- Collecting contact information for key stakeholders from partner organizations  
- Revised website launched |
| **Sustainability**<br>Secure financial and operational partners to sustain DCHI implementation initiatives | - Reconfirm stakeholder financial support for 2018  
- Assess current structure and resources for long-term transformation effort  
- Advance HN sustainability plan | - Stakeholder support for current year secured  
- Initiated outreach to stakeholders to assess commitment for FY 2018 and expanded base of financial contributors  
- HN Sustainability Committee is operational, exploring alignment of funding across organizations and programs |
Context for Technical Advisory Group (TAG) discussion

- Over the last several years, the TAG has primarily served as a working group to provide technical input and guidance into the Common Scorecard.

- During this time, DCHI has focused primarily on the clinical, payment, workforce, and consumer-facing elements of its mission.

- Furthermore, while DCHI has focused primarily on SIM grant activities with a more limited focus on Health IT, it will likely evolve and broaden its focus over the next several years.

- Information on a proposed path forward for TAG was presented in February. However, before deciding on a new path forward, it could be helpful to reassess the evolution of HIT needs and activity in the State.

- A focus group with key stakeholders to review the HIT roadmap and original SIM goals could provide context and help assess what is needed going forward in light of technology already in place, technology tools needed in the future, and areas where DCHI can and should provide input critical to supporting technology as a key driver of broader transformation.

Should a focus group be facilitated to capture this information prior to determining a path forward for TAG?
Practice Transformation Update

- 347 providers (in 101 practices) currently enrolled in Practice Transformation services.

- DHCC and DCHI revised vendor reporting tools to identify practice-level progress toward milestones, data trends, and challenging milestone components.

- The DHCC can now calculate a monthly average practice score (APS) for each milestone.
  - The APS values ranges from 1.00 to 3.00, with 1 indicating that none of the enrolled practices have started the activity associated with the milestone and 3 indicating all enrolled practices are fully performing the activities associated with the milestone.

- Using this data, the DHCC can now better understand the specific areas in which Delaware practices are progressing towards practice transformation milestones.
### Average Practice Scores (APS) and Percentage Change Scores (PCS) by PT Milestone, Sep – Dec 2016

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Sep 2016 APS</th>
<th>Oct 2016 APS</th>
<th>Nov 2016 APS</th>
<th>Dec 2016 APS</th>
<th>Sep - Dec 2016 PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone 1</strong>: Identify 5% of the panel that is at the highest risk and highest priority for care coordination</td>
<td>2.03</td>
<td>2.07</td>
<td>2.10</td>
<td>2.22</td>
<td>9.5%</td>
</tr>
<tr>
<td><strong>Milestone 2</strong>: Provide same-day appointments and/or extended access to care</td>
<td>2.18</td>
<td>2.30</td>
<td>2.33</td>
<td>2.49</td>
<td>14.2%</td>
</tr>
<tr>
<td><strong>Milestone 3</strong>: Implement a process of following-up after patient hospital discharge</td>
<td>1.97</td>
<td>2.10</td>
<td>2.14</td>
<td>2.38</td>
<td>20.8%</td>
</tr>
<tr>
<td><strong>Milestone 4</strong>: Supply voice-to-voice coverage to panel members 24/7 (e.g., patient can speak with a licensed health professional at any time)</td>
<td>2.04</td>
<td>2.07</td>
<td>2.17</td>
<td>2.30</td>
<td>12.5%</td>
</tr>
<tr>
<td><strong>Milestone 5</strong>: Document sourcing and implementation plan for launching a multi-disciplinary team working with highest-risk patients to develop a care plan</td>
<td>1.67</td>
<td>1.69</td>
<td>1.71</td>
<td>1.91</td>
<td>14.2%</td>
</tr>
<tr>
<td><strong>Milestone 6</strong>: Document plan to reduce emergency room overutilization</td>
<td>2.04</td>
<td>2.08</td>
<td>2.11</td>
<td>2.23</td>
<td>9.4%</td>
</tr>
<tr>
<td><strong>Milestone 7</strong>: Implement the process of contacting patients who did not receive appropriate preventive care</td>
<td>1.87</td>
<td>1.99</td>
<td>2.01</td>
<td>2.18</td>
<td>16.1%</td>
</tr>
<tr>
<td><strong>Milestone 8</strong>: Implement a multi-disciplinary team working with highest-risk patients to develop care plans</td>
<td>1.55</td>
<td>1.59</td>
<td>1.60</td>
<td>1.72</td>
<td>10.8%</td>
</tr>
<tr>
<td><strong>Milestone 9</strong>: Document plan for patients with behavioral health care needs</td>
<td>1.48</td>
<td>1.49</td>
<td>1.51</td>
<td>1.67</td>
<td>12.7%</td>
</tr>
</tbody>
</table>
Key Takeaways

- Quantitative data analysis indicates enrolled practices are making progress towards:
  - Implementing a process of **following-up after patient hospital discharge**
  - Implementing the process of **contacting patients who did not receive appropriate preventive care**

- Practices may need additional assistance with implementing a **multi-disciplinary team** for high risk patients and documenting plans for patients with **behavioral health care needs**.

- Challenges to successful practice transformation include, but are not limited to, **staffing resources, behavioral health integration**, and **IT capabilities**.
Status of BHI support program

- CMMI approved the SIM Year 3 Operational Plan and Delaware was awarded $5,604,505. Portions of SIM funding are targeted towards Behavioral Health Integration:
  - Support behavioral health providers to implement electronic medical records ($100,000)
  - Test new models of integrating behavioral health and primary care ($400,000)

- BHI goals and metrics for 2017 include:
  - Contract for Program Manager secured in Q1
  - Implementation Plan complete by end of Q1
  - Needs Assessment complete by end of Q2
  - Training vendor contract secured by end of Q2

- DCHI is actively recruiting and accepting referrals for the Behavioral Health Integration Program Manager.
BHI Business Case Tool

- Estimates the potential **profit/loss** that a practice can generate through Behavioral Health Integration.

- Model developed to identify revenues/costs for a primary care practice which **employs/contracts behavioral health consultants**.

- The tool is driven based on the **assumptions a practice inputs**; it’s not a forecast of expected revenue, rather a tool to **help a practice translate their own information** (e.g., panel size, number of clinicians) **into a business case**.

- Model **assumes certain startup costs** (training, EHR, etc.) and **revenues** via fee-for-service reimbursement.
Next steps to operationalize BHI

March

- Recruit and hire Program Manager
- Identify and reach out to practices at various stages of Behavioral Health Integration
- Meet with practices to understand their specific support needs
- Identify desired vendors for training and expert consultation
- HCC to develop contracts with vendors (DCHI, training vendor, expert consultation vendor)

April

- Launch testing program
Agenda

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ED Update

1. Operational update

2. Communications Plan update
ED Update

1. Operational update

2. Communications Plan update
DCHI Communications Update

• New website has LAUNCHED!
  – www.dehealthinnovation.org
  – Includes CRM which is actively growing DCHI’s distribution lists
    • Continued segmentation and maintenance of existing lists
  – Includes resource center for each committee
    • New content/blogs for each committee
    • Existing content (consensus papers, strategic plan, etc.)

• DCHI social accounts up and running
  – Promoting all DCHI events, committee-specific updates, industry updates
    while utilizing local and national hashtags and interacting with
    influencers/stakeholders
  – Twitter @DCHI_SIM
  – Facebook “Delaware Center for Health Innovation”
  – LinkedIn “Delaware Center for Health Innovation”
DCHI Communications Update

- Communication cadence
  - Monthly update email to general stakeholders
    - Includes DCHI board & committee members
  - Quarterly update to VIP stakeholders
  - Opt-in website communications
    - Ability to choose which committee(s) you’d like to hear from
    - Ability to choose frequency of updates
    - Updates include recent blog/news updates, board/committee meeting minutes, newsletter
DCHI Monthly Report

• **Website analytics**
  – Visitors
    • # of visitors who spent time on the website
  – Traffic sources
    • Where our website’s traffic is coming from (social media, blogs, direct traffic, emails, etc.)
  – Conversion rate
    • % of people who completed a desired action, like opt-in for emails or downloading a document
  – Bounce rate
    • % of people who left the website without after viewing a page, gives us the ability to reevaluate why that page is performing poorly
DCHI Monthly Report Cont.

• **Email marketing analytics**
  – Click-through rate
    • % of email recipients who clicked one or more links within the email
  – Conversion rate
    • % of those who clicked on a link within an email and completed a desired action
  – Bounce rate
    • % of total emails that could not be successfully delivered
  – List growth rate
    • Rate at which email list is growing
  – Email sharing/forwarding rate
    • % of recipients who share or forward email, very important to gaining new contacts!
DCHI Monthly Report Cont.

• **Content marketing analytics**
  – Visits
    • Ability to see site traffic from blogs/content
  – Leads
    • Helps define which topics/formats of blogs that perform well and to be focused on
  – Subscribers
    • Those who opt-in to receive content communication, helps to build distribution lists

• **Social media analytics**
  – New followers
  – Reach
  – Engagement
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- Executive Director Update

**Public Comment**

- Executive Session
Upcoming DCHI Meetings for March – April 2017

**Workforce and Education**
- Mar 9, 1:00 pm
- Del Tech 400 Stanton-Christiana Road Conference Room B240, Newark

**Healthy Neighborhoods**
- Mar 15, 1:00 pm
- DHSS -1901 N. Dupont Hwy, Chapel, New Castle

**Clinical**
- Mar 21, 5:00 pm
- Del Tech Park-DBI- 15 Innovation Way Conference Room 102, Newark

**Board**
- April 12, 2:00 pm
- Del Tech Park-DBI- 15 Innovation Way Conference Room 102, Newark

Please check [www.DEhealthinnovation.org](http://www.DEhealthinnovation.org) for the latest information about all DCHI Board and Committee meetings.
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Executive Session

1. Payment Reform
2. Common Scorecard
Executive Session

1. Payment Reform
2. Common Scorecard
# Potential uses of the Scorecard

<table>
<thead>
<tr>
<th>Use case</th>
<th>What it would take to achieve this use case</th>
<th>Summary perspective</th>
</tr>
</thead>
</table>
| **A. Shaping policy / strategy**  | - Create blinded comparisons of provider performance that surface variation in quality  
                                    | - Share information broadly with stakeholders, to raise awareness of variation in quality  
                                    | - Highlight statewide initiatives that aim to improve the quality and delivery of care | The Scorecard data demonstrates wide variation in quality of care, which underscores the importance of transformation efforts currently underway |
| **B. Reference for payment**      | - Obtain commitment from payers to reference the Scorecard as the primary source for quality, utilization, and cost data  
                                    | - Identify and address implementation hurdles including alignment between Scorecard and payers on technical issues | DCHI should focus efforts on improving alignment and integration with reporting by payers of measures used for purposes of value-based payment |
| **C. Consumer transparency**      | - Give notice of intent to make performance accessible to consumers, while DCHI and payers address provider questions about the Scorecard  
                                    | - DCHI / DHIN create and update consumer web page | Use of Scorecard data for consumer transparency may be counter-productive to physician engagement, at this time; it should be deferred |
| **D. Clinical performance improvement tool** | - Create a performance improvement tool that calculates performance based on clinical data (rather than using numbers/denominators from payers)  
                                    | - Achieve sufficient density on CCD integration to make DHIN-powered tool a reliable basis for performance improvement | This is not the intended purpose of the Scorecard; it would require a complete retooling of the Scorecard (measures, data sources, reporting functionality) |
Timeline to achieve impact from Common Scorecard

**SIM TESTING GRANT**

- **October 2016**
  - Scorecard available to all PCPs in Delaware
  - Includes data from all major Commercial and Medicaid MCOs

- **March 2017**
  - Scorecard accessed by ~30% of PCP practices, to date
  - Only a fraction of physicians are aware of the Common Scorecard
  - Many are not aware of the relevance of the Scorecard to value-based payment

- **March 2018**
  - Decision point on whether to sustain Scorecard beyond SIM, for what purpose(s), and through what funding mechanisms

**AFTER SIM**

- **2019 onwards**

**Proposed goals for the next 12 months**

1. Raise awareness among all stakeholders of variation in quality of care as evidence of need for payment reform, practice transformation

2. Raise understanding among PCPs of multi-payer alignment of payment with Scorecard measures

3. Increase frequency at which PCPs access to the Scorecard to find performance across all Commercial and Medicaid patients
Variation in quality: Medicaid

**Common Scorecard Measures**

- Appropriate tx of URI in children
- Diabetes: nephropathy
- Well child care: 3-6 years
- Breast cancer screening
- Adherence to statins
- Adolescent well care
- Med adherence high BP: RASAs
- Med management for asthma
- Med adherence in diabetes
- Cervical cancer screening
- Well child care: 0-15 months
- Colorectal cancer screening
- Childhood immunizations
- HPV vaccination
- Avoidance of abx in bronchitis

**Quality measures**

- Developmental screening
- 7-day hospital follow-up
- Diabetes: HbA1c >9%
- BMI assessment
- Fluoride varnish
- Screening for clinical depression

**Potential future measures**

- Each dot represents the performance of a single Delaware primary care practice
- Statewide Medicaid Average

Notes: Includes only practices with at least 30 patients in the denominator of a given measure; excludes “High-risk medications in the elderly” due to low statewide denominator count.

1 Delaware average across major Commercial payers contributing data to the Common Scorecard; Data reflects the performance period Q1-Q4 2016

Data as of January, 2017 and does not include full claims run-out for 2016
Variation in quality: Commercial

Common Scorecard Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate tx of URI in children</td>
<td>85.4</td>
</tr>
<tr>
<td>Diabetes: nephropathy</td>
<td>83.4</td>
</tr>
<tr>
<td>Well child care: 3-6 years</td>
<td>83.6</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>80.8</td>
</tr>
<tr>
<td>Adherence to statins</td>
<td>89.9</td>
</tr>
<tr>
<td>Adolescent well care</td>
<td>88.3</td>
</tr>
<tr>
<td>Med adherence high BP: RASAs</td>
<td>86.9</td>
</tr>
<tr>
<td>Med management for asthma</td>
<td>88.3</td>
</tr>
<tr>
<td>Med adherence in diabetes</td>
<td>86.9</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>75.7</td>
</tr>
<tr>
<td>Well child care: 0-15 months</td>
<td>90.7</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>65.2</td>
</tr>
<tr>
<td>Childhood immunizations</td>
<td>56.8</td>
</tr>
<tr>
<td>HPV vaccination</td>
<td>24.8</td>
</tr>
<tr>
<td>Avoidance of abx in bronchitis</td>
<td>24.2</td>
</tr>
<tr>
<td>Developmental screening</td>
<td>56.7</td>
</tr>
<tr>
<td>7-day hospital follow-up</td>
<td>58.8</td>
</tr>
<tr>
<td>Diabetes: HbA1c &gt;9%</td>
<td>43.0</td>
</tr>
<tr>
<td>BMI assessment</td>
<td>23.2</td>
</tr>
<tr>
<td>Fluoride varnish</td>
<td>0.4</td>
</tr>
<tr>
<td>Screening for clinical depression</td>
<td>0.3</td>
</tr>
</tbody>
</table>

Notes: Includes only practices with at least 30 patients in the denominator of a given measure; excludes “High-risk medications in the elderly” due to low statewide denominator count.

1 Delaware average across major Commercial payers contributing data to the Common Scorecard; Data reflects the performance period Q1-Q4 2016

Data as of January, 2017 and does not include full claims run-out for 2016.
Next steps for provider engagement on the Scorecard

Potential steps for provider engagement

▪ Schedule one-on-one meetings between DCHI members and specific practices to review performance, answer questions, and collect feedback

▪ Share blinded comparisons of provider performance that surface variation in quality

▪ Use provider marketing channels to encourage Scorecard enrollment and highlight statewide DCHI initiatives

▪ Designate one or more DCHI representatives with detailed knowledge of the Scorecard to serve as practice liaisons and help address questions/concerns about the Scorecard

Questions for discussion

▪ Which of these, or other, next steps should DCHI take to raise awareness of the variation in quality of care and engage primary care practices with DCHI initiatives?

▪ What privacy concerns might practices have with the data and how can they be mitigated?

▪ How will progress on these efforts be shared back with the Board for further discussion?
Delaware has set our sights on improving quality of care

The quality of care received by Delawareans varies widely

The quality of care delivered in Delaware can vary significantly across patients and providers. Identifying sources of high variation in quality of care can lead to opportunities for Delaware to improve quality and achieve better patient outcomes.

How did we get here?
Historically, little information has been available to providers about the quality of care patients are receiving (or not receiving). PCPs have not been meaningfully rewarded for quality. And there has been neither payment nor infrastructure to manage the care of patients outside of visits to the office.

What steps are we taking to improve the quality of care for all Delawareans?

A Common Scorecard
Single, integrated quality scorecard across payers that shows providers their performance on quality, utilization, and cost measures across their patient panels

Value-based payment
DCHI encourages Delaware’s payers and primary care providers to enter into value-based payment arrangements to reward high quality, low cost care

Transformation support
Clinical and operational change program designed to help you care for patients more effectively and to prepare you for value-based payment

Behavioral health integration
Provides practices with the support, resources, and expertise necessary to help you integrate behavioral health services into primary care

Healthy Neighborhoods
An innovative approach to population health that enables communities to design and implement locally-tailored solutions the state’s most pressing health needs

Percentage of Medicaid patients who received care consistent with guidelines

Selected quality measures from the DCHI Common Scorecard

Percentage of members with diabetes who received medical attention for nephropathy
Percentage of members 50 to 75 years of age who had appropriate screening for colorectal cancer
Percentage of women 21–64 years of age who were screened for cervical cancer
Percentage of children age 3 screened for risk of developmental, behavioral and social delays (note: potential future Scorecard measure)
Percentage of children up to date on CDC-recommended vaccinations by age two
Percentage of children age 3 to 5 who had at least one well-child visit during the year
Percentage of children age 3 to 5 who was adherent when prescribed RAS antagonists
Percentage of children age 3 who had six or more well-child visits before 15 months of age
Percentage of adolescents who had a well-care visit with a PCP or an OB/GYN within the year
Percentage of children age 3 to 5 who was adherent when prescribed RAS antagonists
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Percentage of members 50 to 75 years of age who had appropriate screening for colorectal cancer
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Percentage of children age 3 who was adherent when prescribed RAS antagonists
Percentage of children who had six or more well-child visits before 15 months of age
Percentage of members 50 to 75 years of age who had appropriate screening for colorectal cancer
Percentage of adolescents who had a well-care visit with a PCP or an OB/GYN within the year
Percentage of children age 3 screened for risk of developmental, behavioral and social delays (note: potential future Scorecard measure)

Each dot represents the performance of a single Delaware primary care practice

Data includes Medicaid patients only, from Q1-Q4 2016; Does not include full claims run-out for 2016; excludes practices with >30 patients in the measure denominator

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PRELIMINARY PREDECISIONAL WORKING DOCUMENT: SUBJECT TO CHANGE

PROPRIETARY AND CONFIDENTIAL
### Background on the Common Scorecard (1/2)

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data source</strong></td>
<td>All <strong>Common Scorecard measures are calculated using claims data</strong>. The aspiration conveyed during measure selection was to focus on quality, utilization, and cost measures that could be captured without any additional effort.</td>
</tr>
<tr>
<td><strong>Payers</strong></td>
<td>The Scorecard contains data from three of Delaware’s major payers: Aetna, Highmark, and United. <strong>Commercial data includes Aetna and Highmark</strong>, while <strong>Medicaid data includes Highmark and United</strong>. Note: at present, Aetna data is only available for CY2015 and is excluded from analyses in these materials.</td>
</tr>
<tr>
<td><strong>Timeframes</strong></td>
<td>Analyses in these materials cover the <strong>performance period January 1, 2016 to December 31, 2016</strong>. In general, measure performance periods use a year-to-date methodology. At present, the data does not include a claims-runout period and should be treated as preliminary. The Scorecard also contains data for each quarter, and limited data for 2015.</td>
</tr>
<tr>
<td><strong>Attribution</strong></td>
<td>Patients are attributed to practices based on <strong>PCP choice, claims-based attribution, or assignment</strong>. For purposes of the Scorecard, <strong>each payer uses its own method of patient attribution</strong> to ensure patient attribution lists are accurate relative to those shared between payers and practices.</td>
</tr>
<tr>
<td><strong>Measure sources</strong></td>
<td>Of the 26 Scorecard measures, <strong>19 are based on NCQA HEDIS® definitions</strong>, <strong>4 are based on NQF-endorsed measures</strong> created by various measure stewards, <strong>2 are custom, Delaware-specific measures</strong>, and the <strong>total cost of care relies on a payer-specific methodology</strong>.</td>
</tr>
<tr>
<td><strong>Practice and PCP definitions</strong></td>
<td>The <strong>Common Scorecard contains measure data for all Delaware primary care practices</strong>, which are reflected in the analyses in these materials. Individual primary care practitioners and their attributed members are included in the Common Scorecard if the practitioner is of a specific primary care specialty type (see appendix for complete list).</td>
</tr>
</tbody>
</table>
## Background on the Common Scorecard (2/2)

<table>
<thead>
<tr>
<th></th>
<th>Commercial</th>
<th>Medicaid</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total attributed members</strong></td>
<td>196,676</td>
<td>140,804</td>
<td>337,480</td>
</tr>
<tr>
<td><strong>Attributed members by age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18</td>
<td>44,662</td>
<td>70,165</td>
<td>114,827</td>
</tr>
<tr>
<td>Age 18-64</td>
<td>116,177</td>
<td>69,550</td>
<td>185,727</td>
</tr>
<tr>
<td>Over 65</td>
<td>35,837</td>
<td>1,089</td>
<td>36,926</td>
</tr>
<tr>
<td><strong>Total practices</strong></td>
<td>280</td>
<td>298</td>
<td>361</td>
</tr>
<tr>
<td><strong>Number of individual PCPs</strong></td>
<td>916</td>
<td>909</td>
<td>1,178</td>
</tr>
<tr>
<td><strong>PCPs per practice (average)</strong></td>
<td>3.7</td>
<td>3.6</td>
<td>4.2¹</td>
</tr>
</tbody>
</table>

¹ Higher average for total indicates there are PCPs who have attributed members exclusively within a single insurance segment, leading to a higher average when commercial and Medicaid are combined.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes: Medical attention for nephropathy</td>
<td>Patients with completed nephropathy screening test (urine microalbumin) or documentation of evidence of nephropathy (ESRD, ARB/ACEI, visit with specialist, kidney transplant, positive macroalbumin)</td>
<td>Patients (18-75 years) with DM type 1 or 2 (defined by 2 outpatient, 1 hospital or a medication event associated with a diagnosis of DM)</td>
<td>▪ None</td>
<td>HEDIS</td>
</tr>
<tr>
<td>Medication adherence in diabetes</td>
<td>Patients adherent to diabetic medication (proportion of days covered &gt;80%)</td>
<td>Patients (18+ years) who filled at least 2 prescriptions for diabetic medications (e.g., sulfonylureas, metformin)</td>
<td>▪ One or more prescriptions filled for insulin</td>
<td>NQF: 0541</td>
</tr>
<tr>
<td>Medication adherence in high blood pressure: RASAs</td>
<td>Patients adherent to renin angiotensin system antagonists (proportion of days covered &gt;80%)</td>
<td>Patients (18+ years) who filled at least 2 prescriptions for renin angiotensin system antagonists on different dates during the reporting period</td>
<td>▪ None</td>
<td>NQF: 0541</td>
</tr>
<tr>
<td>Adherence to statins in cardiovascular disease</td>
<td>Patients adherent to statin therapy (proportion of days covered &gt;80%) based on fill dates and days supply</td>
<td>Males (21-75 years) and females (40-75 years) with cardiovascular disease and at least one medication dispensing event</td>
<td>▪ Pregnancy, cirrhosis, IVF, ESRD, muscular pain and disease, or use of clomiphene</td>
<td>HEDIS</td>
</tr>
<tr>
<td>Medication management for people with asthma</td>
<td>Patients who are adherent to controller medication (proportion of days covered &gt;50%)</td>
<td>Patients (5-64 years) with persistent asthma who had a controller medication dispensed. Persistent: ≥1 ED visit, ≥1 hospital, ≥4 medication events and 2 outpatient events, or ≥4 outpatient visits</td>
<td>▪ Emphysema, COPD, respiratory failure, CF</td>
<td>HEDIS</td>
</tr>
<tr>
<td>High risk medications in the elderly</td>
<td>Patients who received at least two prescriptions for the same high risk medication in the reporting period</td>
<td>Patients (66+ years)</td>
<td>▪ None</td>
<td>HEDIS</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>Patients who completed FOBT in the past year, flex sig. in the past 5 years, or colonoscopy in the past 10 years</td>
<td>Patients (51-75 years)</td>
<td>▪ Colorectal cancer, total colectomy</td>
<td>HEDIS</td>
</tr>
</tbody>
</table>
### Measure definitions (2/4)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cervical Cancer Screening</strong>&lt;sup&gt;8&lt;/sup&gt;</td>
<td>Patients screened with cytology every 3 years (21-64 yrs) or cytology &amp; HPV co-testing every 5 years (30-64 yrs)</td>
<td>Female patients (24-64 years)</td>
<td>▪ Absence of a cervix</td>
<td>HEDIS</td>
</tr>
<tr>
<td><strong>Breast Cancer Screening</strong>&lt;sup&gt;9&lt;/sup&gt;</td>
<td>Patients with at least one screening mammogram in the past 2 ¼ years</td>
<td>Females (52-74 years)</td>
<td>▪ Bilateral mastectomy or two unilateral mastectomies</td>
<td>HEDIS</td>
</tr>
<tr>
<td><strong>Avoidance of antibiotics in adults with acute bronchitis</strong>&lt;sup&gt;10&lt;/sup&gt;</td>
<td>Patients with no prescription for an antibiotic within 3 days of diagnosis of acute bronchitis at an outpatient or ED visit</td>
<td>Patients (18-64 years) with a diagnosis of acute bronchitis at an outpatient or ED visit</td>
<td>▪ Antibiotic received in prior 30 days or competing diagnosis (treated with antibiotics) in 30 days prior up to 7 days after</td>
<td>HEDIS</td>
</tr>
<tr>
<td>▪ Co-morbid dx (e.g., HIV, cancer)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Appropriate treatment for children with URI</strong>&lt;sup&gt;11&lt;/sup&gt;</td>
<td>Patients with no prescription for antibiotics within 3 days of diagnosis of URI</td>
<td>Patients (3 months - 18 years) with a diagnosis of URI only on ED or outpatient visit</td>
<td>▪ Antibiotic prescription within 30 days prior or competing diagnosis within 30 days prior to 3 days</td>
<td>HEDIS</td>
</tr>
<tr>
<td>▪ Competing diagnoses: conditions that are treated with antibiotics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Childhood immunization status</strong>&lt;sup&gt;12&lt;/sup&gt;</td>
<td>Patients who received 4 DtaP, 3 IPV, 3 Hib, 3 Hep B, 4 PCV, 1 VZV, 1 MMR, 1 Hep A, 2 flu, 2/3 Rota, history of disease or seropositivity</td>
<td>Patients (2 years of age)</td>
<td>▪ Contraindication to vaccine (e.g., immunosuppression, anaphylactic reaction to vaccine)</td>
<td>HEDIS</td>
</tr>
<tr>
<td><strong>HPV vaccine for adolescents</strong>&lt;sup&gt;13&lt;/sup&gt;</td>
<td>Male and female patients who received three HPV vaccinations by age 13 years</td>
<td>Patients (13 years of age)</td>
<td>▪ Anaphylactic reaction to the vaccine or components</td>
<td>HEDIS</td>
</tr>
</tbody>
</table>
## Measure definitions (3/4)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adolescent well-care visits</strong></td>
<td>Patients with a well visit completed during the reporting period</td>
<td>Patients (12-21 years)</td>
<td>▪ None</td>
<td>HEDIS</td>
</tr>
<tr>
<td><strong>WCC: 0-15 months</strong></td>
<td>Children with six or more well visits completed</td>
<td>Patients who turn 15 months during the reporting period</td>
<td>▪ None</td>
<td>HEDIS</td>
</tr>
<tr>
<td><strong>WCC: 3-6 years</strong></td>
<td>Children with at least one well visit completed during the reporting period</td>
<td>Patients (3-6 years)</td>
<td>▪ None</td>
<td>HEDIS</td>
</tr>
<tr>
<td><strong>Plan all-cause readmissions</strong></td>
<td>Number of acute inpatient stays followed by an unplanned acute readmission within 30 days</td>
<td>Discharges in patients 18+ years from an index hospital discharge</td>
<td>▪ Planned readmission (e.g., chemo, rehab, procedures) ▪ Pregnancy, death</td>
<td>HEDIS</td>
</tr>
<tr>
<td><strong>Inpatient utilization</strong></td>
<td>Number of inpatient hospitalizations (maternity, surgery, medicine MS-DRGs)</td>
<td>Member months</td>
<td>▪ mental health, chemical dependency, newborn care</td>
<td>HEDIS</td>
</tr>
<tr>
<td><strong>ED utilization</strong></td>
<td>Number of emergency department visits that don’t result in an inpatient hospitalization</td>
<td>Member months</td>
<td>▪ Mental health, chemical dependency</td>
<td>HEDIS</td>
</tr>
<tr>
<td><strong>Total Cost of Care per patient</strong></td>
<td>Payer defined (e.g., pharmacy claims + medical claims; risk adjusted)</td>
<td>Member months</td>
<td>▪ None</td>
<td>Payer specific</td>
</tr>
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</table>

**Quality measures (cont’d)**
## Measure definitions (4/4)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes: HbA1c control</strong></td>
<td>Patients with most recent HbA1c ≤ 9% CPTII: 3045F (HbA1c 7-9%), 3044F (HbA1c&lt;7%)</td>
<td>Patients (18-75 years) with DM type 1 or 2 (defined by 2 outpt, 1 hosp or med associated with DM)</td>
<td>GDM, PCOS, steroid-induced diabetes</td>
<td>HEDIS</td>
</tr>
<tr>
<td><strong>BMI assessment</strong></td>
<td>Patients with a BMI completed in the past two years ICD-9: v85.x; ICD-10 z68.x</td>
<td>Patients (18-74 years) with an encounter in the past 2 years</td>
<td>Pregnancy</td>
<td>HEDIS</td>
</tr>
<tr>
<td><strong>Screening and follow-up for clinical depression</strong></td>
<td>Patients screened for depression with a standard tool and follow-up documented if positive G8431 (+ screen, + follow-up), G8510 (- depression screen)</td>
<td>Patients (12+ years) with an encounter in the reporting period</td>
<td>Pt refuses, urgent situation, patient’s motivation to improve may impact results (court appointed), currently diagnosed with depression</td>
<td>NQF: 0418</td>
</tr>
<tr>
<td><strong>Developmental screening</strong></td>
<td>Patients with a standard developmental tool CPT-I: 96110</td>
<td>Patients (1-3 years) old during the reporting period</td>
<td>Contraindication to vaccine (e.g., immunosuppression, anaphylactic reaction to vaccine)</td>
<td>NQF: 1448</td>
</tr>
<tr>
<td><strong>Fluoride varnish</strong></td>
<td>Patients who received a fluoride varnish application in the reporting period CPT-I: 99188</td>
<td>Patients (6 months to 4 years) with Medicaid insurance and a well child encounter in the past year</td>
<td>None</td>
<td>Delaware custom measure</td>
</tr>
<tr>
<td><strong>Follow-up within 7 days after hospital discharge</strong></td>
<td>Patients with a face to face, outpatient encounter with a health care provider within 7 days</td>
<td>Patients (18+ years) hospitalized with a primary diagnosis of COPD, CHF, pneumonia, ischemic vascular disease</td>
<td>Surgical procedures, Delivery, Discharges to acute care facility, Readmissions</td>
<td>Delaware custom measure</td>
</tr>
</tbody>
</table>
## Common Scorecard primary care practitioner definition

<table>
<thead>
<tr>
<th>Taxonomy code</th>
<th>Specialty type</th>
<th>Provider specialty group</th>
</tr>
</thead>
<tbody>
<tr>
<td>207Q00000X</td>
<td>Family Medicine</td>
<td>Allopathic &amp; Osteopathic Physicians</td>
</tr>
<tr>
<td>207QA00000X</td>
<td>Adolescent Medicine</td>
<td>Allopathic &amp; Osteopathic Physicians</td>
</tr>
<tr>
<td>207QA0505X</td>
<td>Adult Medicine</td>
<td>Allopathic &amp; Osteopathic Physicians</td>
</tr>
<tr>
<td>208D00000X</td>
<td>General Practice</td>
<td>Allopathic &amp; Osteopathic Physicians</td>
</tr>
<tr>
<td>207R00000X</td>
<td>Internal Medicine</td>
<td>Allopathic &amp; Osteopathic Physicians</td>
</tr>
<tr>
<td>207RA00000X</td>
<td>Adolescent Medicine</td>
<td>Allopathic &amp; Osteopathic Physicians</td>
</tr>
<tr>
<td>208000000X</td>
<td>Pediatrics</td>
<td>Allopathic &amp; Osteopathic Physicians</td>
</tr>
<tr>
<td>2080A00000X</td>
<td>Adolescent Medicine</td>
<td>Allopathic &amp; Osteopathic Physicians</td>
</tr>
<tr>
<td>363L00000X</td>
<td>Nurse Practitioner</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers</td>
</tr>
<tr>
<td>363LA2200X</td>
<td>Adult Health</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers</td>
</tr>
<tr>
<td>363LC1500X</td>
<td>Community Health</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers</td>
</tr>
<tr>
<td>363LF00000X</td>
<td>Family</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers</td>
</tr>
<tr>
<td>363LP0200X</td>
<td>Pediatrics</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers</td>
</tr>
<tr>
<td>363LP2300X</td>
<td>Primary Care</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers</td>
</tr>
<tr>
<td>363LW0102X</td>
<td>Women’s Health</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers</td>
</tr>
<tr>
<td>363A00000X</td>
<td>Physician Assistant</td>
<td>Physician Assistants &amp; Advanced Practice Nursing Providers</td>
</tr>
</tbody>
</table>