Healthier WASHINGTON

Washington State SIM Operational Plan

Round 2 Model Test Awardee – Submitted December 1, 2015
Plan is a draft document until approved by Centers for Medicare and Medicaid Services

Reviewed edition 12.16.15

The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Contents

A. Project Summary

1. Healthier Washington: Planning Year Progress and the Path Forward

During the first year of Washington's State Innovation Models grant, the Health Care Authority (HCA) and our partners focused intensely on collaborative planning and development. As a result, we are poised to move to transformational action in years two through four of the grant.

During this planning year, our focus included:

Supporting Accountable Communities of Health (ACHs)

We know the best way to improve health is by focusing our efforts in the places where people live, work, and play. The nine regional ACHs are a key driver of health system transformation. They bring together public and private community partners to tackle shared regional health goals and harness the collective impact of clinical delivery, community services, social services, and public health.

Key accomplishments in 2015:

- In July, HCA officially designated four ACHs: North Sound, King, Cascade Pacific Action Alliance and Better Health Together. The remaining five are working toward designation with support and technical assistance from HCA.
- The ACHs have already begun partnering with the State to inform the development of other Healthier Washington investments, such as data analytics and practice transformation support.

Building payment reform test models

Washington is testing four payment reform models as part of our vision of achieving value-based purchasing. We aim to move 80 percent of State-financed health care and 50 percent of the commercial market from volume to value by 2019. Preparing the four test models has required intensive partnering and a willingness to move beyond "business as usual" when it comes to purchasing.

Key accomplishments in 2015:

- **Model 1-Early Adopter of Medicaid Integration** tests integration of behavioral and physical health services into a seamless delivery and payment system. Beginning with the Southwest Washington region in 2016, we are fully integrating physical and behavioral health services for our Medicaid (Apple Health) population into managed care contracts, with a separate contract for delivery of payer-blind crisis services to the region's entire population. By 2020, Apple Health clients across the state will be served in this fully integrated manner that will provide better whole-person care.
- **Model 2-Encounter-based to Value-based** tests whether we can move away from the traditional cost-based reimbursement system for federally qualified health centers and rural health clinics to a simpler, less burdensome, population-based approach. HCA has identified an apparently successful bidder to provide technical assistance as we and partners explore a new payment model in 2016. Also in Model 2, we are seeking a new facility type designation that will allow

critical access hospitals to continue serving as the acute and primary care backbone for rural communities. More than 10 critical access hospitals have submitted letters of intent to collaborate in developing this new approach, and HCA has engaged the Washington State Hospital Association to facilitate high-level model design.

- **Model 3-Accountable Care Program and Multi-Purchaser** tests accountable care delivery and payment strategies for public employees for whom HCA purchases care. Beginning with a five-county region in 2016, we are offering UMP Plus, a new product with a unique benefit design that promotes lower costs and high-quality member experience. The two accountable care plans—Puget Sound High Value Network and the UW Medicine Accountable Care Network — are risk-based contracts with stipulations to meet performance measures and use evidence-based practices.
- **Model 4-Greater Washington Multi-Payer** will test a data platform that integrates data across multiple payers and delivery systems, allowing providers to improve care coordination and population health management. HCA and partners continue to explore the structure and design of this model.

Shaping the Practice Transformation Support Hub

The Practice Transformation Support Hub will support primary and behavioral health providers as they integrate care, adopt value-based payment systems, and link with community-based services to strengthen whole-person care. The Hub team is housed at the Washington State Department of Health (DOH).

Key accomplishments in 2015:

- The Hub team completed an environmental scan, including a 14-stop listening tour, site visits, and key informant interviews. This intentional engagement yielded important information that is shaping the Hub plan.
- DOH and partners have begun work to plan the suite of practice transformation activities and supports, to include online tools as well as an extension program that offers coaching, learning communities, and technical assistance.

Creating a plan for improving population health

The Plan for Improving Population Health (P4IPH) moves our state's prevention framework—which prioritizes prevention and management of chronic disease and behavioral health issues, while addressing root causes—from "what" to "how." The plan will align population health efforts across State agencies, and provide the language for public and private partners to speak about and take action on population health.

Key accomplishments in 2015:

- The DOH P4IPH team is fully staffed as of October 2015.
- The team has convened an interagency advisory group and an external advisory board.

Exploring ways to strengthen workforce capacity

Healthier Washington aims to ensure the right people are delivering the right health care services. This includes those outside traditional health care services.

Key accomplishments in 2015:

- The HCA and its partners convened a Community Health Worker task force to develop recommendations around attributes, roles, and skills of those who do community health work, and how they can be included in the transformed delivery system. The task force includes community health workers, health plans, employers, educators and others. The task force will deliver a set of actionable recommendations by December 2015.

Investing in data analytics and visualization

The Analytics, Interoperability and Measurement (AIM) portion of Healthier Washington will help our state build our capacity to translate, analyze, and visualize data from multiple sectors.

Key accomplishments in 2015:

- The team established an information governance program to provide structures, policies, procedures, processes and controls to responsibly manage Healthier Washington data and information.
- An interim vendor was selected to build a Healthier Washington dashboard reporting tool.

Establishing a strong, collaborative governance structure

No one entity or agency "owns" Healthier Washington. It is by design a collaborative effort that involves multiple partners at the state, regional and community levels. The Healthier Washington initiative includes a strong governance structure that facilitates collaborative engagement across state agencies and geographic areas.

Key accomplishments in 2015:

- The HCA launched the public-private Health Innovation Leadership Network (HILN)—a group of providers, business leaders, philanthropists, tribal entities, health plans and others—to champion the goals of Healthier Washington. HILN has met three times, focusing on Healthier Washington activities as well as broader conversations around social determinants of health including housing and education.
- A group of five HILN accelerator committees are forming, focusing on specific and timely efforts to accelerate the goals of Healthier Washington—not to simply advise on policy and operational components of the initiative. Those committees are focused on: clinical engagement; equity; integrated care; rural health innovation; and collective responsibility.

Looking ahead

Moving into test year two, Washington's transformation efforts will shift from planning and design into full-scale implementation. For example:

- All Accountable Communities of Health will be designated and testing the most effective structures through a "Triple Aim" approach to achieve healthier populations.
- Payment model tests 1 and 3 will launch, and we will build relationships and set the groundwork for action in models 2 and 4.
- The Plan for Improving Population Health will be completed, to include population health measures that align with the statewide common measure set.
- We will launch a web-based clearinghouse of curated resources for the Practice Transformation Support Hub, and engage the extension agents.
- The development of more robust state data and analytic capacity will begin in earnest, with the procurement of significant tools and services under AIM.
- The HILN accelerator committees will begin their efforts in earnest.

Moving from planning to action will no doubt provide challenges and learning opportunities. Most of all, it will build on our growing momentum toward our goal of a Healthier Washington.

2. Driver Diagram

Table 1: Driver Diagram for Washington State Innovation Model Evaluation

Aims: What are you trying to improve, by how much, and by when?	**Primary Drivers**: What are the major categories of effort that will help achieve the aim(s)?	**Secondary Drivers**: What specific activities will be undertaken to help achieve the primary driver?	**Metrics**: What data will be used to track progress (how much and by when)?	**Measureable Outcomes:** Outcomes measures linked to aims (aligned with Results Washington and State Common Measure Set)
(1) Build healthy communities and people through prevention and early mitigation of disease throughout the life course **Goal:** By 2019, 90% of Washington residents and their communities will be healthier	**Accountable Communities of Health**			Behavioral Health: percent of adults reporting 14 or more days of poor mental health Plan readmission rate by all-causes Psychiatric hospitalization readmission rate Potentially avoidable emergency department visits Adult access to preventive/ ambulatory health services Child and adolescents' access to primary care practitioners Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) Childhood immunization
	Governance, structure and capacity: Define the vision and build the foundation for ACH collaborative efforts in each region	• Develop leadership and governance structures; • Strengthen stakeholder representation and engagement; • Plan for sustainability and local investment; • Build data capacity; • Continue community engagement	**Operational capacity measures:** Extent of common agenda; effective ACH governance and decision-making structures in place; appropriate people at the table; role of the "backbone" organization is clear and effective; sustainability plan in place; consistent and effective communication within ACH	
	Collaborative health	• Develop a regional health needs inventory	**Intermediate:** Project-specific	

(2) Integrate care and social supports for individuals with physical and behavioral comorbidities **Goal:** By 2019, all with physical and behavioral (mental health/substance abuse) comorbidities will receive high quality care (3) Pay for value, instead of volume, with the state leading by example as "first mover" **Interim Goal:** By 2019, Washington will drive away from Fee For Service and 80% of state-financed health care and 50% of commercial health care will be in value-based payments. **Goal:** By 2019, Washington's annual health care cost growth will be 2% less than the national health expenditure trend	**improvement activities:** Develop and strengthen regional partnerships so that collaboration can lead to complementary and collective health improvement activities	and a regional health improvement plan, • Align on a key set of health improvement priorities informed by regional data • Facilitate alignment on complementary health improvement activities • Develop and implement collective ACH projects that are community driven • Engage and grow collaboration needed to support regional efforts	process and outcome measures tailored to measure ACH's individual projects **Long term:** Each ACH selects measures from a subset of the official Healthier Washington Common Measure Set aligned with its project-specific goals, which may include: -Child/adolescent health - Adult primary/preventive care - Adult behavioral health - Adult emergency visits and readmissions - Health care costs	status Patient experience: provider communication (CG-CAHPS) Patient Experience: communication about medications and discharge instructions (HCAHPS) Well-child visits (two rates) Annual per-capita state-purchased health care spending growth relative to state GDP Medicaid spending per enrollee First trimester care Tobacco: percent of adults who smoke cigarettes Mental health treatment penetration Personal care provider (HCA CP03C) Chronic care engagement with Personal care provider (HCA CP02B)
	Participate in broader Healthier Washington activities, including delivery system transformation	• Coordinate with statewide activities of the Hub, behavioral/physical health integration; payment redesign, etc. • Advise, consult and bring regional perspective on delivery system transformation decisions and implementation	- Assess the extent to which the ACHs play an active and productive role in delivery system transformation - Specific measures to be developed once the ACH role in Healthier Washington activities is further developed	
	Practice Transformation			
	Create culture: Create a culture of quality improvement and shared learning	Create learning collaboratives	Number of practices participating	
		Develop group of peer mentors	List of peer mentors; number of mentor/mentee interactions; satisfaction with interaction	
	Understand needs: Understand the practice transformation training and	Engage stakeholders through listening sessions, site visits, key informant interviews, and surveys	Counts of sessions and number by type of stakeholders involved; summary of	

	technical assistance needs of providers to inform Hub services		results	
		Create a public/private Hub Advisory Committee	Committee charter; meeting minutes	
	Make tools and resources available: Establish online inventory of relevant high quality resources	Develop a web-based clearinghouse portal of evidence based and best practice tools, on-demand training resources, and curated resource lists	Website analytics; user satisfaction	
	Provide Services: Focusing on small and medium sized practices, provide and refer practices to training, technical assistance, and facilitation services	Engage subject matter experts to provide training and technical assistance	Number of trainings; satisfaction with trainings; changes in practice	
		Give practices hands-on coaching, technical support and assistance to implement new processes	-Number of sessions, satisfaction with sessions; changes in practice -By January 2019 connect 80% of primary care, mental health, and substance use disorder providers in small to medium practices with Hub-sponsored transformation services	
		Create network of extension center agents aligned with regional service areas	Proportion of regions with an extension center agent; satisfaction with agents; changes in practice	
	Advance physical and behavioral health integration: Focusing on small and medium sized practices, provide technical assistance and training to increase clinical physical and behavioral health integration	Develop a framework to measure the current degree of physical and behavioral health integration	Quantitative assessment of current degree of physical and behavioral health integration as baseline	
		Give practices technical support, training, and information resources to advance physical and behavioral health integration	Mixed methods assessment of degree of change in of physical and behavioral health integration; Qualitative	

			assessment of use cases, barriers, integration process, and adoption patterns for Hub resources	
	Advance clinical-community linkages: Focusing on small and medium sized practices, provide technical assistance and training to increase linkages to agencies and organizations that are working at the community level	Develop a framework to measure the current use of clinical-community linkages	Quantitative assessment of current degree of community linkages use	
		Give practices technical support, training, and information resources to increase community linkages	Mixed methods assessment of degree of change in of use of community linkages; Qualitative assessment of use cases, barriers, integration process, and adoption patterns for Hub resources	
	Advance adoption of value-based payment systems: Focusing on small and medium sized practices, provide technical assistance and training to increase adoption of value-based payment systems	Develop a framework to measure the current state of value-based payment systems	Quantitative assessment of current degree of value based payment	
		Give practices technical support, training, and information resources to increase adoption of value-based payment systems	Mixed methods assessment of degree of change in of use of value-based payment systems; Qualitative assessment of use cases, barriers, integration process, and adoption patterns for Hub resources	
	Advance shared decision making: Promote the use of shared decision making as a practice	Provide training and practice coaching opportunities on SDM implementation	Proportion of eligible practices receiving training; Mixed methods assessment of value of training	
		Promote and spread the integration of shared decision making and use of certified patient decision aids in clinical practice	Mixed methods assessment of degree of change in use of SDM; Qualitative assessment of	

			use cases, barriers, integration process, and adoption patterns for SDM	
		Develop a multi-state SDM Innovation Network	SDM Innovation Network formed	
	Support an enhanced and expanded workforce	Engage Community Health Workers	TBD based on CHW task force recommendations and further development of Sentinel Network. Could include measures of access.	
		Survey the health care industry and make targeted investments to address identified workforce needs		
	Payment Redesign			
	Payment Redesign Model Test 1 (Early Adopter: Integration of Physical and Behavioral Health Purchasing): - Integrate Medicaid purchasing of physical and behavioral health services within accountable managed care organization (MCO) - Create new internal MCO processes and structures - Improve service delivery process	**Internal MCO processes and structure:** • Identify beneficiaries with behavioral health needs and actively engage them in treatment • Build more effective referral and/or integrated systems of care at the delivery system level • Increase Washington behavioral health capacity **Service delivery process:** • Increase mental health service penetration • Increase substance use disorder service penetration • Increase primary care access	**Health care use and costs:** • Alcohol or Drug Treatment Retention • Alcohol/Drug Treatment Penetration • Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia • Childhood Immunization Status • Comprehensive Diabetes Care • First Trimester Care • Mental Health Treatment Penetration • Plan All-Cause Readmission Rate • Psychiatric Hospitalization Readmission Rate • Well Child Visits	

	Payment Redesign Model Test 2 (Encounter-Based to Value-Based): The state will introduce a value-based alternative payment methodology in Medicaid for FQHCs and RHCs and pursue flexibility in delivery and financial incentives for participating CAHs. The model will test how increased financial flexibility can support promising models that expand care delivery options such as email, telemedicine, group visits and expanded care teams.	**Model participation:** -Population covered by payment model type (i.e., FFS not linked to quality, payment linked to quality, alternative payment method, population-based payment) -Providers participating by model type • -Payers participating by model type	**Cost:** Total cost of care per member per month (PMPM) **Utilization:** ED visits and plan all-cause readmissions **Quality:** subset of HEDIS clinical quality metrics and patient experience metrics (e.g., HCAHPS publicly reported hospital-based surveys[1]) **Population health:** -Screening for clinical depression -Blood pressure control - BMI screening and follow-up	
	Primary Drivers: **Payment Redesign Model Test 3 (Accountable Care Program):** -One new payment model available to PEBB members in Puget Sound starting in January 2016	**Secondary Drivers** -Invest in infrastructure to advance primary care medical home (PCMH) standards across all network partners to NCQA Level III standards (or equivalent) - Adopt clinical policies of HCA and state coverage decisions of Washington State Technology Clinical Committee	**Metrics**: **19 quality metrics from the HCA's own QI model** (a subset of the Washington Statewide Common Measure Set) in the following categories: - Chronic conditions	

[1] See the following reference for HCAHPS: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html

	- Intent is to offer to offer ACPs statewide in 2017 - Two ACPs are available in 2016: Puget Sound High Value Network LLC and (led by Virginia Mason Medical Center) and UW Medicine Accountable Care Network ACP contracts will incorporate four major transformation components: - Coordinating and standardizing care - Improving member access and experience - Integrating the financial and quality improvement model - Providing timely, relevant, and actionable data to help providers manage PEBB members and keep them healthy Expand ACP offering statewide in 2017 Multi-Purchaser Initiative to spread and scale Model 3 - Convene with key partners a statewide purchasers' pay-for-value dialogue	- Adopt certified HIT infrastructure to participate in Washington State Health Information Exchange (HIE) - Develop quality improvement plans including Bree recommendations for specific high cost, high use, and high variation procedures[2] - Conduct biennial RFI to determine the speed of adoption of value-based payments in the Washington State marketplace - ACP performance tracking and quarterly reporting and communication to Washington public and private purchasers to create statewide momentum - 1:1 meetings with private and public purchasers to educate them on the importance of value-based purchasing, explore joining PEB's ACP (private purchasers), and share CP contract language for use in contracts -Convene PAG Plus group (senior leaders of Washington Health Alliance PAG plus other large employers in Washington) -Co-convene purchaser conference with King County, Washington Health Alliance, and the Washington Roundtable annually	- Behavioral health management - PEBB member experience - Medical screenings and immunizations - Obstetrical care Total cost of care (PMPM) Movement away from Fee For Service and Adoption of Value-based Payments (state-financed and commercial health care) (achieving 80% state-financed and 50% commercial health care by 2019) Public and private purchasers include Model 3 components (QIM, care transformation strategies, financial approach) into their contracts Other Public Purchasers have the option of joining PEBB and gaining direct access to Model 3 options	

[2] From Healthier Washington Fact Sheet (Accessed August 20, 2015): http://www.hca.wa.gov/hw/Documents/acpfactsheet.pdf
Procedures include: Care coordination for high-risk members, potentially avoidable hospital readmissions, obstetrics, total knee and hip replacement surgery bundles, spinal fusion bundle, cardiology, low back pain, end of life care, and addiction and substance dependence treatment.

	and call-to-action			
	Payment Redesign Model Test 4 (Greater Washington Multi-Payer Data Aggregation Solution): - Secure Lead organization (LO) – LO will convene payers and providers to advance an integrated multi-payer data aggregation solution and increase adoption of value-based payment strategies - Align the data aggregation solution with principles of clinical and financial accountability (from Model 3), centered on the Washington Statewide Common Measure Set - Leverage and expand existing data aggregation solution that includes at least one or more payers and/or provider group - Provide resources and state-purchased health care data to accelerate building of a common infrastructure of integrated claims-based and clinical data	-Scale and spread data aggregation solution for multiple purchasers - Deploy the solution to provide aggregated data for multiple payers, including state-purchased programs and commercially insured covered lives - Provide integrated financial (claims-based) and clinical (EMR-based) data to providers, including medical and pharmacy data) - Provide data to health plans, primary care provider groups, and hospitals that aligns with the Washington Statewide Common Measure Set	Implementation measures: - Payer/provider commitments and readiness to incorporate ≥ 25 K enrollees from state-purchased programs and ≥ 25 K commercially insured by year 1 (2016), expanding significantly, including Medicare enrollees, by years 2 and 3 (2017 and 2018) - All partners of LO to adopt value based purchasing (VBP) for 80% of covered lives by end of year 3 (Jan 31, 2019) Process/Outcomes: Performance on the Statewide Common Measure Set (52 measures[3]): -Population health (5 measures) -Clinical processes or outcomes for health plans only (4 measures for children and adolescents; 9 for adults); primary care medical groups (4 measures for children and adolescents; 17 for adults; 10 for hospitals) - Cost of care (3 measures)	

[3] http://www.hca.wa.gov/hw/Documents/pmcc_final_core_measure_set_approved_121714.pdf

3. Core Progress Metrics and Accountability Targets

Healthier Washington's Portfolio of Reporting Metrics, Appendix A, captures model participation and core outcomes metrics with accountability targets. This portfolio of metrics will assist in tracking progress toward SIM goals, identify trends in progress, and identify gaps and barriers to implementation over the three-year test.

The model participation metrics are intended to capture data on the participation of providers and provider organizations in SIM as well as the number of beneficiaries impacted. Through the SIM grant, we are testing four payment models. Model participation metrics will be reported quarterly by individual payment model, in addition to an aggregated total, demonstrating progress and adoption of value-based payment strategies by providers, provider organizations, and beneficiaries impacted. All model participation metrics were defined by the CMMI SIM program. Information captured by each model participation metric, by individual payment test model, is as follows:

- Metric Area
- Metric Title
- Metric Definition/Description
- Numerator Definition
- Denominator Definition
- Notes
- Payment Taxonomy (category 2-4)
- Baseline Value
- Accountability Target

Payment taxonomy was categorized by the guidance outlined by CMMI:

- Category 1: Fee for Service-No Link to Quality
- Category 2: Fee for Service-Link to Quality
- Category 3: Alternative Payment Models on Fee-for Service Architecture
- Category 4: Population-Based Payment

The model participation metrics will allow us to better identify, track and understand provider, beneficiary and payer participation.

The outcomes metrics identify and detail the specific quarterly performance metrics intended to capture data on quality, cost, utilization, and population health. The cross-system measures were selected for their ability to demonstrate performance across all SIM investment areas. While CMMI provided a set of recommended metrics, as permissible we elected to select alternative metrics that better reflect the demographics, needs, and priorities of Washington State. The following information will be collected and reported annually for each performance metric:

- Metric area
- Metric title
- Metric definition/description

- Numerator definition
- Denominator definition
- NQF Number, if applicable
- Alignment to other CMS Programs
- Baseline value
- Accountability target

4. Master Timeline for SIM Model

The following timeline is aligned with the Operational Plan's SIM Component Summary Tables, in section B below. As with the Component Summary Tables, the master timeline provides detailed milestones for grant year 2016, with high-level milestones for future years.

SIM Component/Project Implementation Gantt Chart (Year 1)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Provide ACH Development and Implement Technical Assistance	Accountable Communities of Health													2016 Q1-Q2: Priority technical assistance topics identified 2016 Q3-Q4: Summits hosted and adjustments to TA materials and guidance.
Governance/ Structure: Develop and Sustain ACH Infrastructure	Accountable Communities of Health													2016 Q1-Q2: ACHs confirm the lead organization/define shared functions. 2016 Q3-Q4: ACHs have completed a backbone evaluation/survey in alignment with state guidance. 2017 Q1-Q4: ACHs implement improvement strategies; infrastructure sustainability planning options outlined.
Governance/ Structure: Develop ACH Governance and Engagement Structures and Strategies	Accountable Communities of Health													2016 Q1-Q2: ACHs identify gaps and opportunities based on state guidance. 2016 Q3-Q4: ACHs implement necessary adjustments based on identified gaps.
Regional Health Improvement/Delivery System Transformation: ACH Project Implementation	Accountable Communities of Health													2016 Q1-Q2: ACHs finalize a 2016 Regional Health Needs. 2016 Q3-Q4: All ACHs have implemented the first phase of a project, identified measures and established mechanisms to track progress.
Provide Technical Assistance to ensure effective tribal and urban consultation, engagement, and coordination	Accountable Communities of Health													2016 Q1-Q2: Provide assistance with tribal engagement and communication. 2016 Q3-Q4: Analyze survey and develop recommendations. 2017 Q1-Q4: Implement recommendations
Maintain a strong governance and expert advisory function	Plan for Improving Population Health													2016 Q1: External Advisory Board formed. 2016 Q2: Assess and Inventory current and related initiatives. 2016 Q2: Stakeholder Listening Sessions.
Implementation Plan and the Guide / Toolkit (process tools for facilitating evidence-based	Plan for Improving Population Health													2016 Q1: Define the plan elements, timelines and expectations 2016 Q3: Package of change interventions that can be implemented to improve population health

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interventions)														
Sustainability Plan	Plan for Improving Population Health													2016 Q3: Sustainability Plan, funding and resources are identified to implement plan, continuous improvement of the guide
Development of an innovative model to certify Patient Decision Aids in Washington that builds on key legislation and can be spread to other states	Shared Decision Making													2016 Q1-Q2: Certification process has been approved, tested, and finalized and staffing is in place 2016 Q2-Q4: Accountable Care Programs have begun to use certified decision aids
Development of Rulemaking Process that builds on key legislation that supports the spread of shared decision making	Shared Decision Making													2016 Q1-Q2: Final approval and implementation of Washington certification process
Train Providers on Shared Decision Making Strategies 101	Shared Decision Making													2016 Q1: Initial master training conducted to ensure spread across state 2016 Q2 - Q4: Participants of master training have conducted and least two additional trainings
Provide practice coaching opportunities to assist providers engaged in payment model tests to implement shared decision making, including use of certified patient decision aids	Shared Decision Making													2016 Q2: Implement vendor contract to provide practice coaching 2016 Q3- Q4: Provide training/coaching to at least 10% of eligible practices
Develop a plan to promote and spread the integration of shared decision making and use of certified patient decision aids in clinical practice	Shared Decision Making													Q1 - Develop a draft and a final implementation plan

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		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Certification of Decision Aids to Support Maternity Aids	Shared Decision Making													Q1 - Q3: Complete two rounds of review and certification of maternity care decision aids
Certification of Decision Aids to Support Joint Replacement/Spine Care Aids	Shared Decision Making													2016 Q3- Q4: One round of review and certification of joint replacement/spine care decision aids 2017 Q1- Q2: Two rounds of review and certification of joint replacement/spine care decision aids
Certification of Decision Aids to Support Cardiac/End of Life Care Aids	Shared Decision Making													2017 Q3- Q4: One round of review and certification of cardiac and end of life care decision aids 2018 Q1- Q2: Two rounds of review and certification of cardiac and end of life care decision aids
Negotiate discounts and/or scholarships for certified decision aid licenses for use by providers engaged in Healthier Washington payment model tests, to integrate into clinical practice.	Shared Decision Making													2016 Q3- Q4: Negotiate discounts/scholarships for at least one certified decision aid 2017 Q1- Q2: Negotiate discounts/scholarships for at least two certified decision aids
Develop Benefit design/payment incentive structure to provide positive incentives for SDM adoption/use.	Shared Decision Making													2017 Q1 - Q4: Monitor ACP contractual requirements to implement SDM strategies and use of certified decision aids into their health systems 2017 Q1 - Q4: Engage payers in discussions about incorporating SDM methodologies into payment system to provide incentives to providers and members.
Develop a multi-state SDM Innovation Network	Shared Decision Making													2016 Q1 - Q2: Engage national partner to co-sponsor multi-state SDM Innovation Network 2016 Q3 - Q4: Identify and engage states developing and/or implementing innovative
Analysis of development and testing process for Decision Aid Certification, including a summary of findings, successes, lessons learned, etc. to share with other states considering developing a certification	Shared Decision Making													2016 Q1 - Q2: Track process, lessons learned, successes, barriers, resources needed to sustain certification process 2016 Q3 - Q4: Write up and publish summary of findings

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		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
process.														
Annual follow-up on CHW Taskforce actionable policy recommendations	Workforce													TBD based on final Task Force recommendations – Q4 2015
Industry Sentinel Network: web portal survey, collect, analyze and disseminate workforce trends to educational teams/boards.	Workforce													2016 Q1-Q2: Survey questions vetted and established. Portal Established 2016 Q3-Q4 initial survey conducted analysis conducted and results disseminated
Workforce investments identified based on data	Workforce													2017 Q1 Workforce investments identified in response to data 2018 Q1 Workforce investments identified in response to data
Procure managed care organizations providing fully-integrated services and operationalize transition to full-integration.	Payment Model 1, Early Adopter Program													2016 Q2: At least 2 fully-integrated MCOs pass readiness review.
Modify information systems to support fully-integrated managed care and new behavioral health services only benefits.	Payment Model 1, Early Adopter Program													2016 Q1: ProviderOne system changes tested and live (HCA); Healthplanfinder (HPF) system changes tested and live (HBE). 2016 Q2: New behavioral health data reporting system tested and live (DSHS).
Obtain federal/state regulatory approval	Payment Model 1, Early Adopter Program													2016 Q1: CMS approves SPA and 1115(b) waiver 2016 Q2: Washington Administrative Code (WAC) amendments approved by code reviser
Develop and implement an early warning capacity to identify and resolve implementation issues rapidly	Payment Model 1, Early Adopter Program													2016 Q1: Identify early warning system metrics, establish and test process for tracking early warning system metrics and responding via triage system. 2016 Q2: Early warning/triage system implemented.

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		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Develop and implement a culturally appropriate outreach plan to Medicaid beneficiaries, to educate on upcoming Medicaid changes	Payment Model 1, Early Adopter Program													2016 Q1: Outreach plan implemented, materials distributed and public meetings underway. 2016 Q2-Q4: Continued education and outreach to ensure Medicaid populations understand the transition to fully-integrated managed care.
Educate fully-integrated managed care plans on behavioral health system and new services in preparation for transition to full-integration	Payment Model 1, Early Adopter Program													2016 Q1: Conduct facilitated trainings/education with fully-integrated MCOs, providers, and county staff to educate them on processes of current BH system. 2016 Q2-Q4: Continued education and learning opportunities for MCOs, providers and State/County staff to improve BH system
Provide technical assistance to behavioral health and physical health providers to assist in transition to fully-integrated managed care	Payment Model 1, Early Adopter Program													2016 Q1: Provide a series of trainings to physical and behavioral health providers to assist with the transition to fully-integrated managed care. 2016 Q2-Q4: Provide as-needed continued education and training
Enroll Medicaid clients in fully-integrated managed care plans	Payment Model 1, Early Adopter Program													2016 Q1: Enrollment in fully-integrated managed care plans begins February 29, 2016. 2016 Q2-onging: Same-day enrollment begins in April, 2016 and continues through duration of Contracts.
Provide practice transformation support to providers to support delivery system integration	Payment Model 1, Early Adopter Program													2016 Q1: Practice transformation resources selected available to providers by January 2016. Train providers on SBIRT.
Medicaid beneficiaries with co-occurring disorders receive care coordination through a whole-person system of care	Payment Model 1, Early Adopter Program													2016 Q2: ongoing: Enrollees with co-occurring disorders continue or begin to receive the coordinated care specified under the new fully integrated managed care contract.

SIM Component/Project Implementation Gantt Chart (Year 1)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Expand fully-integrated model to additional regional services areas	Payment Model 1, Early Adopter Program													2016 Q2: 2020 roll-out plan completed. 2016 Q3: Engage county government and other stakeholders within regional service areas in discussions around fully-integrated care model and timeline for implementation prior to 2020. 2016 Q4: Non-binding letter of intent due from mid-adopter regions in November, 2016. 2016 Q3-Q4: Continued engagement regarding the benefits of fully-integrated managed care and the implementation process. Consultant communications campaign on best practices and early successes from Early Adopter region. 2017 Q 1: Binding letter of intent from mid-adopter regions in February 2017. 2017 Q2- Q3: Conduct procurement to procure fully-integrated MCOs in mid-adopter regions. Apparently successful bidders announced in July, 2017. 2017 Q4: Conduct readiness review of fully-integrated MCOs in mid-adopter regions by December 2017. 2018: Q1: Fully-integrated coverage effective on January 1, 2018 in "mid-adopter" regions.
Consulting Support for Facilitation and APM Development	Payment Model 2, Encounter to Value Model													2016 Q1 - Q2: FQHC/RHC alternative payment methodology (APM) working session materials/facilitation. 2016 Q1 - Q2: Provide subject matter expertise to help develop and validate an APM.
State Plan Amendment: APM Development	Payment Model 2, Encounter to Value Model													2016 Q2 - Q4: Develop and submit a State Plan Amendment for value-based APM.
Pilot Implementation	Payment Model 2, Encounter to Value Model													2017 Q1: Pilot implementation for FQHC/RHC APM.

SIM Component/Project Implementation Gantt Chart (Year 1)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Stakeholder Engagement and Conceptual Model Development	Payment Model 2, Encounter to Value Model													2016 Q1 - Q4: New payment and delivery model for critical access hospitals (CAHs). 2016 Q1 - Q4: Educate and develop community support for piloting participation.
CAH Stakeholder Development of Support	Payment Model 2, Encounter to Value Model													2016 Q1 – Q4: Work plan and summary report.
State Plan Amendment: CAH Payment and Delivery Model	Payment Model 2, Encounter to Value Model													2016 Q4 – 2017 Q2: Develop and submit a State Plan Amendment for CAH payment and delivery model.
Implement Regulatory Changes: CAH Payment and Delivery	Payment Model 2, Encounter to Value Model													2016 Q2 – 2017 Q2: Develop and submit regulatory changes in partnership with DOH.
Pilot Implementation	Payment Model 2, Encounter to Value Model													2017 Q3: Pilot implementation for CAH Payment and Delivery.
External Validation	Payment Model 2, Encounter to Value Model													2016 Q2 - Q4: Work with external auditors to verify and validate new rates for payment and delivery models.
Transformation Support	Payment Model 2, Encounter to Value Model													2016 Q2 - Q3: Working at FQHC/RHC pilot site(s) to educate and support the transformation to a new model. 2017 Q1 - Q2: Working at CAH pilot site(s) to educate and support the transformation to a new model.
Provider Payment Changes	Payment Model 2, Encounter to Value Model													2016 Q1 - Q3: Identify and implement changes to internal HCA systems for facilitating new APM. 2016 Q3 – 2017 Q2: Identify and implement changes to internal HCA systems for facilitating new payment and delivery model for CAHs.

SIM Component/Project Implementation Gantt Chart (Year 1)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Statewide Adoption Planning	Payment Model 2, Encounter to Value Model													2016 Q4 - 2019 Q1: Work with HCA and FQHC/RHC Stakeholders to develop an action plan, stakeholder engagement strategy, impact report/glide path assessment, community engagement activities. 2016 Q4 - 2019 Q1: Work with HCA and CAH Stakeholders to develop an action plan, stakeholder engagement strategy, impact report/glide path assessment, community engagement activities
Enrollment/Participation in ACP options, 2016	Payment Model 3, Accountable Care Program													2015 Q4: A sufficient number of PEBB members enroll in one of the two options for January 2016 coverage 2015 Q4: Conduct survey of PEBB members who selected and didn't select new ACP options and apply learnings for 2017 enrollment strategy
Expansion of ACP options,	Payment Model 3, Accountable Care Program													2016 Q2: Signed contracts completed with new ACP partner and/or current ACP partners' expansion plans completed. 2016 Q3 - Q4: Pre-launch activities/operational tasks with new partner completed (if there are new partners)
Multi-Purchaser engagement to Spread and Scale Model 3 and VBP (activities include individual meetings with public and private purchasers, semi-annual meetings with group of selected purchasers, annual purchasers conference)	Payment Model 3, Accountable Care Program													2015 Q4: Identify, meet and present to at least 6 public or private purchasers. 2015 Q4: Governor Inslee presents 'Call to Action' to business roundtable. 2016 Q1: Issue VBP Request for Information (RFI) to survey payers and providers on VBP journey using CMS payment framework. 2016 Q1: Purchaser Conference held (cosponsored with King County, Washington Health Alliance and the Washington Roundtable); meet with at least 3 purchasers. 2016 Q2: 1st meeting with select purchasers (PAG Plus); meet with at least 3 purchasers/make presentations 2016 Q3: Meet with at least 3 purchasers/make presentations 2016 Q4: 2nd meeting with select purchasers (PAG Plus); meet with at least 3 purchasers/make presentations *Multi-purchaser activities in 2016 will be repeated annually with the same cadence and milestones.*
Lead Organization Procurement Activities	Payment Model 4, Multi-Payer Strategy													2016 Q1-Q2: Finalize and execute contract with lead organization, including work plan.

SIM Component/Project Implementation Gantt Chart (Year 1)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Manage PEBB/Medicaid data flow from state to lead organization	Payment Model 4, Multi-Payer Strategy													2016 Q3-Q4: Initial data dump complete, move toward periodic transmission
Apply Model 4 learnings into PEBB purchasing strategies	Payment Model 4, Multi-Payer Strategy													2016 Q1: Establish internal workgroup/steering committee for oversight to project manager 2016 Q2-Q3: Develop and finalize plan/recommendation for application of Model 4 and PEBB purchasing
Model 4 Evaluation Consultant	Payment Model 4, Multi-Payer Strategy													2016 Q1-Q2: Model 4 evaluation criteria established with UW team 2016 Q3-Q4: Model 4 evaluation data stream established; data collection initiated 2016 Q1-Q2: strategy for convening additional partners
Contract management	Payment Model 4, Multi-Payer Strategy													2016 Q1: Contract executed, LO performance initiated 2016 Q2-Q3: Plans for convening additional payers/providers and advancing VBP established 2016 Q3-Q4: LO plans for FY 2017 developed and presented to HCA; seek CMMI approval for contract renewal2016 Q1-Q2: Model 4 evaluation criteria established with UW team 2016 Q3-Q4: Model 4 evaluation data stream established; data collection initiated 2016 Q4: LO fulfills requirements of contract to renew for FY
Healthier Washington Dashboard Reporting Tool	Analytics, Interoperability, Measurement / Accountable Communities of Health													2016 Q1 • (1a) Data Infrastructure Design • (1b) Dashboard Reporting Tool Design • (1c) Work Plan • (1d) Data Infrastructure Build • (1e) Dashboard Reporting Tool Build • (1f) Data Validation • (2a,b,c) Select Measure Development, Validation, Filters • (2d) Initial DRT Release 2016 Q2 • (2a,b,c) Additional Measure Development, Validation, Filters • (2d) DRT Updates 2016 Q3 • (2a,b,c) Final Measure Development, Validation and Filters • (2d) DRT Updates

SIM Component/Project Implementation Gantt Chart (Year 1)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
														2016 Q4 • (2d) DRT Updates
Healthier Washington Information Governance	Analytics, Interoperability, Measurement													2016 Q1 • Healthier Washington Information Governance contract approved 2016 Q3 • Healthier Washington Information Governance Charter approved
AIM Project Quality Assurance	Analytics, Interoperability, Measurement													2016 Q1 • AIM Project Quality Management Plan • AIM Initial Quality Assessment Report 2016 Q2 • AIM Quarterly Quality Progress Report 2016 Q3 • AIM Quarterly Quality Progress Report 2016 Q4 • AIM Quarterly Quality Progress Report 2017 Q1 • AIM Quarterly Quality Progress Report
AIM BI/Analytics Platform Implementation	Analytics, Interoperability, Measurement													2016 Q1 • AIM BI/Analytics Platform Procurement Strategy and Plan approved • RFPs for AIM BI/Analytics Platform released 2016 Q2 • Apparent Successful Vendors for AIM BI/Analytics platform and Implementation Support selected • Contracts finalized for AIM BI/Analytics Platform and Implementation Support • AIM Data Acquisition Plans finalized 2016 Q3 • AIM BI/Analytics Platform Design Plans complete • AIM BI/Analytics Platform Implementation Plans finalized 2016 Q4 • AIM data source Data Use Agreements finalized 2017 Q1 • AIM BI/Analytics Platform implemented • AIM data source acquisition mechanisms (e.g., ETL) built • AIM data sources added to Healthier Washington AIM Logical Data Warehouse
Healthier Washington Evaluation Support	Analytics, Interoperability, Measurement													2016 Q1 • Assist with Healthier Washington Evaluation Plan 2016 Q2 • Refine Healthier Washington Evaluation metrics and supporting data collection plan 2016 Q4 • Evaluation data sources identified, Data Use Agreements (DUAs) in place 2017 Q1 • Evaluation data collection repositories designed, implemented and populated
BH Data Assessment	Analytics, Interoperability, Measurement													2016 Q1 • BH Data Assessment Gaps, Alternatives and Recommendation Report

SIM Component/Project Implementation Gantt Chart (Year 1)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
BH EHR Implementation	Analytics, Interoperability, Measurement													2016 Q1 Healthier Washington Leadership decision on BH EHR approach If decision to move forward with BH EHR Implementation: 2016 Q3 • BH EHR RFP Released, Vendor selected 2016 Q4 • BH EHR Contract finalized • BH EHR Implementation Project start
BHO Data Consolidation Project	Analytics, Interoperability, Measurement													2016 Q1 • BH Data Consolidation Tool Development • BH Data Consolidation Tool Testing 2016 Q2 • BH Data Consolidation Tool Release
Washington All Payer Claims Database	Analytics, Interoperability, Measurement													2016 Q1 • Vendor selected • APCD project starts 2017 Q3 • APCD released
BH EMR Implementation EMR Assessment	Analytics, Interoperability, Measurement													2016 Q1 - Q4: BH EMR Vendor Selected and Implementation Project Kick-off 2017 Q1: BH EMR Implementation complete2016 Q1 - 2017 Q1: BH EMR Gap Analysis and Alternatives Report
Evolution and evaluation of the Statewide Common Measure Set: Convening Governor-appointed Performance Measures Coordinating Committee (PMCC)	Performance Measurement Analytics, Interoperability, Measurement													2016 – 2018 - Convene the PMCC quarterly to develop and submit recommendations to HCA for annual updates to the common measure set. Q1 2019: Final Common Measure Set
Evolution and evaluation of the Statewide Common Measure Set:	Performance Measurement													2016 Q2: Identify members for up to three ad hoc workgroups 2016 Q2 - Q3: Convene ad hoc measure selection workgroups to research, review, and identify measures to

SIM Component/Project Implementation Gantt Chart (Year 1)														
SIM Component/ Project Area	**Component/ Project Lead**	**2016**				**2017**				**2018**				**Milestone(s) with Due Dates**
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
Convening ad hoc measure selection workgroups														include in Statewide Common Measure Set 2016 Q4: Convene ad hoc evaluation workgroup to review current measure set and submit any proposed changes to PMCC for consideration. Annually: Public comment survey to solicit feedback for proposed changes to Common Measure Set
Communication Campaign: Promote the spread and uptake of the common measure set.	Performance Measurement													2016 -2018: • Implement communication campaign to promote the spread and uptake of the common measures set by engaging payers, purchasers and providers • Develop and implement process to track reach of campaign
Reporting: Accelerate statewide spread of medical group level reporting	Performance Measurement													2016 Q1-Q2: Submit provider rosters for four new communities 2016 Q3-Q4: Submit provider rosters for three to four new communities Q1 2017: Roster Complete
Reporting: Produce and report results for Statewide Common Measure Set	Performance Measurement													2016-2018 - Q4: Annual public report results for Statewide Common Measure Set released, using a web-based platform, annually through 2018, (or when APCD is established and ready for reporting.)

5. Budget Summary Table

The budget summary below outlines the grant year two requested budget, outlined by investment area. Please note this budget summary table does not include the grant year one carry over request.

	Budget Category	Community Empowerment & Accountability	Practice Transformation	Payment Redesign	Analytics, Interoperability and Measurement (AIM)	Project Management	Total GY2 budget request
A.	**Personnel**	$ 341,589	$ 411,932	$ 359,708	$ 1,024,496	$ 594,487	$ 2,732,212
B.	**Fringe benefits**	$ 117,617	$ 137,767	$ 103,776	$ 282,266	$ 219,852	$ 861,278
C.	**Travel**	$ 27,947	$ 3,369	$ 12,862	$ 9,734	$ 28,331	$ 82,243
D.	**Equipment**	$ -	$ -	$ -	$ -	$ -	$ -
E.	**Supplies**	$ -	$ -	$ -	$ -	$ -	$ -
F.	**Consultant/ contractual**	$ 167,910	$ 2,424,391	$ 1,030,734	$ 853,469	$ 1,780,091	$ 6,256,595
G.	**Construction**	$ -	$ -	$ -	$ -	$ -	$ -
H.	**Other**	$ 3,061,861	$ 4,118	$ 42,169	$ -	$ 87,825	$ 3,195,972
I.	**Direct**	$ 3,773,457	$ 3,036,486	$ 1,604,040	$ 2,223,251	$ 2,491,066	$ 13,128,300
J.	**Indirect**	$ 6,426	$ 6,426	$ 6,426	$ 6,426	$ 6,426	$ 32,130
	TOTAL	$ 3,779,883	$ 3,042,912	$ 1,610,466	$ 2,229,677	$ 2,497,492	$ 13,160,430

Additionally, the state has projected a high-level budget for years three and four.

6. Total Direct Costs

Budget Category	GY1 Awarded Budget	GY2 Requested Budget	GY3 Projected Budget	GY4 Projected Budget	Total
Personnel	$2,858,745	$2,732,212	$3,082,962	$2,535,432	$11,209,351
Fringe benefits	$857,623	$861,278	$924,889	$760,630	$3,404,420
Travel	$33,145	$82,243	$44,455	$30,170	$190,012
Equipment	$1,200,000	$0	$0	$0	$1,200,000
Supplies	$324,499	$0	$42,838	$35,432	$402,769
Consultant/contracting	$9,180,000	$6,256,595	$11,658,823	$7,717,278	$34,812,696
Construction	N/A				
Other	$4,547,060	$3,195,972	$4,305,895	$1,517,174	$13,566,101
Total direct costs	$19,001,072	$13,128,300	$20,059,862	$12,596,115	$64,785,349

B. Detailed SIM Operational Plan

Community Empowerment and Accountability

Healthier Washington recognizes and leverages pockets of innovation and collaboration already occurring in local communities by bringing public and private entities together to work on shared health goals. This collaboration is replicated and scaled through nine regional Accountable Communities of Health (ACHs). Through these diverse multi-sector partnerships, ACHs are an integral part of all strategies under the Healthier Washington initiative. Specifically, ACHs are:

- Bringing together diverse public and private community partners to work on shared regional health goals.
- Identifying opportunities for the ACH and community partners to understand and bridge health and quality of life issues.
- Coordinating systems so that services address all aspects of health at both the community and individual level.
- Partnering with the state to inform the development of other Healthier Washington investments, recognizing ACHs are the connection to communities and the local conduit to achieve systems change.

The component summary for the ACH initiative represents Washington's path forward for the duration of the SIM grant, including strategic adjustments to the funding model and areas of focus over the next three years. The state recognizes ACHs must be supported as system integrators, not solely project implementers. Achieving better health, better care and reduced costs requires investing in local solutions to complex problems that cut across delivery systems, social supports and community environments.

Under the collective impact framework, the backbone organization provides the administrative support and functions as the leader by convening, facilitating, coordinating and guiding the processes and structures within the ACH. These functions must be adequately supported in order for the ACH to be effective. The learnings of the 2015 design year led to the conclusion that backbone functions need to be the primary SIM investment under the ACH initiative.

To reflect these learnings, the state will leverage SIM funding to provide ACHs with the flexibility to sustain the necessary backbone infrastructure over the remainder of the grant. This includes empowering communities to identify the path toward sustainability, for example, how to phase-down SIM funding levels.

In addition to the regional sub-awards provided to the ACHs, the components summary reinforces the need to provide technical assistance as an intentional support for further ACH development and implementation. Technical assistance covers two areas:

1. Outreach and communications to ensure each tribal government is aware of collaboration opportunities and is able to actively inform Healthier Washington and ACH processes on tribal engagement.
2. Direct support for ACHs as key issues are identified during the ongoing implementation (e.g., transparency, community engagement, data sharing, etc.)

ACHs will lead local transformation that connects SIM investments, including Practice Transformation, Payment Redesign, and the Plan for Improving Population Health, to regions and communities across the state. ACH design and implementation has been a year and a half journey, preceded by years of strategic planning. ACHs are on a path to sustainable collective action that strives to realize the Triple Aim, and the SIM investments represented in this Operational Plan are the accelerators.

SIM Component Summary Table

Activity/Budget Item:	Description of activities	Primary Driver	Metric
Provide ACH Development and Implementation Technical Assistance	Identify technical assistance priorities and coordinate corresponding information sharing and shared learning across regions, specifically focusing on Governance, Infrastructure, Engagement, and Project Identification and Implementation.	Define the vision and build the foundation for ACH collaborative efforts in the region	Minimum of two technical assistance summits to address priority topics by 1/31/2017
Governance/Structure: develop and sustain ACH infrastructure	Develop and maintain regional capacity, including backbone support, for the administrative functions of the ACH. This includes sustainability planning.	Define the vision and build the foundation for ACH collaborative efforts in the region	All nine ACHs have a model in place for administrative support, including sustainability, by 1/31/2019
Governance/Structure: Develop ACH governance and engagement structures and strategies	Develop and adjust governance structures to meet state guidelines and regional needs.	Define the vision and build the foundation for ACH collaborative efforts in the region	All nine ACHs have multi-sector and community representation in decision making, including a sustainability plan. By 1/31/2019
Regional health improvement/delivery system transformation: ACH project implementation	Implement a regional improvement project based upon needs assessment and common agenda	Develop and strengthen regional partnerships so that collaboration can lead to complementary and collective health improvement activities; and Participate in Broader Healthier Washington activities, including delivery system transformation	All nine ACHs have completed project reports demonstrating the value proposition and/or ROI by 1/31/2019

Activity/Budget Item:	Description of activities	Primary Driver	Metric
Provide Technical Assistance to ensure effective tribal and urban consultation, engagement, and coordination	Provide guidance to Washington tribes and Urban Indian Health Programs regarding ACH. Assist in the design and implementation of regional ACHs that meet the needs of the American Indian/Alaska Native communities they serve. Ensure effective engagement, coordination and consultation by regional ACHs with the Indian health service, tribes/tribal health programs, UIHPs (together, the I/T/Us), and tribal organizations for Washington State. Assess interest in, and potential need for technical assistance for, tribes' development and enhancement of tribal ACH(s) or tribal coordinating entities in health system transformation.	Develop and strengthen regional partnerships so that collaboration can lead to complementary and collective health improvement activities	Written materials on ACHs and tribes and how they will engage Series of meetings – 1 for each ACH and associated Tribes. Series of 31 in-person meetings. Interviews with every tribe and every Indian Health Organization to understand what needs each organization has and how they want to engage. In particular, whether they want to engage with regional ACH or have a tribal coordinating entity (or both) Final report with recommen- dations provided by 1/31/17

Quarterly Accountability Targets/Milestones

	Accountability Objectives	Quarterly Accountability Targets/Milestones	End of FY2016[4] Key Milestones
1	Provide ACH Development and Implementation Technical Assistance	Q1-Q2: Priority technical assistance topics identified Q3-Q4: Summits hosted, including adjustments to TA materials and guidance based on newly identified priorities	All ACHs have participated in the TA priority development; Members/leaders from all nine ACHs have participated in both TA summits.
2	Governance/ Structure: Develop and Sustain ACH Infrastructure	Q1-Q2 of FY 16: ACHs confirm the lead backbone organization or defined shared backbone functions, including a process for ongoing evaluation and confirmation. Q3-Q4 of FY 16: ACHs have completed a backbone evaluation or survey in alignment with state guidance. FY17: ACHs implement improvement strategies based on survey results and state guidance; infrastructure sustainability planning options outlined.	All ACHs have backbone organizations in place with documented accountability to the ACH; All ACHs have results highlighting backbone performance and opportunities for improvement.
3	Governance/ Structure: Develop ACH Governance and Engagement Structures and Strategies	Q1-Q2: ACHs identify gaps and opportunities based on state guidance regarding governance and engagement. Q3-Q4: ACHs implement necessary adjustments based on identified gaps.	State and TA partners have strengths/gaps identified by ACH structure; ACH decision making reflects an informed and engaged multi-sector partnership that spans multiple counties and communities.
4	Regional Health Improvement/Delivery System Transformation: ACH Project Implementation	Q1-Q2: ACHs finalize a 2016 Regional Health Needs Inventory with identified priorities and project area based on regional needs and in alignment with criteria Q3-Q4: all ACHs have implemented the first phase of a project, identified measures and established mechanisms to track progress.	Regional needs and assets mapped and priority areas agreed upon; Projects implemented in alignment with priority areas and state measures. ACHs are using data to monitor progress.
5	Provide Technical Assistance to ensure effective tribal and urban consultation, engagement, and coordination	Q1-Q2: Provide assistance with tribal engagement and communication regarding ACHs. Tribes surveyed to inform expectations and mechanisms regarding ACH and Healthier Washington engagement	Options and recommendations have been vetted through Healthier Washington; Recommendations have been communicated to key partners, including ACHs.

[4] Throughout, FY indicates SIM grant year, February -January

	Accountability Objectives	Quarterly Accountability Targets/Milestones	End of FY2016[4] Key Milestones
		Q3-Q4: Analyze survey and develop recommendations. FY17: Implement recommendations	

Plan for Improving Population Health (P4IPH)

In 2013, the DOH and HCA formed a public-private, multi-sector partnership to develop a comprehensive Prevention Framework as a blueprint for state and community partners to drive population health improvement. The development of the Prevention Framework was largely driven by research based on available state health data reflecting disease rates, underlying causes of disease and preventable death, synthesis and alignment of existing state health improvement plans, and review of public health department and 501(c)3 hospital community health needs assessments. Informed by this research and the State Health Care Innovation Plan, the committee established the core Prevention Framework elements of the vision, goal, principles, objectives, and strategies. Additionally, the Prevention Framework proposed how the state, regional and local communities could measure their success in alignment with the statewide common measure set. The Prevention Framework effort forged stronger linkages between public health and the delivery system, and positions Washington well to develop the required Plan for Improving Population Health as part of Healthier Washington.

The goal of the P4IPH is to have a clear sustainability plan in place by September 2016. Informed by stakeholder input, national experts and literature, this work will determine what elements need to be in place for the plan to make implementation of population health initiatives sustainable. This plan also will deliver a proposed payment model (along with the sustainability plan) to fund the interventions.

Washington's Plan for Improving Population Health will guide how the state and local communities can best implement population health improvement strategies. It will deliver process tools and resources that would allow any community to take virtually any health priority and implement public health and clinical interventions that:

- Assess;
- Engage;
- Measure impact;
- Quantify return on investment; and
- Apply the latest evidence.

As a result of using the process tools, population health will improve and communities will have communication tools to effectively tell their story. The element of storytelling is essential to the sustainability of certain population health improvement initiatives.

Much of the SIM pre-implementation year was spent hiring the P4IPH team. As of October 2015, it is fully staffed, trained and ready to begin the work of developing the "change package" in collaboration with an intra-agency council and an external advisory board peopled with subject-matter experts and national leaders.

SIM Component Table

Activity/ Budget Item	Description of activities	Primary Driver	Metric
Maintain a strong governance and expert advisory function	Bring together an intra-agency design group as well as an External Advisory Board; coordinate listening sessions; gather best practices in change management	Develop and strengthen regional partnerships so that collaboration can lead to complementary and collective health improvement activities	Advisory board has met 10 times by 1/31/17
Implementation Plan and the Guide / Toolkit (process tools for facilitating evidence-based interventions)	Develop a change management framework; process; tools	Develop and strengthen regional partnerships so that collaboration can lead to complementary and collective health improvement activities	Tangible product (toolkit) available for distribution by September 2016
Sustainability plan	Develop a sustainability plan to ensure ongoing success; determine resources and costs; annually update plan	Develop and strengthen regional partnerships so that collaboration can lead to complementary and collective health improvement activities	Delineated sustainability plan incorporated into the toolkit by 9/2016.

Quarterly Accountability Targets/Milestones

	Accountability Objectives	Quarterly Accountability Targets/Milestones	End of FY2016 Key Milestones
1	Maintain a strong governance and expert advisory function	Q1: External Advisory Board formed Q2: Assess and Inventory current and related initiatives Q2: Stakeholder Listening Sessions	External Advisory Board and national experts will have met monthly or bi-monthly throughout first three quarters of 2016. Listening sessions are complete. Inventory of current related initiatives complete.
2	Implementation plan and the guide/ toolkit (process tools for facilitating evidence-based interventions)	Q1: Define the plan elements, timelines and expectations Q3: Intra-agency council will have prepared a package of change interventions that can be implemented to improve population health	The Plan (a set of process tools) has been created and is ready for use.
3	Sustainability Plan	Q3: Sustainability Plan Q3: Funding and resources are identified to implement plan Q3: Continuous Improvement of the Guide	Sustainability plan in place, complete with funding and resources identified and a plan for CQI of the Plan.

Practice Transformation Support Hub

The Practice Transformation Support Hub will support clinical providers across the state to effectively coordinate care, increase capacity, and benefit from value-based reimbursement strategies. It is a key component of shifting and supporting the delivery system as we manage the transition to value-based payment models.

The Practice Transformation Support Hub will convene, coordinate and develop resources to give health care providers the training, coaching and tools they need to succeed in health transformation efforts to:

- Stimulate and accelerate the uptake of integrated and bidirectional behavioral health and primary care.
- Support progress toward value-based payment systems.
- Improve population health by strengthening clinical practice alignment with community-based services for whole-person care.

The objectives of the Hub include:

- Support clinician knowledge and practice translation to spread efficiency, quality, evidence-based decisions, and best practices to improve health through the lifespan.
- Improve microsystem and clinic site data management capacity by providing training and tools that strengthens providers' use of data to drive decision-making, contract negotiations, demonstrate health improvement/outcomes, and connect care delivery transformation success with cost reduction (performance, outcome, value-based approaches).
- Facilitate communication, referrals and collaboration among related practice transformation initiatives, to optimize and align technical assistance.
- Robust and effective linkages between providers and community resources to improve population health.
- Health outcomes efforts to support Washington's Common Performance Measures Set and adoption of state's plan for improving population health, and are targeted, measured, and based on health, disparity, and risk in the community/region.

DOH will oversee the Practice Transformation Support Hub, to accelerate the dissemination and implementation of new and existing practice change supports. Throughout this planning year, DOH has been completing an environmental scan including strategic engagement activities with key stakeholders and partners throughout the state to develop a vision that aligns practice transformation initiatives, strategies and priorities.

Some approaches to support transformation efforts that are currently planned, include:

- A web-based resource portal that will serve as an integrated gateway, providing clinicians with a single point of contact for online access to best practices, practice transformation-related services, and a channel for communication of training, policy, licensing, and payment reform activities.
- A consortium of publicly funded practice coaching and technical assistance agencies.
- Dedicated and user-friendly referral mechanism to access technical support.

- Strengthening primary care and behavioral health learning communities through targeted regional and statewide webinars and learning collaboratives.

The intent of the Hub is to build upon the excellent support already available in many areas throughout Washington State by coordinating transformation efforts, engaging local peer champions, and optimizing usability, openness and transparency to resources to accelerate practice translation and adoption. An extensive inventory of existing support and services will inform the final business plan for an integrated, customized information delivery Hub portal.

Driver Diagram: Hub-specific

In some cases, Washington found it helpful to develop strategy-specific driver diagrams to help enlighten the dialogue and better align our initiatives with the overall aims of SIM.

Aims	Primary Drivers	Secondary Drivers	Metrics
By January 2019, engage 80 percent of primary care, mental health, and substance use disorder practices with transformation activities that strengthen: (1) Delivery of integrated physical and behavioral health, (2) Adoption of value-based payment, and (3) Use of clinical-community linkages to improve population health.	**Create culture:** Create a culture of quality improvement and shared learning	Create learning collaboratives	Number of practices participating, survey instruments assessing perceived value/benefit of collaborative
		Develop group of clinical practice mentors	List of clinical practice mentors, number of mentor/mentee interactions, survey instruments assessing perceived value/benefit of mentorship
	Understand needs: Understand the practice transformation training and technical assistance needs of providers to inform Hub services	Engage stakeholders through listening sessions, site visits, key informant interviews, and surveys	Counts of sessions and number by type of stakeholders involved, qualitative analysis to discern current landscape, ideas for Hub services, and barriers/facilitators to practice transformation
		Create a public/private Hub Advisory Committee	Committee charter, meeting minutes, attendance by members
	Make tools and resources available: Establish online inventory of relevant high quality resources	Develop a web-based clearinghouse portal of evidence based and best practice tools, on-demand training resources, and curated resource lists	Website analytics, survey instruments assessing user satisfaction, perceived ease of use and value/benefit of clearinghouse portal
	Provide Services: Focusing on small and medium sized practices, provide and refer practices to training, technical assistance, and facilitation services	Engage subject matter experts to provide training and technical assistance	Number of trainings, attendance, survey assessing training value and changes in practice post training, post-training satisfaction surveys and knowledge assessment
		Give practices hands-on coaching, technical support and assistance to implement new processes	Number of sessions, perceived value, post coaching survey to assessing perceived value and changes in practice, proportion of practices in Washington engaged

		Create network of extension center agents aligned with ACH regions	Proportion of ACH regions with an extension center agent; survey assessing satisfaction with agents and changes in practice
	Advance physical and behavioral health integration: Focusing on small and medium sized practices, provide technical assistance and training to increase physical and behavioral health integration	Develop a framework to measure the current degree of physical and behavioral health integration	Quantitative assessment of current degree of physical and behavioral health integration as baseline
		Give practices technical support, training, and information resources to advance physical and behavioral health integration	Mixed methods assessment of degree of change in of physical and behavioral health integration, Qualitative assessment of use cases, barriers, integration process, and adoption patterns for Hub resources
	Advance clinical-community linkages: Focusing on small and medium sized practices, provide technical assistance and training to increase linkages to agencies and organizations that are working at the community level	Develop a framework to measure the current use of clinical-community linkages	Quantitative assessment of current degree of community linkages use
		Give practices technical support, training, and information resources to increase community linkages	Mixed methods assessment of degree of change in of use of community linkages, qualitative assessment of use cases, barriers, integration process, and adoption patterns for Hub resources
	Advance adoption of value-based payment systems: Focusing on small and medium sized practices, provide technical assistance and training to increase adoption of value-based payment systems	Develop a framework to measure the current state of value-based payment systems	Quantitative assessment of current degree of value based payment
		Give practices technical support, training, and information resources to increase adoption of value-based payment systems	Mixed methods assessment of degree of change in of use of value-based payment systems, qualitative assessment of use cases, barriers, integration process, and adoption patterns for Hub resources

SIM Component Summary Table

Activity/Budget Item:	Description of activities	Primary Driver	Metric
Develop technical assistance (TA) support package for Early Adopter region (SWWA) in 2015	Debut curated resources and to support Early Adopter transformation needs	Make tools and resources available: Establish online inventory of relevant high quality resources	Some pilot tools and resources available for Southwest Washington by 4/1/2016.
Deliver a web-based clearinghouse portal: a single point of contact for on-line access to best practices, practice transformation-related services, and a channel for communication	Create business plan, publishing agreements, practice coaching referral mechanisms,, deploy evidence-based tools, webinars and training capacity, etc.	Make tools and resources available: Establish online inventory of relevant high quality resources	Website analytics; survey instruments assessing perceived ease of use and value/benefit of clearinghouse portal
Extension Center Support network / agent model with (up to) nine extension agents in the Regions	Phased in regionalized extension agents model for regionally tailored referrals, fostering peer to peer improvement mentors, to practices & providers, various tools to support the clinical practices in ACHs in accessing Hub support, etc.	Provide Services: Focusing on small and medium sized practices, provide and refer practices to training, technical assistance, and facilitation services	Proportion of ACH regions with an extension center agent; perceived value/benefit of agents; changes in practice
Practice Coaching and Facilitation Consortium	Establish referral mechanism. Address gaps with coaching and facilitation services	Provide Services: Focusing on small and medium sized practices, provide and refer practices to training, technical assistance, and facilitation services	Number of sessions, satisfaction with sessions; changes in practice; proportion of practices in Washington engaged
Inception of Public and Private Advisory Board for oversight	Create a public-private advisory board for oversight as well as to ensure ongoing engagement with real needs of stakeholders	Understand needs: Understand the practice transformation training and technical assistance needs of providers to inform Hub services	Board minutes, strategic plan, targets met
Regional cooperative partnerships with small to medium size practices to build/expand community provider technical assistance, provider facilitation, and QI infrastructure and capacity	In a second phase for the extension service model, provide the local extension agency "spokes" with the skills and knowledge to better support the ACHs.	Provide Services: Focusing on small and medium sized practices, provide and refer practices to training, technical assistance, and facilitation services Make tools and resources available: Establish online inventory of relevant high quality resources	• Regional extension agents' contacts/completed; referrals and measures of intervention impact appropriate to strategy • Increased volume of web services and analytics to refine investment • Demonstrated competencies and skill sets of extension agents with strong employee performance metrics

Activity/Budget Item:	Description of activities	Primary Driver	Metric
Bree Implementation Pilot	Developing Bree Implementation readiness assessment and dashboard and adoption strategies	Develop comprehensive dashboard showing comparative progress (e.g., red/yellow/green) on state-wide adoption of Bree Collaborative recommendations. Identify fidelity factors that contribute to success adoption.	Dashboard developed. Bree Collaborative implementation roadmaps: change management and adoption strategies
Develop a sustainability plan	Create and annually refresh the sustainability plan		Plan completed by December 2016

Quarterly Accountability Targets/Milestones

	Accountability Objectives	Quarterly Accountability Targets/Milestones	End of FY2016 Key Milestones
1	Deliver a web-based clearinghouse portal of curated resources	Permanent site: Q1: Publish the RFP Q3: Select a vendor Q3: Hub business requirements delivered Q4: Establish the process and team for vetting and aligning the resources for the clearinghouse; this is a service. Temp site: Q1: Sole source a temp provider Q2: Temp site live Mid-adopter region may emerge around August 2016 – We should have extension agent, practice coaching/facilitation resources up AND temp website so this should not have unplanned budget impacts.	By Jan. 1, 2017 – we will have criteria for resources. Will have selected a vendor to develop website. Will have selected a vendor to select content for website. Temporary website up in spring 2016 Permanent website live by end of January 2017.
2	Practice Coaching and Facilitation Network	Q1: Publish the RFP Q2: Select one or more vendors to create consortium of practice coaching services Q2: Cross-agency network group will determine role of Hub to develop referrals process, and additional tools Q4: Have an established catalog of services	We will be engaged with practices in the community and on the ground. Vendors will be engaged. We will be offering services by June 2016. Some learning collaboratives starting up.
3	Extension Agents Program	Q1: Publish the RFP Q2: Select a vendor Q3: Phased roll-out of agents (1-4) Q4: Phased roll-out of agents (5-9)	All 9 RSA extension agents hired by 1/31/17. Phased in. Training will have started for agents. System of improvement exists – with feedback coming back to central office to continue refining Agents understand their local region (people, clinical practices heavy)
3	Advisory Board created / stood up	Q1: Select and recruit membership Q2: Determine role related to oversight of services Q2: Start meeting ~ April Q3: Board will provide feedback on features, services, guidance on alignment with needs of clinical practice community	By Jan 31, 2017 – we will have a functioning Hub Advisory Board who meets regularly. Alignment with key priorities.

Shared Decision Making

Practice transformation support is a core element of Healthier Washington and provides a platform to support health care providers transitioning to new payment models, using evidence-based practices to improve the quality of care they provide by engaging patients in their health care decisions. The use of shared decision making as an evidence-based strategy is not only supported in Washington legislation, but the use of certified decision aids is an innovative practice that Washington has an opportunity to lead as a "first mover."

Washington is currently working with national and state experts to develop a process to certify decision aids and may use the Practice Transformation Support Hub and other mechanisms to spread the use of shared decision making as a practice, as well as the use of certified patient decision aids.

As Washington State develops a plan for implementation, sustainability, and spread, HCA will engage a national co-sponsor and other states working on innovative strategies to engage patients in their healthcare to help create a multi-state shared decision making network to share best practices and to spread this model on a national level.

SIM Component Summary Table

Activity/Budget Item:	Description of activities	Primary Driver	Metric
Development of an innovative model to certify patient decision aids in Washington that builds on key legislation and can be spread to other states	HCA, working with national and state stakeholders develops a process to certify patient decision aids in Washington.	Promote the use of shared decision making as a practice	Written and tested process in place that builds on legislation no later than March 1, 2016
Development of rulemaking process that builds on key legislation that supports the spread of shared decision making	HCA, working with state agency and state legal experts, develops language to update Washington Administrative Code (WAC) that informs the process to certify patient decision aids in Washington.	Promote the use of shared decision making as a practice	Updated WAC approved and implemented no later than April 1, 2016
Training providers on Shared Decision Making Strategies 101	Train practices engaged in payment model tests to spread the use of evidence-based shared decision making strategies in Washington using the AHRQ SHARE curriculum.	Promote the use of shared decision making as a practice	75% of practices engaged in SIM payment model tests receive SHARE training by January 2019
Provide practice coaching opportunities to assist providers engaged in payment model tests to implement shared decision making, including use of certified patient decision aids	Provide onsite and virtual hands on training and coaching to practices to build systems within their practices that incorporate shared decision making strategies and use of certified decision aids.	Promote the use of shared decision making as a practice	Up to 50% of practices engaged in payment model tests receive virtual and/or hands on coaching/training and virtual consulting to maximize adoption by January 2019

Activity/Budget Item:	Description of activities	Primary Driver	Metric
Development and implementation of a process to integrate use of certified Patient Decision Aids	Develop a plan to promote and spread the integration of shared decision making and use of certified patient decision aids in clinical practice.	Promote the use of shared decision making as a practice	Written plan in place no later than March 1, 2016 Implementation: Ongoing
Certification of decision aids to support maternity care	Using final written process to certify decision aids, solicit submissions for aids that support maternity care, convene review panel, and certify successful submissions as appropriate. Post certified aids to Healthier Washington website.	Promote the use of shared decision making as a practice	Certification of up to five decision aids that address maternity care by January 2019
Certification of Decision aids to support joint replacement/spine care aids	Using final written process to certify decision aids, solicit submissions for aids that support joint replacement/spine care, convene review panel, and certify successful submissions as appropriate. Post certified aids to Healthier Washington website.	Promote the use of shared decision making as a practice	Certification of up to five decision aids that address joint replacement/ spine care by January 2019
Certification of decision aids to support cardiac/end of life care aids	Using final written process to certify decision aids, solicit submissions for aids that support cardiac/end of life care, convene review panel, and certify successful submissions as appropriate, post certified aids to Healthier Washington website.	Promote the use of shared decision making as a practice	Certification of up to five decision aids that address cardiac and end of life care by January 2019
Negotiated discount/scholarships for decision aid license/use (EMR/web based/other format).	Negotiate discounts and/or scholarships for certified decision aid licenses for use by providers engaged in Healthier Washington payment model tests, to integrate into clinical practice	Promote the use of shared decision making as a practice	50% of practices engaged in Healthier Washington payment model tests and eligible for discount/scholarship have implemented discounted certified decision aids into clinical practice by January 2018
Develop benefit design/payment incentive structure to provide positive incentives for SDM adoption/use.	Discussions with plans and payers to support integrating SDM into clinical process, including members and providers	Promote the use of shared decision making as a practice	100% of MCOs commit to supporting the integration of SDM strategies in their provider practices by January 2019

Activity/Budget Item:	Description of activities	Primary Driver	Metric
Develop a multi-state SDM Innovation Network	Coordinate the development of a multi-state shared decision making innovation network to collaborate with other states implementing innovated strategies to spread evidence-based shared decision making strategies.	Promote the use of shared decision making as a practice	Create a SDM collaborative and convene members up to four times by January 2018
Evaluation of development and testing process to certify decision aids	Analysis of development and testing process for Decision Aid Certification, including a summary of findings, successes, lessons learned, etc. to share with other states considering developing a certification process.	Promote the use of shared decision making as a practice	Complete and post/publish final summary of findings by December 31, 2016

Quarterly Accountability Targets/Milestones

	Accountability Objectives	Quarterly Accountability Targets/Milestones	End of FY2016 Key Milestones
1	Development of an innovative model to certify patient decision aids in Washington that builds on key legislation and can be spread to other states	Q1-Q2: Certification process has been approved, tested, and finalized and staffing is in place Q2-Q4: Accountable Care Programs have begun to use certified decision aids	Up to three clinics participating in each ACP have implemented the use of certified decision aids that address maternity care.
2	Development of rulemaking process that builds on key legislation that supports the spread of shared decision making	Q1-Q2: Final approval and implementation of Washington certification process	Washington Administrative Code (WAC) is in place and supporting the ongoing certification process
3	Train providers on Shared Decision Making Strategies 101	Q1: Initial master training conducted with representation from ACPs, ACHs, and targeted provider participation to ensure spread across state Q2 - Q4: Participants of master training have conducted and least two additional trainings	At least 50 practices have received training using the AHRQ SHARE curriculum
4	Provide practice coaching opportunities to assist providers engaged in payment model tests to implement shared decision making, including use of certified patient decision aids	Q2 FY16: Implement vendor contract to provide practice coaching Q3- Q4 FY16: Provide training/coaching to at least 10% of eligible practices by Q4 FY16	Up to 30% of providers engaged in payment model tests receiver hands on coaching/training and virtual consulting to maximize adoption by January 2019
5	Development and implementation of a plan to promote and spread the integration of shared decision making and use of certified patient decision aids in clinical practice.	Q1 - Develop a draft implementation plan Q1 - Finalize an implementation plan Q2 – Begin implementation of plan to promote and spread shared decision making	Written SDM implementation plan in place no later than March 1, 2016 Implementation – Ongoing through January 2019.
6	Certification of decision aids to support maternity care	Q1 - Q3: Complete two rounds of review and certification of maternity care decision aids	Have at least three decision aids that address maternity care by end FY16.
7	Certification of decision aids to support joint replacement/spine care aids	Q3- Q4: FY16 Complete one round of review and certification of decision aids that address joint replacement/spine care Q1- Q2 FY17: Complete two rounds of review and certification of decision aids that address joint replacement/spine care	Have at least three decision aids that address joint replacement/spine care by Q2 FY17.
8	Certification of decision aids to support cardiac/end of life care	Q3- Q4: FY17 Complete one round of review and certification of	Have at least three decision aids that support cardiac and end of life

	aids	decision aids that support cardiac and end of life care Q1- Q2 FY18: Complete two rounds of review and certification of decision aids that support cardiac and end of life care	care by Q2 FY18.
9	Negotiate discounts and/or scholarships for certified decision aid licenses for use by providers engaged in Healthier Washington payment model tests, to integrate into clinical practice.	Q3- Q4: FY16 Negotiate discounts/scholarships for at least one certified decision aid Q1- Q2 FY17: Negotiate discounts/scholarships for at least two certified decision aids	Provide discounted licenses/scholarships for 20% of practices engaged in payment model tests by FY17 Q2.
10	Develop benefit design/payment incentive structure to provide positive incentives for SDM adoption/use.	Q1 - Q4 FY16: Monitor ACP contractual requirements to implement SDM strategies and use of certified decision aids into their health systems Q1 - Q4 FY17: Begin to engage payers in discussions about incorporating SDM methodologies into payment system to provide incentives to providers and members.	All MCOs commit to supporting the integration of SDM strategies in their provider practices.
11	Develop a multi-state SDM Innovation Network	Q1 - Q2 FY16: Engage national partner to co-sponsor multi-state SDM Innovation Network Q3- Q4 FY16: Identify and engage states developing and/or implementing innovative SDM strategies	Convene at least one multi-state SDM network meeting to share best practices by Q4 FY16
12	Analysis of development and testing process for decision aid certification, including a summary of findings, successes, lessons learned, etc. to share with other states considering developing a certification process.	Q1 - Q2 FY16: Track process, lessons learned, successes, barriers, resources needed to sustain certification process Q3 - Q4: Write up and publish summary of findings	Complete and post/publish final summary of findings by December 31, 2016

Workforce

Community Health Worker Task Force Follow-up

The Community Health Worker (CHW) aspect of the workforce initiative is key to containment of costs, increased client uptake and health activity compliance. The task force mandate is to make actionable policy recommendations to be woven back into Healthier Washington for the period of the SIM grant.

If the recommendations are implemented, it will lead to a workforce that is more responsive to clients, workforce resources will go further and overall costs will be impacted as client adherence is linked to lower costs and higher health levels.

Industry Sentinel Network Implementation And Response

In the fast-evolving workforce market, it is critical to link employer needs and educational offerings in a timely manner. This network which consists of clusters of employers, such as hospitals, labs, and behavioral health centers can be queried to see what qualifications, skills, or experience they find lacking or those that are already well met. This information can be fed to educational entities and providers of continuing education to see how to quickly reduce the disparity in need.

This information will be useful to those providing training and education to see what they can do at at the site level to address issues. Healthier Washington will use this data to identify and make targeted investments in the state's workforce. As with implementation of the Community Health Worker task force recommendations, these investments may be woven into the Practice Transformation Support Hub or ACH efforts.

SIM Component Summary Table

Activity/Budget Item:	Description of activities	Primary Driver	Metric
Annual follow-up on actionable policy recommendations of Community Health Worker Task Force	Annually pursue quality follow-up on whether and how the recommendations of the CHW Task Force were adopted.	Support an enhanced and expanded workforce	TBD based on CHW task force recommendations
Industry Sentinel Network: web portal to survey and collect and disseminate workforce trends.	Related to workforce capacity and transformation… survey schedule setup, demographic targets established	Support an enhanced and expanded workforce	By 2017 initial survey implemented through portal, and results shared
Targeted workforce investments based on data.	Deploy targeted investments to advance the state's workforce based on data	Support an enhanced and expanded workforce	Resources deployed in 2017 and 2018 evaluated annually

Quarterly Accountability Targets/Milestones

	Accountability Objectives	Quarterly Accountability Targets/Milestones	End of FY2016 Key Milestones
1	Annual follow-up on CHW Taskforce actionable policy recommendations	Based on CHW Taskforce TBD recommendations, completed Q4 2015	TBD
2	Industry Sentinel Network: web portal survey, collect, analyze and disseminate workforce trends.	Q1-Q2: Survey questions vetted and established. Portal Established Q3-Q4 initial survey conducted analysis conducted and results disseminated	Analysis results distributed
3	Targeted workforce investments based on data	FY 16 Q4: Identify workforce investments strategy and criteria FY17 Q1: Identify and deploy targeted investments FY18 Q1: Identify and deploy targeted investments	Workforce investment strategy and criteria developed Q4 16.

Payment Redesign

Payment Model 1: Early Adopter of Medicaid Integration

Payment model 1 tests how integrated Medicaid financing for physical and behavioral health services accelerates the delivery of whole-person care. Starting in April 2016, approximately 120,000 Medicaid beneficiaries (nearly 7 percent of the state Medicaid population) in the Southwest Washington (SWWA) regional service area (RSA), comprised of Clark and Skamania counties, will have the full continuum of comprehensive physical and behavioral health services provided through Medicaid managed care plans.

Access to care standards that have previously been used to determine medical necessity for specialty mental health services will no longer be applicable. Instead Medicaid beneficiaries will receive services when they need them, in the setting that best suits their need, based on medical necessity and level of care guidelines.

HCA released a request for proposals in August 2015, to procure at least two managed care organizations to provide fully-integrated services to the SWWA RSA Medicaid population. The state received letters of intent to bid from four MCOs and in November 2015 named Molina Healthcare of Washinton and Community Health Plan of Washington as the successful plans.

The selected MCOs will coordinate care across the physical and behavioral health systems and develop systems of care that restructure service delivery for enrollees with complex, high risk, co-occurring disorders, through the use of co-located services or protocols between physical and behavioral health care settings that promote continuity of care and services. As the state transitions toward fully-integrated Medicaid purchasing statewide in 2020, HCA will work with additional regions, known as "mid-adopters" to implement this model.

SIM Component Table

Activity/Budget Item:	Description of activities	Primary Driver	Metric
Procure managed care organizations providing fully-integrated services and operationalize transition to full-integration.	Sign contracts with managed care organizations (MCOs) providing fully-integrated PH/BH benefits. Finalize fully-integrated Medicaid rates. Update and distribute client handbooks to include new services. In conjunction with local Southwest Washington implementation team, conduct readiness review of MCOs. Review health plan care management tools, assessment and screenings tools, network adequacy, coverage and authorization criteria, plans to provide bi-directional care, grievance and appeal processes.	Integration of physical and behavioral health purchasing	At least 2 managed care plans procured with signed contracts. Rates approved by CMS as actuarially sound. By December 15, 2015.

Activity/Budget Item:	Description of activities	Primary Driver	Metric
Modify information systems to support fully-integrated managed care and new behavioral health services only benefits.	Develop, test and implement MMIS and Health Insurance Exchange system updates. Test the new DSHS behavioral health data reporting system. - do we need to connect this to the AIM positions out there?	Integration of physical and behavioral health purchasing	ProviderOne and HPF changes are tested and implemented so that the enrollment process can begin on 2/29/16. New DSHS behavioral health data reporting system is tested and available for use by the MCO's on 4/1/16.
Obtain federal/state regulatory approval	Amend and obtain approval for 1932(a) SPA to include BH services for Medicaid managed care population. Submit and obtain approval for 1915(b) waiver to provide BH managed care services to the Behavioral Health Services Only population. Amend Washington Administrative Code (WAC) to include additional services in managed care WACs.	Integration of physical and behavioral health purchasing	Federal waiver authority and Washington Administrative Code amendments in place prior to April 2016, with cost-effectiveness for the 1915(b) waiver demonstrated by actuaries in December 2015.
Develop and implement an early warning capacity to identify and resolve implementation issues rapidly	Survey stakeholders to determine early warning signs, that may indicate gaps in services, provider payment issues, access to care issues, etc. Develop metrics to track for early warning signals. Develop and implement rapid response system and triage system to react to and correct implementation issues as they arise.	Integration of physical and behavioral health purchasing	Minimum of 5 "early warning" metrics established and stakeholdered by February 2016. Early warning metrics tracked beginning in April, 2016 to identify access to care or provider payment issues. Rapid response/triage system in place between local SWWA implementation team, HCA and managed care plans to ensure corrective action plans are developed within 7 days of issue identification.
Develop and implement a culturally appropriate outreach plan to Medicaid beneficiaries, to educate on upcoming Medicaid changes	Develop and implement a multifaceted and multicultural outreach campaign. Develop culturally specific outreach materials. Work with schools in SWWA to target children/families receiving Medicaid. Leverage social services providers and local organizations that serve communities of color to help disseminate information.	Integration of physical and behavioral health purchasing	By April 2016 - 3- 4 public forums hosted targeted to African Americans, Eastern Europeans, Latinos, Native Americans and Pacific Islanders. Run at least 1 ad in on multicultural radio stations (1480 AM and 1520 AM), distribute materials via 7 multicultural community-based organizations serving SWWA and through community

Activity/Budget Item:	Description of activities	Primary Driver	Metric
			meetings.
Educate fully-integrated managed care plans on behavioral health system and new services in preparation for transition to full-integration	Conduct facilitated trainings and educational sessions with apparently successful bidder MCOs, providers, and county staff to educate MCOs on nuances and processes of current behavioral health system, including but not limited to: Western State hospital transfers, local CLIP Committee referral, WISe program, coordination with DD programs coordination with locally-funded BH programs, etc.	Integration of physical and behavioral health purchasing	Conduct 5-6 training sessions with fully-integrated managed care plans, providers and the state to cover 23 high-risk issues. Managed care plans fully-trained on transition issues by March 2016.
Provide technical assistance to behavioral health and physical health providers to assist in transition to fully-integrated managed care	Provide managed care 101 training; Provide training on managed care payment models and how to price services; Provide training on bidirectional systems of care; provide training on data system/reporting requirements; provide training on back office procedures necessary to operate in a fully-integrated care model. Facilitated topical discussions between PH/BH providers on: care coordination, access to care/workforce shortage issues and solutions, case conferencing, provider resource sharing, integrated care models.	Integration of hysical and behavioral Health purchasing	Trainings made available to 95% of primary care and behavioral health providers in the SWWA region between November 2015 – April 2016.
Enroll Medicaid clients in fully-integrated managed care plans	Enroll Medicaid clients in Clark and Skamania counties in fully integrated plans	Integration of physical and behavioral health purchasing	Approximately 120,000 Clients seamlessly enrolled in new managed care plans in Clark and Skamania counties by April 2016.
Medicaid beneficiaries with co-occurring disorders receive care coordination through a whole-person system of care	Beneficiaries have access to a system of care, that includes availability of co-located or bidirectional care, or access to physical and behavioral health care that have protocols	Integration of physical and behavioral health purchasing	TBD

Activity/Budget Item:	Description of activities	Primary Driver	Metric
	established to ensure closely coordinated care for individuals with co-occurring disorders.		
Conduct outreach to expand fully-integrated model to additional regional services areas	Finalize and publicize timeline for additional regions to opt-in to fully-integrated care prior to 2020. Conduct outreach to county authorities.	Integration of physical and behavioral health purchasing	County authorities in two or more additional Regional Service Areas opt-in to fully-integrated managed care. Non-binding letters of intent submitted in November 2016 and binding letters of intent submitted in February 2017.
Implement fully-integrated managed care in mid-adopter regions.	Engage county authorities in the implementation and design of fully-integrated managed care model in mid-adopter regions. Release procurement to select fully-integrated MCOs to serve mid-adopter regions, and set fully-integrated Medicaid rates for additional regions.	Integration of physical and behavioral health purchasing	Two or more regional service areas elect to pursue fully-integrated managed care and submit binding letters of intent by February 2017. In each region, at least two fully-integrated MCOs procured by July 2017 for coverage effective January 2018. Over 50% of the state's Medicaid population enrolled in a fully-integrated managed care plan by January 2018.

Quarterly Accountability Targets/Milestones

	Accountability Objectives	Quarterly Accountability Targets/Milestones	End of FY2016 Key Milestones
1	Procure managed care organizations providing fully-integrated services and operationalize transition to full-integration.	Q2: At least 2 fully-integrated MCOs pass readiness review.	At least two fully-integrated managed care plans procured with signed contracts, finalized rates and system changes in place pass their readiness reviews.
2	Modify information systems to support fully-integrated managed care and new behavioral health services only benefits.	Q1: ProviderOne system changes tested and live (HCA). Q1: Healthplanfinder (HPF) system changes tested and live (HBE). Q2: New behavioral health data reporting system tested and live (DSHS).	ProviderOne and HPF changes are tested and implemented so that the enrollment process can begin on 2/29/16. New DSHS behavioral health data reporting system is tested and available for use by the MCO's on 4/1/16.
3	Obtain federal/state regulatory approval	Q1: CMS approves SPA and 1115(b) waiver	Federal waiver authority in place and WAC amendments approved prior to April 2016.

	Accountability Objectives	Quarterly Accountability Targets/Milestones	End of FY2016 Key Milestones
		Q2: WashingtonC amendments approved by code revisor	
4	Develop and implement an early warning capacity to identify and resolve implementation issues rapidly	Q1: Identify early warning system metrics via stakeholder surveys. Establish and test process for tracking early warning system metrics and responding via triage system. Q2: Early warning/triage system implemented.	Minimum of five "early warning" metrics established and tracked beginning in April 2016. Triage system implemented to ensure corrective action plans are developed within seven days of issue identification.
5	Develop and implement a culturally appropriate outreach plan to Medicaid beneficiaries, to educate on upcoming Medicaid changes	Q1: Outreach plan implemented, materials distributed and public meetings underway. Q2-Q4: Continued education and outreach conducted to respond to public questions and ensure Medicaid populations understand the transition to fully-integrated managed care.	Culturally appropriate education/ informational materials made available to 100% of Medicaid beneficiaries in the SWWA region, with a focus on hard-to-reach minority populations.
6	Educate fully-integrated managed care plans on behavioral health system and new services in preparation for transition to full-integration	Q1: Conduct facilitated trainings and educational sessions with fully-integrated MCOs, providers, and county staff to educate MCOs on nuances and processes of current behavioral health system. Q2-Q4: Continued education and learning opportunities for MCOs, providers and state/county staff to improve BH system	Conduct 5-6 training sessions with providers and fully-integrated MCOs to cover 23 high-risk issues. MCOs fully trained on transition issues by March, 2016.
8	Enroll Medicaid clients in fully-integrated managed care plans	Q1: Enrollment in fully-integrated managed care plans begins on February 29, 2016. Q2-onging: Same-day enrollment begins in April 2016 and continues through duration of contracts.	Approximately 120,000 Medicaid clients seamlessly enrolled in new managed care plans in SWWA regional service area.
9	Provide practice transformation support to providers to support delivery system integration	Q1: Practice transformation resources selected available to providers by January 2016.	Physical and behavioral health providers receive practice transformation support trainings focused on care coordination in a fully-integrated managed care model.
10	Conduct outreach to expand fully-integrated model to additional regional services areas	Q4: Complete roll-out plan for 2020 is developed Q3-Q4: Engage regional service areas in discussions around fully-integrated care model and timeline for implementation prior to 2020. Q3-Q4: Continued engagement with all potential fully-integrated regional service	County authorities in two or more regional service areas opt-in to fully-integrated managed care.

	Accountability Objectives	Quarterly Accountability Targets/Milestones	End of FY2016 Key Milestones
		areas regarding the benefits of fully-integrated managed care and the implementation process to move forward prior to 2020.	

Payment Model 2: Encounter-based to Value-based

Payment Redesign Model 2: Encounter-based to value-based purchasing will pioneer new Medicaid payment methodologies and service delivery models for federally qualified health centers (FQHCs) and rural health clinics (RHCs), and look at innovative solutions to serve the most vulnerable within Washington's critical access hospital (CAH) network.

Alternative Payment Methodology (APM) Development
FQHCs and RHCs serve as the backbone of Washington's primary care services for Medicaid beneficiaries. Given the essential nature of care delivered in these facilities, federal law stipulates a cost-based reimbursement methodology known as the prospective payment system (PPS). The PPS reimbursement methodology is based on clinic-specific reasonable cost-per-visit rates for the fiscal years of 1999 and 2000. Under this federal law, states are required to reimburse FQHCs and RHCs minimally at the PPS level. However, within these stipulations CMS permits states to develop an APM in the Medicaid state plan.

Washington State is on its third iteration of an APM in five years. The current APM reimburses FQHCs and RHCs at a rate above the PPS rate via enhancement payments. This cost-based payment and delivery system is driven by face-to-face 'encounters' with providers, a reimbursable expense. The current APM is inefficient and forces an incentive structure that drives up costs for payers and providers, the result of driving volume over value. Under the current system, FQHCs and RHCs are constrained to an encounter-based payment structure with no links to outcomes. This cost-based, encounter-driven reimbursement structure stifles innovation and limits how care can be delivered. Model 2 hopes to reform this process through an APM 4 for FQHCs and RHCs. An APM 4 will reduce the task heavy process faced by these facilities, provide flexibility and encourage sustainability to meet changing community needs. The goal is to make it simple, fair, transparent, and inexpensive to administer. It will link gain-sharing and risk to quality, and provide the opportunity for shared savings. It will also address the burdensome reconciliation process. Ultimately, the APM developed under Model 2 will pave the way for a true population-based pay for performance system.

At present we are in the design phase of APM modeling. The HCA has released a request for proposals to procure technical assistance for APM working session facilitation and development. This technical assistance will be carried out through the beginning of the second quarter of 2016. HCA is also assessing and building the data analytic capacity to support the APM development phase. Operational components are being identified and mapped to support the facilitation of a new APM.

Specific to APM design, the Washington Association of Community and Migrant Health Centers (WACMHC) brought forth a suggested model, signaling a willingness to engage and move this work forward. Some of the desired components HCA wishes to see in a new APM include:

- Budget neutral to an alternative payment methodology 3
- Incentives tied to quality
- Reduced reconciliation process
- Gain sharing and risk

Critical Access Hospitals
The Public Hospital District (PHD) designation and the Critical Access Hospital (CAH) program have prevented the closure of many rural hospitals, but the current payment and delivery system is unsustainable in the long-term. These vital institutions serve as the single point of access to essential health services and act as the hub of care delivery within the regions they serve.

Identifying with the community need, HCA recognizes the importance of the preservation of access to essential health services in the rural areas of Washington State. Under Model 2, we are aiming to design a new facility type designation that 'right-sizes' CAHs to the community they serve. On the long-term we are leveraging Healthier Washington and Model 2 to maintain Washington's acute and primary care backbone for rural communities.

Washington's rural population tends to be older, has higher mortality rates, and in general has less access to primary and acute care than their urban counterparts. The CAHs located in these communities face the challenge of managing this population across geographically vast and diverse regions. Linking rural populations to care is costly and resource intensive.

These communities recognize the importance of backbone institutions. As Public Hospital Districts (PHDs) many communities have moved to increase levy revenue to maintain these access points. Without redress of the payment and delivery systems CAHs rely on, these institutions are not sustainable in the long-term.

Payment Structure
Washington's CAH infrastructure is tasked with supporting this population while maintaining a payer mix based on average 50 percent Medicare and 16 percent Medicaid. At present CAHs are reimbursed on a cost-basis, Medicare covering 101 percent of cost and Medicaid covering 100 percent.

It is clear that allocating additional funding for these facilities in their current form is not feasible, nor is it sustainable. From a federal and state perspective, there is no additional funding to address these challenges. Through the initiative we have the opportunity to work closely to find win-win solutions; we can redirect our current payment and delivery system to achieve the Triple Aim. In order to do so we must begin asking what is needed with the community and how can we align payment and delivery to meet these needs?

New Designation
Through the formative work of the Washington Rural Health Access Preservation (WRHAP) Project, and supported by the goals of the Healthier Washington initiative, a unique and timely window of opportunity is available for Washington State to address this issue. Under the work of

Model 2 we are seeking to build a new facility type designation that meets the needs of both payers and providers, and to deliver care in new and innovative ways. We hope to identify a model that not only prioritizes a robust primary care and emergency services system, but also reforms payment methodology to encourage value and incentivize chronic disease management.

Partnering with Medicare

Washington has adopted the federal statutory and regulatory requirements for CAHs. Because Medicare is a significant payer in rural communities, changes to Medicaid alone under the initiative will not address the need for sustainability in rural health systems. CMMI support is needed to provide a pathway for states like Washington to pilot payment and delivery models. A Medicare demonstration is needed to address both payment and delivery concerns for the rural health system. Cost-based reimbursement is a model predicated on volume. Payment Redesign Model 2 needs the ability to pilot new approaches that will move hospitals to a new payment approach while sustaining access to essential health services in low-volume settings.

SIM Component Table

Activity/ Budget Item:	Description of activities	Primary Driver	Metric
Consulting Support for Facilitation and APM Development	Hiring of consultant to support alternative payment methodology (APM) development/ vetting and working session facilitation.	Encounter-based to value-based	An alternative payment methodology is ready for a state plan amendment (SPA).
Stakeholder Engagement and Conceptual Model Development	Hiring of consultant to engage with diverse stakeholders on the local level, and convene critical access hospital (CAH) leaders for model development.	Encounter-based to value-based	Official commitment to pilot a model from at least one CAH Stakeholder.
CAH Modeling Support	Working with cost report data and aggregate level data to develop model details/options.	Encounter-baed to value-based	A CAH payment and delivery model vetted by CAH stakeholders.
Provider Payment Changes	HCA system changes to support model in payment system.	Encounter-based to value-based	Model(s) can be managed from ProviderOne payment system.
External Validation	Actuarial analysis of rate formula by external third party.	Encounter-based to value-based	The new payment and delivery models are implemented in at least 1 FQHC/RHC and 1 CAH.

Quarterly Accountability Targets/Milestones

	Accountability Objectives	Quarterly Accountability Targets/Milestones	Key Milestones
1	Consulting support for facilitation and APM development	Q1/Q2 FY2016 - Conduct working sessions with Stakeholders to iteratively refine an FQHC/RHC alternative payment methodology (APM). Deliverables - Working session materials/facilitation, APM relevant materials	An alternative payment model (APM) has been developed and is ready for submission to the Washington Medicaid state plan amendment (SPA) process.
		Q1/Q2 FY2016 - Assist HCA in navigating Stakeholder relationships and provide subject matter expertise to help develop and validate an APM. Deliverables - Stakeholder assessments and recommendations, APM relevant materials	At least 1 FQHC or RHC has committed to piloting the new model.
2	Stakeholder engagement and conceptual model development	Q1-Q4 FY2016 - Conduct working sessions with Stakeholders to iteratively refine a new payment and delivery model for critical access hospitals (CAHs). Deliverables - Working session materials/facilitation, model conceptual consensus building materials	A new payment and delivery model developed and is ready for submission to the Washington Medicaid state plan amendment (SPA) process.
		Q1-Q4 FY2016 - Work at the local level with CAH Stakeholders participating in payment redesign to educate and develop community support for piloting participation. Deliverables - Stakeholder engagement materials (presentation/outreach materials), focus groups	At least 1 CAH has committed to piloting the new model.
3	CAH modeling support	Q1-Q4 FY2016 - Working with CAH cost report data and aggregate claim information to develop and refine the payment and delivery model. Deliverables – payment and delivery model relevant materials.	Fully drafted payment and delivery model for CAHs
6	Provider payment changes	Q1-Q3 FY2016 - Identify and implement changes to internal HCA systems for facilitating new APM. Coordinating efforts with Provider One contractor. Deliverables - Based on APM implementation needs	HCA is ready to implement the new APM by the end of Q3 FY2016
		Q1-Q4 FY2016 - Identify and implement changes to internal HCA systems for facilitating new payment and delivery model for CAHs. Coordinating efforts with Provider One contractor. Deliverables - Based on model implementation needs	HCA is ready to implement the new payment and delivery model by the end of Q4 FY2016.

8	External validation	Q2-Q4 FY2016 - Work with external auditors to verify and validate new rates for payment and delivery models. Deliverables - Official rates	An established rare for the new payment and delivery models.

Payment Model 3: Accountable Care Program and Multi-Purchaser

Payment model 3 tests new accountable delivery and payment models compared to existing fee-for-service models. Model test 3 has the following goals:

- Improve health status of PEBB members
- Improve member experience
- Improve quality of care (as defined by performance of measures in quality improvement model)
- Reduce cost trend over the life of the contract
- Decrease inappropriate utilization

The Model Test 3 has three phases:

- An accountable care option for state employees (PEBB) starting in January 2016, in the five-county Puget Sound region. Healthier Washington began development on model test 3 in fall of 2014, and issued a Request for Applications for accountable care network partners in December 2014. Evaluation of applications, including on-site reviews, and contract negotiations occurred in Q1 and Q2 2015, ending with 2 signed contracts the beginning of June 2015. Puget Sound High Value Network (led by Virginia Mason) and the University of Washington Accountable Care Network were the two networks selected.
- Under this model test, the networks have agreed to risk-based contracts. The networks will assume clinical and financial risk for PEBB members who choose or are attributed to one of the network options during open enrollment, November 1-30, 2015. Both networks will be eligible to 'share' in the savings depending on their performance on quality improvement measures and member experience. In July 2015 a marketing firm was hired to help promote the new options to PEBB members. With the marketing firm's assistance, various outreach and education strategies have been employed using different mechanisms (email, mail, webinars, and videos) to inform PEBB members of these new offerings.
- Statewide expansion of accountable care options, starting in 2017. Healthier Washington's goal is to expand the accountable option statewide to make it available to PEBB members beyond western Washington in 2017. Healthier Washington staff has been working on formulating an expansion strategy. Under consideration are two approaches: 1) work with current accountable care partners to expand to other counties, and/or 2) explore new partners (under the previous procurement process). New partners or expansion plans need to be finalized by June 2016 in order for any new options to be operationalized by 2017.
- Multi-Purchaser Strategy - Spread and scale accountable care model by other purchasers in their 2017 benefit offerings. To drive value-based payment across the community, this strategy will engage public and private purchasers and union trusts to educate, adopt and test the model with their own employee populations. Other

purchasers will find significant benefit from learning from and building upon the state's purchasing strength and model performance results to drive quality and cost outcomes for their employees and beneficiaries. Purchaser strategies include:

- Work with a subset of senior purchaser leaders that participate in the Washington Health Alliance Purchaser Affinity Group as well as additional large purchasers (PAG Plus);
- Conduct one-on-one meetings with purchasers; and
- Co-convene purchaser conference annually. Healthier Washington staff will also issue a Request for Information annually, starting in first quarter of 2016, to track the Washington State marketplace's movement to value-based payments and assist with setting the benchmark. Most of these activities will need to take place in Q4 2015 and Q1 / Q2 2016 in order to be implemented in 2017 benefit planning strategies.

SIM Component Table

Activity/ Budget Item:	Description of activities	Primary Driver	Metric
Enrollment/ Participation in ACP options, January 2016	Promote options during different mediums (benefit fairs, PEBB newsletter, presentations, and webinars)	Accountable Care Program	Number of PEBB members who select ACP options
Expansion of ACP options, 2017	Expand the ACP products beyond the Puget Sound region. Currently evaluating different mechanisms (i.e., issue another procurement)	Accountable Care Program	In 2017, 2018 and 2019 ACP product available in additional counties beyond the five-county Puget Sound region.
Purchaser engagement to Spread and Scale Model and value-based purchasing strategies	Individual meetings with public and private purchasers Work with a select subset of the Washington Health Alliance Purchaser Affinity Group (PAG) and additional purchaser leaders from large employers to adopt similar accountable care payment strategies and value-based payments, semi-annually. Co-sponsor purchaser conference with the Washington Health Alliance, King County, and the Washington Roundtable (target audience: benefit managers)	Accountable Care Program	Meet with at least nine purchasers through 1:1 meetings At least two purchasers integrate Model 3 strategies into 2017 contracts. 90% of senior level invitees attend PAG Plus meetings Over 40 purchasers attend annual purchaser conference
Issue Request for Information to survey moment towards and adoption of value-based payments (using the CMS payment framework)	Similar to the RFI released in April 2014, this RFI will be organized using the CMS payment framework.	Accountable Care Program	Response rate Percentage of commercial health care in value-based payments

Quarterly Accountability Targets/Milestones

	Accountability Objectives	Quarterly Accountability Targets/Milestones	End of FY2016 Key Milestones
1	Enrollment/Participation in ACP options, 2016	Q4 (2015): 7,000 enrolled beneficiaries.	Q4 (2015): 7,000 enrolled beneficiaries. Q4 (2016): The number of PEBB members choosing to enroll in an ACP option increases by 10%.
2	Expansion of ACP options, 2017	Q1-Q2: Strategy implemented, and negotiations and signed contracts completed with new ACP partners; and current ACP partners' expansion plans completed. Q3-Q4: Pre-launch activities/operational tasks with new partner completed.	Q2: ACP option offered in more than 10 counties throughout Washington State.
3	Purchaser engagement – Spread and Scale of ACP Model (individual meetings with public and private purchasers, semi-annual meetings with group of selected purchasers (PAG Plus), annual purchasers conference	Q1: RFI released Q1: Purchaser conference held; meet with three purchasers Q2: First meeting of PAG Plus; meet with at least three new purchasers/make presentations Q3: Meet with at least three new purchasers/make presentations Q4: Second meeting with PAG Plus; meet with at least three new purchasers/make presentations Please note that purchaser engagement/spread and scale activities will occur annually (e.g. the 2016 milestones will occur again in 2017 and 2018).	Q2: 2 purchasers execute risk-based contracts including clinical and financial components from Model 3 contracts, for 2017 benefits Q4 2018: 200,000 beneficiaries receiving care through model

Payment Model 4: Greater Washington Multi-Payer

Providers need new and expanded sets of real-time data; more specifically, an integrated and longitudinal view of their patients across multiple payers in order to take on financial and clinical accountability, care coordination practices, and population health management responsibilities. Simply changing financial incentives and reimbursement to providers will not achieve the Triple Aim, as learned from a legislatively mandated multi-payer medical home reimbursement pilot in 2009 and responses to the Accountable Delivery and Payment Reform Request for Information HCA and King County jointly issued in April 2014.

Healthier Washington Payment Model Test 4: Greater Washington Multi-Payer seeks to engage multiple payers and provider systems and accelerate the adoption of value-based payment (VBP).

The resulting multi-payer network will have the capacity to coordinate care, share risk, and engage a large population comprising commercial, Medicaid, public employee, and Medicare beneficiaries. Claims and clinical data integration and aggregation will provide a unified view of patient care and timely feedback to providers, regardless of payer, facilitating improved care coordination and population health management.

Multiple innovative efforts around common infrastructure that empower providers to take on new forms of reimbursement are emerging across Washington State. This payment model aims to accelerate capacity through a lead organization, while aligning with foundational elements of the initiative, including the Practice Transformation Support Hub and Accountable Communities of Health, to ultimately inform more efficient and value-based state health care purchasing practices. HCA released an RFA, seeking applicants with demonstrable leadership skills and successful experience convening payers and providers, to serve as the lead organization, advance an existing data aggregation solution, and increase the adoption of value-based reimbursement strategies.

The purpose of the RFA was to provide resources and data to the selected lead organization to accelerate an existing strategy in the lead organization's operation while at the same time incorporating key components of the initiative, including the Washington State Common Measure Set for Health Care Quality and Cost and delivery system reform strategies. The goal was to increase the adoption of VBP by increasing providers' access to patient data across multiple payers and provider systems. HCA received no bids for this procurement and is revisiting the development and discovery process to identify the appropriate path forward. HCA expects to finalize detailed plans to pursue another similarly purposed procurement in early- to mid-December.

SIM Component Table

Activity/Budget Item:	Description of activities	Primary Driver	Metric
Procure a lead organization to fulfill Payment Model 4	Execute a procurement process, negotiate contract terms with a lead organization	Greater Washington Multi-Payer	Successful execution of a contract for Model 4 with a lead organization by the end of Q2 2016
Manage PEBB/Medicaid data flow from state to lead organization	Transfer appropriate data through data intermediary's secure data stream	Greater Washington Multi-Payer	Successfully and securely transfer data to lead organization data intermediary over the course of the contract by the end of Q2 2016
Integrate Model 4 into PEBB purchasing strategies	Periodically consult with internal partners to discuss options for future integration of Model 4 into PEBB purchasing contracts	Greater Washington Multi-Payer	Completed plan detailing options for future integration of Model 4 into PEBB purchasing contracts by the end of Q4 2016
Renew contract terms with lead organization each year	Negotiate terms with lead organization, submit to CMMI for approval in 2016, 2017, 2018	Greater Washington Multi-Payer	Obtain CMMI approval of contract terms in 2016, 2017, 2018 by the end of Q2 2016
Lead organization contract fulfillment	Lead organization will convene multiple payers and expand a data aggregation solution to advance value based purchasing strategies	Greater Washington Multi-Payer	Multiple payers convened through a data aggregation solution; VBP in 80% of lead organization's purchasing arrangements by Q4 2019
Contract management	Manage contract with lead organization, track deliverables, oversee financials, manage communication	Greater Washington Multi-Payer	Maintain and manage contract through Dec. 31, 2018. Lead organization deliverables: engage payers/providers as agreed to in contract terms, advance VBP to 80% of lead organization purchasing strategies by Q4 2019

Quarterly Accountability Targets/Milestones

	Accountability Objectives	Accountability Targets for Objectives	End of FY2016 Key Milestones
1	Manage PEBB/Medicaid data flow from state to lead organization	Q1-Q2: Communication strategy established between LO/LO's data intermediary and HCA/Regence/P1 Q3-Q4: Initial data dump complete, move towards periodic transmission	Lead organization to have received historical data dump and periodic data transfers established

	Accountability Objectives	Accountability Targets for Objectives	End of FY2016 Key Milestones
2	Integrate Model 4 into PEBB purchasing strategies	Q1: Consult internal partners Q2-Q3: Develop plan/recommendation for integration of Model 4 and PEBB purchasing Q4: Finalize recommendation to leadership for FY 2017	Present recommendation to HCA/PEBB leadership for integrating Model 4 into PEBB purchasing strategies
3	Renew lead organization contract terms and review contract fulfillment annually	Q1: Release new RFA Q2-Q3: Implement contract with lead organization Q4: Lead organization begins outreach to additional payers and providers; advancing VBP; lead organization fulfills requirements of contract to renew for FY 2017	Lead organization successfully convenes at least two commercial/QHP plans and one Medicaid plan; Model 4 contract renewed for FY 2017
4	Consultant	Q1-Q2: Darryl Price provides advice on revised procurement approach and convening additional external partners Q3-Q4: HCA provides assistance to lead organization in convening additional partners	Long term strategy developed to assist lead organization in convening additional partners
5	Model 4 Evaluation	Q1-Q2: Model 4 evaluation criteria established with UW team Q3-Q4: Model 4 evaluation data stream established; data collection initiated	UW begins collecting Model 4 data and provides year 1 assessment
6	Contract management	Q1: RFA developed and released Q2-Q3: Contract executed, lead organization performance initiated; Plans for convening additional payers/providers and advancing VBP established Q3-Q4: Lead organization plans for FY 2017 developed and presented to HCA; seek CMMI approval for contract renewal	Lead organization convenes payers/providers according to contractual schedule and makes significant strides in advancing VBP among partners

Analytics, Interoperability and Measurement (AIM)

The Analytics, Interoperability and Measurement (AIM) investment area is a program within Healthier Washington, tasked with providing an innovative solution portfolio that builds analytic and measurement capacity and develops a diverse tool set needed for the translation and visualization of data from multiple sectors into actionable information. The AIM program consists of several efforts necessary to support the health system transformation projects under the SIM grant.

Goal

The goal of AIM is to meet the data, analytic, interoperability and measurement decision support needs of Healthier Washington, from service delivery to policy and program development, to SIM investment areas.

Objectives

AIM objectives are clustered around three high level domains:

- Business Intelligence/Shared Analytics (BI/SA) Capacity and Capabilities, including:
  - Governance – Program, project and data
  - Organization – Structure, processes, staffing and skills
  - Client (Demand) Management and Assistance
  - Partners and Vendors
  - Business Intelligence/Analytics – Human capacity and process
  - Measurement, Metrics Coordination and Performance Management
- Enterprise Information Management, including:
  - Data Sources
  - Data Quality
  - Data Stewards and Management
  - Privacy/Confidentiality
- Technology Infrastructure, including:
  - Source Systems and Owners
  - Extensible, Agile, Adaptable Infrastructure(s)
  - BI/Analytic Tools
  - Health Information Technology (HIT) Exchanges and Secure Messaging
  - Connectivity, Interfaces and Integration
  - Security

The table below lists the objectives in further detail, by domain.

BI/SA Capacity and Capabilities	Enterprise Information Management	Technology Infrastructure
Establish Client-centric Healthcare Service Management, Reporting and Analytics Actively manage the efficacy and cost of services through client-centric coordination of services, benefits and, measurements.	**Establish and Manage Data Sources** Identify and leverage the most appropriate state and external master, transactional and unstructured data sources to generate the metrics and measurements required for Healthier Washington.	**Implement Extensible and Adaptable Architecture** Ensure the solution architecture is able to provide 'quick wins' while being extensible and adaptable as it relates to BI/SA needs for Healthier Washington and beyond.
Implement Evidence-based Approach to Innovation and Improvement Drive innovation and improvement through the ability to analyze information and create an information/knowledge-based and disciplined culture for Healthier Washington and HealthCare Authority (HCA).	**Establish Data Quality Culture** Ensure processes are in place to measure, enhance and maintain data quality.	**Facilitate a Variety of Analytical Roles and Data Usage** Breadth of BI/SA tools must be available for all intended users (citizens, "business" users, analysts, executives, super users) and use of the data.
Establish Governance and Shared Resources Establish and enable program and project governance, as well as policy and processes with a clear multi-entity organizational structure for management of AIM, as Washington must coordinate a number of highly critical and competing initiatives.	**Ensure Multi-entity Data Governance** Ensure data governance and decision making driven by "business" needs as well as strong organizational leadership and participation. AIM needs a data governance structure that can manage evolving data sharing needs through the facilitation, compliance and enforcement of policies, standards and data sharing agreements.	**Protect Existing Systems Investments** Ensure that any enterprise data interchange, aggregation and analytics solutions can coexist with existing agency systems by being based on IT industry and national standards for interoperability and data sharing; thus protecting existing investments, ensuring uptake of national standards and supporting incremental adoption.
Establish Business Intelligence/Shared Analytics (BI/SA) Delivery and Support Capability Establish the optimal organizational structure and multi-disciplinary dedicated resources essential to implement and support BI and Shared Analytics in a phased approach.	**Establish Data Stewardship** Establish responsibility and accountability for active and continuous data quality audit and corrective action by making units and individuals accountable for the quality of the data they process.	
Implement Change Management and Robust Communication Implement and maintain a robust communication plan and change management activities (e.g. awareness, leadership and participation campaigns and training) to ensure that stakeholders at all levels are aware and understand the AIM efforts and how planned deployments may impact end users' work.	**Ensure Privacy and Security** Implement processes, procedures and controls to assure that data is secure with privacy and integrity assured.	

BI/SA Capacity and Capabilities	Enterprise Information Management	Technology Infrastructure
Leverage Funding and Investments Fully leverage Federal Financing Participation (FFP) for the benefit of Washington stakeholders and well-being of residents.		

Scope

The scope of AIM includes the design and implementation of the following capabilities and capacities for Healthier Washington:

- Measurement
  - Aligned with the Washington Statewide Common Measure Set, provide the governance, capacity and capabilities to measure the initiative as identified and defined by the teams responsible for performance measures and metrics.
- Analytics and Interoperability
  - Information Governance – Establish a comprehensive approach to governance over Healthier Washington data and information, per legal, regulatory (e.g., HIPAA, 42 CFR Part 2, etc.), contractual and ethical requirements of data. Implement governance and quality controls through multi-entity policies, and procedures.
  - BI/SA Decision Support tools – Aligned with Healthier Washington measurement metrics and the decision support needs for performance management and predictive capacity needs, AIM will provide a number of business intelligence and analytic tools, including:
    - Business Intelligence and Reporting tools on defined, descriptive metrics, such as those in support of decision making or evaluation;
    - Analytics capabilities, allowing Healthier Washington stakeholders to explore data through visualization, programming, modeling and other diagnostic, predictive and prescriptive analysis methods.
  - Logical Data Warehouse – A central data architecture, spanning multiple data repositories (both structure and unstructured), containing data from multiple sources, including those inside and outside of HCA.

AIM and Healthier Washington Investment Areas/Related Projects

The Healthier Washington initiative consists of many interrelated programs and projects. Many of these efforts will rely on AIM for various data and analytic tools and capabilities. AIM is considered the facilitator of all Healthier Washington aims, and contributes to all drivers and activities of the initiative. The table below describes the scope of AIM as it relates to each of these areas. The list includes examples of AIM deliverables for each.

Healthier Washington Investment Area/Related Project	AIM Scope
Accountable Communities of Health (ACH)	• Aligned with ACH initiatives, provide measurement metrics, reporting and analytics capabilities to ACHs, in order to help ACH's meet their goals for Healthier Washington initiative. Specifically, provide data reporting and dissemination tools to ACHs, to help them identify health care and social service purchasing and delivery models to meet unique local needs, challenges and requirements. • Provide data and analytics capabilities, where and as needed, to supplement existing reporting on Statewide Performance Measure set, per unique ACH measure needs and requirements.
Plan for Improving Population Health (P4IPH)	• Aligned with P4IPH goals and objectives, provide measurement metrics, reporting and analytics capabilities to P4IPH initiative, as needed. • Enhance statewide performance measure set, per goals of P4IPH.
Payment Model 1: Early-Adopter of Medicaid Integration	• Aligned with Model 1 goals, objectives and KPIs, provide decision support where and when needed, in support of the initiative's reporting and analytic capacity. • Provide info governance, privacy and security controls to Early Adopters program.
Payment Model 2: Encounter-based to Value-based	Aligned with Model 2 goals and objectives, provide measurement metrics where and when needed, in support of the initiative's reporting and analytic capabilities (e.g., data modeling and decision support capabilities), as needed.
Payment Model 3: Accountable Care Program and Multi-Purchaser	Aligned with Model 3 goals and objectives, provide measurement metrics where and when needed, in support of the initiative's reporting and analytic capabilities.
Payment Model 4: Greater Washington Multi-Payer	• Aligned with Model 4 goals and objectives, provide measurement metrics where and when needed, in support of the initiative's reporting and analytic capabilities. • Provide data governance, privacy and security support and controls and oversight to Model 4 data sharing efforts
Practice Transformation Support Hub	Aligned with the Practice Transformation Hub goals and objectives, provide measurement metrics, where and when needed, in support of the initiative's reporting and analytic capabilities.
Shared Decision Making	Aligned with Shared Decision Making goals and objectives, provide data, reporting and analytics capabilities.
Healthier Washington SIM Evaluation	Aligned with Healthier Washington Evaluation team goals, objectives and KPIs, and in coordination with Department of Social and Health Services' (DSHS) Research Data Analysis (RDA) division, provide data, reporting and analytics tools to University of Washington (UW) Evaluation team and Group Health Research Institute (GHRI) Center for Community Health and Evaluation (CCHE) team.
Washington State Common Performance Measures	In coordination with DSHS's RDA group, the Department of Health (DOH), the Washington Health Alliance (WHA) and the Washington State Hospital Association (WSHA), support the definition and refinement of Common Performance Measures and provide data, reporting and analytics tools (as needed) to Washington Health Alliance in alignment with needs of Statewide Common Measures effort.
Behavioral Health Data Assessment	Find practical solutions that will assist behavioral health providers in the adoption of certified EHRs and successful connection to the CDR.

Healthier Washington Investment Area/Related Project	AIM Scope
Link4Health Clinical Data Repository (CDR) project	• Provide requirements to Link4Health CDR Project, in support of Healthier Washington goals and objectives. Specific areas of requirements may include: o ETL to Healthier Washington AIM Data Warehouse o Data, Reporting and Analytics needs of Healthier Washington investment areas o Healthier Washington data governance and best practices • Design, build and implement systems for integrating CDR data into AIM logical data warehouse
All Payer Claims Database (APCD)	• Provide requirements to APCD project, in support of Healthier Washington goals and objectives. • Specific areas of requirements include: o ETL to Healthier Washington AIM Data Warehouse o Data, Reporting and Analytics needs of Healthier Washington investment areas o Healthier Washington data governance and best practices • Design, build and implement systems for integrating APCD data into AIM logical data warehouse

SIM Component Table

Activity/ Budget Item	Description of activities	Primary Driver	Metric
Healthier Washington Dashboard Reporting Tool	Provide interim data, analytics and reporting capabilities to Healthier Washington ACH's, while full, long term AIM infrastructure portfolio is procured and implemented. Work includes: Collaboratively design, plan and strategically build a data infrastructure and a dashboard reporting tool to support quality metric reporting for ACHs. These metrics will initially include a starter subset of the statewide common measure set stratified by region and zip code (when possible) and will be derived from Medicaid claims and encounter data, IIS, BRFSS and PRAMS and DSHS data. Create a supporting working plan of the build and future phases of work. Develop a basic filter within the DRT that enables the ACHs to filter to their regions.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	Release of, and iterative updates to, Healthier Washington Dashboard Reporting Tool, including reporting capabilities covering subset of Washington Statewide Common Measure Set identified as most beneficial to ACHs.

Activity/ Budget Item	Description of activities	Primary Driver	Metric
	Implement, validate and report on selected starter measures from the Healthier Washington measure set on an incremental development schedule. Regularly scheduled DRT release deliverables will begin and continue for the duration of the contract period. Each release will be enhanced and developed to contain additional measures, functions and views. This will also include more advanced filter development for the DRT. At the discretion of HCA, additional data sets may be included at a later time during the contract's duration. These additional data sets would potentially be added in order to show a more complete picture of the social determinants of health.		
Healthier Washington Information Governance	Establish Healthier Washington Information Governance program to provide structures, policies, procedures, processes and controls mean to responsibly manage Healthier Washington data and information, per regulatory, legal, contractual, risk and environmental requirements.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	• Approval of Healthier Washington Information Governance charter • Approval of Healthier Washington Information Security and Privacy Plan • Approval of Healthier Washington Information Architecture and Data Management Plan • Approval of Healthier Washington Information Quality Assurance Plan • Approval of Healthier Washington Information Access Management Plan
AIM Project Quality Assurance	Provide QA oversight for AIM Program, per Washington State Office of the CIO requirements for IT projects.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	• AIM Program managed on time, on budget and within scope
AIM BI/Analytics Platform	Multi-component data, reporting and analytics (IT) infrastructure, involving the following capabilities: • Data Integration • Data Storage (Logical Data Warehouse) • Business	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	Approval of Healthier Washington AIM Procurement Strategy and Plan Release of RFPs for AIM BI/Analytics Platform components Selection of vendors for

Activity/ Budget Item	Description of activities	Primary Driver	Metric
	Intelligence/Analytics • Data Quality		AIM BI/Analytics Platform RFPs Implementation of AIM BI/Analytics Platform
Healthier Washington Evaluation Support	• Define, collect and store data (e.g., survey data, cost reporting, client level encounter and clinical data, provider data) to support Baseline, Intermediate and Outcome measures (e.g., for the Statewide Common Core Set of Measures, and other measures sets needed for Healthier Washington) • Provide consumable decision support information to help make enhancements and modifications in program models, target geographies and populations, resource allocations, coordination efforts, etc.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	By July 2016, define plan for collecting and storing Baseline Evaluation data as needed
Healthier Washington Data Acquisition - BRFSS	Per requirements of Healthier Washington investment areas, Healthier Washington Evaluation Team, and as needed for Washington Performance Measures, acquire data sources and load data into AIM logical data warehouse. At project start, one known data set is included in this activity/budget item – the Washington State Behavioral Risk Factor Surveillance System (BRFSS). The Washington State Department of Health (DOH) is further enhancing this survey sample, to include annual estimates for small counties or sub-county geographic areas	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	BRFSS enhanced to include annual estimates for small counties or sub-county geographic areas

Activity/ Budget Item	Description of activities	Primary Driver	Metric
BH Data Assessment	Identify practical solutions that will bring Behavioral Health data into the Washington Link4Health Clinical Data Repository.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	By February 2016, approved BH Data Assessment Gap Analysis and Recommendations Report
BH EHR Implementation	Per interoperability goals of Healthier Washington, identify and purchase solution for behavioral health provider connection to Link4Health Clinical Data Repository	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	BH EHR system implemented for BH providers
BHO Data Consolidation Project	DSHS's Behavioral Health Service Integration Association (BHSIA) proposes to create a data store which will accept and store patient information for mental health and chemical dependency clients from Behavioral Health Organizations (BHOs), as well as the Tribes and Problem Gambling providers.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	System designed, generated and released Successful adoption by customers
Washington All Payer Claims Database	Purchase quarterly reports on price and quality information across payers, aligned with the common measure set and other ad hoc reporting requests	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	Selection of lead organization to design and implement APCD by January 2016 Implementation of APCD by Q3 2017 All Washington plans submitting data to APCD by January 2019. Annual reports on common measure set upon completion of APCD build (anticipated beginning Q3 2017)
Evolution and evaluation of the Statewide Common Measure Set: Convening Governor-appointed Performance Measures Coordinating Committee (PMCC)	Convene the PMCC quarterly to review and approve new measure topics for the Statewide Common Measure Set drawing from the current "parking lot of measures"; review recommendations from ad hoc measure selection workgroups; submit recommendations to HCA for annual updates to the current "starter" set of common measures.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	2016-2018 Annual updates to common measure set. Final set of common measures in place no later than January 2019.

Activity/ Budget Item	Description of activities	Primary Driver	Metric
Evolution and evaluation of the Statewide Common Measure Set: Convening ad hoc measure selection workgroups	Convene up to three ad hoc workgroups annually to explore evidence and feasibility for adding new measures that address measure topics identified by the PMCC.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	Final set of recommendations of new/replacement measures submitted to the PMCC annually for consideration.
Evolution and evaluation of the Statewide Common Measure Set: Convening evaluation workgroup	Convene one ad hoc workgroup of data/results suppliers to evaluate annual implementation of reporting from the measure set and recommend changes to the process and/or replacement or retirement of currently approved measures to the PMCC for 2017.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	Final set of recommendations submitted to the PMCC annually for consideration.
Evolution and evaluation of the Statewide Common Measure Set: Public Comment Survey	Launch an online survey to solicit feedback from the public on the proposed updates to the common measure set. Results will be shared with workgroups and PMCC before formal recommendations to HCA.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	Four opportunities to participate in annual survey to review proposed changes to Statewide Common Measure Set by end of calendar year 2018.
Communication Campaign: Promote and spread the ongoing use of the common measure by purchasers, payers and other entities.	Develop, launch, and implement an ongoing communication campaign, including materials, videos, talking points, and web content, to educate purchasers, payers, providers, and communities about the purpose of the common measure set and to promote the uptake.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	Up to 100% of large purchasers, payers, and large medical groups have indicated they have received targeted information by January 2019.
Reporting: Accelerate statewide spread of medical group level reporting	Build out provider roster for primary care medical groups to enable broader reporting, continuing work started in FY2015. Starter list completed in January 2016.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	Final provider roster for primary care medical groups complete by January 31, 2017.
Reporting: Produce and report results for Statewide Common Measure Set	Design, develop and launch a robust, interactive web platform to report results for the common measure set.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	Final web platform completed for reporting in late 2016.

Activity/ Budget Item	Description of activities	Primary Driver	Metric
Reporting: Produce and report results for Statewide Common Measure Set	Using a web-based platform to capture appropriate data sources, publicly report results using an online platform, as well as a written report for the Statewide Common Measure Set on an annual basis.	AIM is considered a facilitator of all Healthier Washington aims and is not tied to one primary driver	Public reporting of results, using a web-based platform, annually through January 2019 (or when APCD is established and ready for reporting.)

Quarterly Accountability Targets

Accountability Objectives	Quality Accountability Targets/Milestones	End of FY2016 Key Milestones
Healthier Washington Dashboard Reporting Tool	2016 Q1 • (1a) Data Infrastructure Design • (1b) Dashboard Reporting Tool Design • (1c) Work Plan • (1d) Data Infrastructure Build • (1e) Dashboard Reporting Tool Build • (1f) Data Validation • (2a,b,c) Select Measure Development, Validation, Filters • (2d) Initial DRT Release 2016 Q2 • (2a,b,c) Additional Measure Development, Validation, Filters • (2d) DRT Updates 2016 Q3 • (2a,b,c) Final Measure Development, Validation and Filters • (2d) DRT Updates 2016 Q4 • (2d) DRT Updates	• Healthier Washington DRT released • Select subset of Washington Statewide Common Measures reported in DRT identified, validated and filtered appropriately
Healthier Washington Information Governance	2016 Q1 • Healthier Washington Information Governance contract approved 2016 Q3 • Healthier Washington Information Governance Charter approved	• Healthier Washington Information Governance Charter approved
AIM Project Quality Assurance	2016 Q1 • AIM Project Quality Management Plan • AIM Initial Quality Assessment Report	• AIM Project Quality Management plan approved • Quarterly AIM Project Quality Management Reports

Accountability Objectives	Quality Accountability Targets/Milestones	End of FY2016 Key Milestones
	2016 Q2 • AIM Quarterly Quality Progress Report 2016 Q3 • AIM Quarterly Quality Progress Report 2016 Q4 • AIM Quarterly Quality Progress Report 2017 Q1 • AIM Quarterly Quality Progress Report	
AIM BI/Analytics Platform	2016 Q1 • AIM BI/Analytics Platform Procurement Strategy and Plan approved • RFPs for AIM BI/Analytics Platform released 2016 Q2 • Apparent Successful Vendors for AIM BI/Analytics platform and Implementation Support selected • Contracts finalized for AIM BI/Analytics Platform and Implementation Support • AIM Data Acquisition Plans finalized 2016 Q3 • AIM BI/Analytics Platform Design Plans complete • AIM BI/Analytics Platform Implementation Plans finalized 2016 Q4 • AIM data source Data Use Agreements finalized 2017 Q1 • AIM BI/Analytics Platform implemented • AIM data source acquisition mechanisms (e.g., ETL) built • AIM data sources added to Healthier Washington AIM Logical Data Warehouse	• AIM BI/Analytics Platform Procurement Strategy and Plan approved • AIM BI/Analytics Platform RFP(s) released, Lead Organizations/vendors selected • AIM BI/Analytics Platform Implementation Plan approved • AIM BI/Analytics Data Acquisition Strategy Plan approved
Healthier Washington Evaluation Support	2016 Q1 • Assist with Healthier Washington Evaluation Plan 2016 Q2 • Refine Healthier Washington Evaluation metrics and supporting data collection plan 2016 Q4	• Healthier Washington Evaluation Plan Finalized • Healthier Washington Evaluation Baseline Data Collected

Accountability Objectives	Quality Accountability Targets/Milestones	End of FY2016 Key Milestones
	• Evaluation data sources identified, Data Use Agreements (DUAs) in place 2017 Q1 • Evaluation data collection repositories designed, implemented and populated	
BH Data Assessment	2016 Q1 • BH Data Assessment Gaps, Alternatives and Recommendation Report	• BH Data Assessment Gaps, Alternatives and Recommendation Report
BH EHR Implementation	2016 Q1 Healthier Washington Leadership decision on BH EHR approach (if decision to move forward with BH EHR Implementation: 2016 Q3 • BH EHR RFP Released, Vendor selected 2016 Q4 • BH EHR Contract finalized • BH EHR Implementation Project start	• BH EHR Vendor Selected • BH EHR Implementation Project start
BHO Data Consolidation Project	2016 Q1 • BH Data Consolidation Tool Development • BH Data Consolidation Tool Testing 2016 Q2 • BH Data Consolidation Tool Release	• BH Data Consolidation Tool Released
All Payer Claims Database	2016 Q1 • Vendor selected • APCD project starts 2017 Q3 • APCD released	• APCD Leader Organization selected • APCD project start
Evolution and evaluation of the Statewide Common Measure Set: Convening Governor-appointed Performance Measures Coordinating Committee (PMCC)	Q1-Q2 FY16: Convene the PMCC twice to identify and approve measure topics for research Q2-Q4 FY16: Convene PMCC twice to review recommendations from ad hoc committee and approve and recommend final updates	Final measure recommendations are submitted to HCA for approval by December 31, 2016
Evolution and evaluation of the	Q2 FY16: Identify members for up to	Final set of recommendations of

Accountability Objectives	Quality Accountability Targets/Milestones	End of FY2016 Key Milestones
Statewide Common Measure Set: Convening ad hoc measure selection workgroups	three ad hoc workgroups Q2 - Q3 FY16: Convene up to three ad hoc measure selection workgroups to research, review, and identify measures to include in Statewide Common Measure Set	new/replacement measures submitted to the PMCC for consideration by December 15, 2016
Communication Campaign: Promote and spread the ongoing use of the common measure by purchasers, payers and other entities.	Q1 - Q4: Continue to engage payers, purchasers and providers to promote the spread and uptake of the common measures Q1 - Q4: Develop process and track reach of campaign	Up to 100% of large purchasers, payers, and large medical groups have indicated they have received targeted information by January 2019.
Reporting: Accelerate statewide spread of medical group level reporting	Q1 - Q2 FY16: Submit provider rosters for four new communities Q3- Q4 FY16: Submit provider rosters for three to four new communities	Final provider roster for primary care medical groups complete by January 31, 2017.
Reporting: Establish state All Payer Claims Database (APCD)	Q1 - Q2 FY16: Establish contract with successful bidder to lead development of ACPD Q3 - Q4 FY16: Begin development process for APCD	All Washington plans submitting data to the APCD by January 2019.
Reporting: Produce and report results for Statewide Common Measure Set	Q1 - Q2 FY16: Publicly report two instances of results for Statewide Common Measure Set Q1 - Q2 FY16: Publicly report two instances of results for Statewide Common Measure Set	Public reporting of results, using a web-based platform, four times annually through January 2019.

C. General SIM Operational and Policy Areas

Healthier Washington aligns systems, resources, priorities and action to achieve the Triple Aim of better health, better care and lower costs in Washington State.

Healthier Washington will:

- Build healthier communities and people by recognizing the best way to improve health is in the community where people live, work and play.
- Integrate care and social supports for individuals who have both behavioral and physical health needs.
- Reward quality health care over quantity, with state government leading by example as Washington's largest purchaser of health care.

State actors are breaking from traditional provider, purchaser and consumer roles to recognize health is more than health care. Recognizing that financial and clinical actions are important, the state is going beyond its role as a purchaser and payer to broaden our definition of health system and more directly partner with communities and the supports within them.

Accountable Communities of Health

Healthier Washington recognizes and leverages pockets of innovation and collaboration already occurring in local communities by bringing public and private entities together to work on shared health goals. This collaboration is replicated and scaled by nine regional Accountable Communities of Health (ACHs). Through these diverse multi-sector partnerships, ACHs are an integral part of achieving the Triple Aim and an equitable health system. Specifically, ACHs are:

- Bringing together diverse public and private community partners to identify and work on shared regional health goals.
- Identifying opportunities for the ACH and community partners to understand and bridge health and quality of life issues.
- Coordinating systems so services address all aspects of health at both the community and individual levels.
- Partnering with the state to inform the development of other Healthier Washington investments, recognizing ACHs are the connection to communities and the local conduit to achieve true systems change.

ACHs will lead local transformation that connects Healthier Washington investments within the context of communities across the state. While ACHs have flexibility to tailor projects based on regional needs, the expectation under the SIM test is that ACHs employ a Triple Aim strategy that links communities to health care delivery systems, public health and supports that contribute to the health of the individual, in addition to better care and lower cost. For example, one of the state's ACHs found a need within their region regarding Adverse Childhood Experiences (ACEs). The ACH will rely on the activities and expertise of school districts, social service organizations, and health care providers to implement a project focused on earlier identification and treatment of children with mental health or chemical dependency issues. This project requires a common agenda across partners with mutually reinforcing activities – a demonstration of regional collaboration that can have a far greater impact than any one sector or organization working independently.

ACHs are key partners in many Healthier Washington initiatives. Below are a few examples:

- As it is finalized, ACHs will play a role in the local implementation of the **Plan for Improving Population Health** to address conditions including ACEs, diabetes, obesity and smoking cessation. The Plan for Improving Population Health will be a valuable resource to guide and enhance ACH investments.
- With clear alignment between ACH regions and the regional service areas for Medicaid purchasing, ACHs are a local partner under the **SIM payment model tests**. Specifically the ACHs are functioning as a partner in purchasing as Washington moves away from traditional fee for service and drives toward paying for value that focuses on the health of the community and individual. One example under Payment Model 1 is the "early warning system" being designed by the Southwest Washington ACH. This system will provide an on-the-ground perspective

of the transition to fully integrated managed care. This includes alerts regarding regional/local health and community system or access issues and corresponding recommendations.

- In addition to value-based purchasing, ACHs will play a key role as part of **the Practice Transformation Support Hub's** regional extension model to promote clinical-community linkages and physical and behavioral health integration.
- The **Analytics, Interoperability, and Measurement** effort relies upon the ACH to identify local solutions to statewide priorities through data-driven decision making. The evaluation requires short-term and long-term measures, along with a Triple Aim lens based on the representation that exists within the ACH and the desire to link communities and delivery systems. The ACHs will use a Chain of Impact (see draft in Appendix B) approach to link process measures to project-specific interventions (based on meaningful data) to ultimate outcomes as identified in the Statewide Common Measure Set. This relationship is further demonstrated in the Theory of Change (Appendix C).

New levers to address old challenges

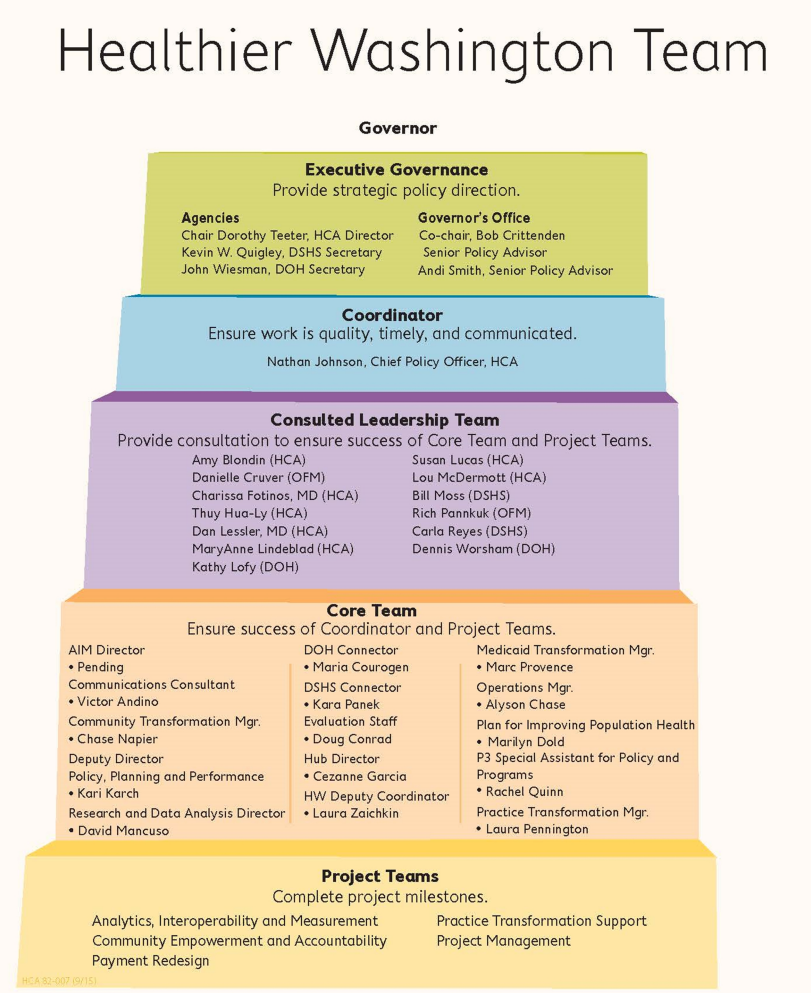
Washington is reaching outside of the traditional health care system and pulling multiple levers that work in unison to treat the whole person. These levers include regulatory, contracting/purchasing, community engagement, person and family engagement, convening, learning and collaboration, financial, data and measurement, and technology. The following components of the Operational Plan outline how Healthier Washington is using these levers and aligning multiple complex activities to create a new system that delivers a healthier Washington.

SIM Governance, Management Structure and Decision Making Authority

As directed by state law, the HCA will continue its leadership role and executive sponsorship of Healthier Washington. Washington State possesses the requisite experience, expertise and collaborative culture across state agencies, local governments, community partners, health systems, and consultants to successfully complete implementation of all Healthier Washington components.

Governor Jay Inslee directs the Healthier Washington initiative, and has been closely involved in ensuring alignment of the initiative with other state innovation initiatives including the development of Healthier Washington. The governor has directed alignment of agency initiatives and performance measures in support of health and wellness, and emphasized the importance of health system reform at the state and community levels. The governor successfully obtained statutory and budget authority in the 2014 and 2015 legislative sessions in support of Healthier Washington.

Similar to Healthier Washington's multi-sector approach to innovation and the achievement of the Triple Aim, the initiative is led, managed and implemented by leveraging the talents and resources of multiple state agencies in addition to HCA, namely, the Department of Health (DOH), the Department of Social and Health Services (DSHS), and the Office of Financial Management (OFM). All agencies are represented in the Healthier Washington governance structure (*see graphic below).*



In Healthier Washington governance, decision making is not merely vertical it is also bi-directional and horizontal. Each staff member wears an organizational hat and a functional hat. Team leads are encouraged to make the most of their decision-making authority. Each level of program governance has a specific role and accountability, as follows:

- **Executive Governance,** comprised of members of the Governor's cabinet and his senior advisors, provides strategic policy direction and ensures the overall success of the program.
- The **Healthier Washington Coordinator** ensures work is quality, timely, and communicated. As the program sponsor, the Coordinator is a critical resource for team leads and project managers. Sponsors are leaders and subject matter experts who are available to consult and advise on all decision types. Of paramount importance is the sponsor's ability to present an escalated or cross-agency program issue to the Consulted Leadership Team or Executive Governance. The Healthier Washington Coordinator is a key program sponsor who informs decision recommendations and suggests strategies.
- In a sponsoring and advising role, the **Consulted Leadership Team**, comprised of leaders and subject matter experts across the agencies, provides weekly consultation to ensure the success of Core Team and Project Teams.
- The **Core Team** is the functional and operational coordinating body for the program. The Core group meets bi-weekly to review status, address hot topics, resolve issues, and ensure the forward momentum of Healthier Washington.
- Healthier Washington has a number of **Project Teams**, comprised of team leaders, program managers and staff, working collaboratively to manage the projects under the Healthier Washington umbrella. The project managers are responsible for identifying decisions that need to be made as well as helping to prepare the requisite data required to make a final and firm decision. The project management group is also responsible for documenting and tracking all project-related decisions.

See Appendix D for a complete Healthier Washington staff list.

The enterprise of Healthier Washington is innovative in itself. Multiple state agencies are working together and cross-pollinating on an effort of enormous magnitude. We have largely abandoned siloed approaches commonly thought of in state government. This reinforces the driving philosophy of Healthier Washington: agencies are taking a "Health in All Policies" approach and identifying areas where they can align resources, priorities and action toward the common vision of Healthier Washington.

In-kind support (non-SIM funded staff contributing to the program) has been and will continue to be provided at the state level. Many key members of the Healthier Washington team, including the Healthier Washington Coordinator, are state-funded employees. Additionally, as evidenced in Section B components, significant activities are resourced by the state. This is not only necessary for an initiative of this magnitude, but will ensure elements are integrated into state business and are sustainable.

In addition to building upon the strengths of multiple state agencies, Healthier Washington leverages strong private sector support and adoption of the initiative. Some of this exists within the

contractual arrangements between the state and private entities, while some is voluntary. For example, Healthier Washington's partnership with the Washington Health Alliance includes funded deliverables around quality and price measurement and reporting, but it also has contributed in-kind resources and subject matter expertise around value-based models.

ACHs—by design—are unique within the Healthier Washington structure as sub-awardees of the SIM grant. ACHs reinforce the relationship between the state and community partners and are more than a community grant program. ACHs partner with the state across multiple investment areas to achieve the goals of Healthier Washington and ultimately the Triple Aim at the community level. The unique nature of the ACH efforts, including the state-community partnership, requires balanced multi-sector coalitions within each region. These coalitions require governance structures that are tailored by community leaders to most effectively implement the goals of Healthier Washington at the local level. ACH structures are designed to support local solutions in alignment with state priorities. The ACH Designation Criteria (Appendix E) provide an example of the balance between minimum standards and local flexibility.

Stakeholder Engagement

The Healthier Washington initiative recognizes health is a complex interplay of physical health, behavioral health, basic needs such as food, housing, education, and employment, personal and family supports, welcoming communities and quality of life. Health and recovery services, without a strong foundation of equitable system supports and community services geared to sustain health, do not serve individuals as whole people. Additionally, without supports, such as payment models that incentivize outcomes, the system responsible for health cannot effectively deliver it. There are many interdependencies that are not the responsibility of any single organization or state agency. These complex problems require a new way of doing business that reaches across organizational silos.

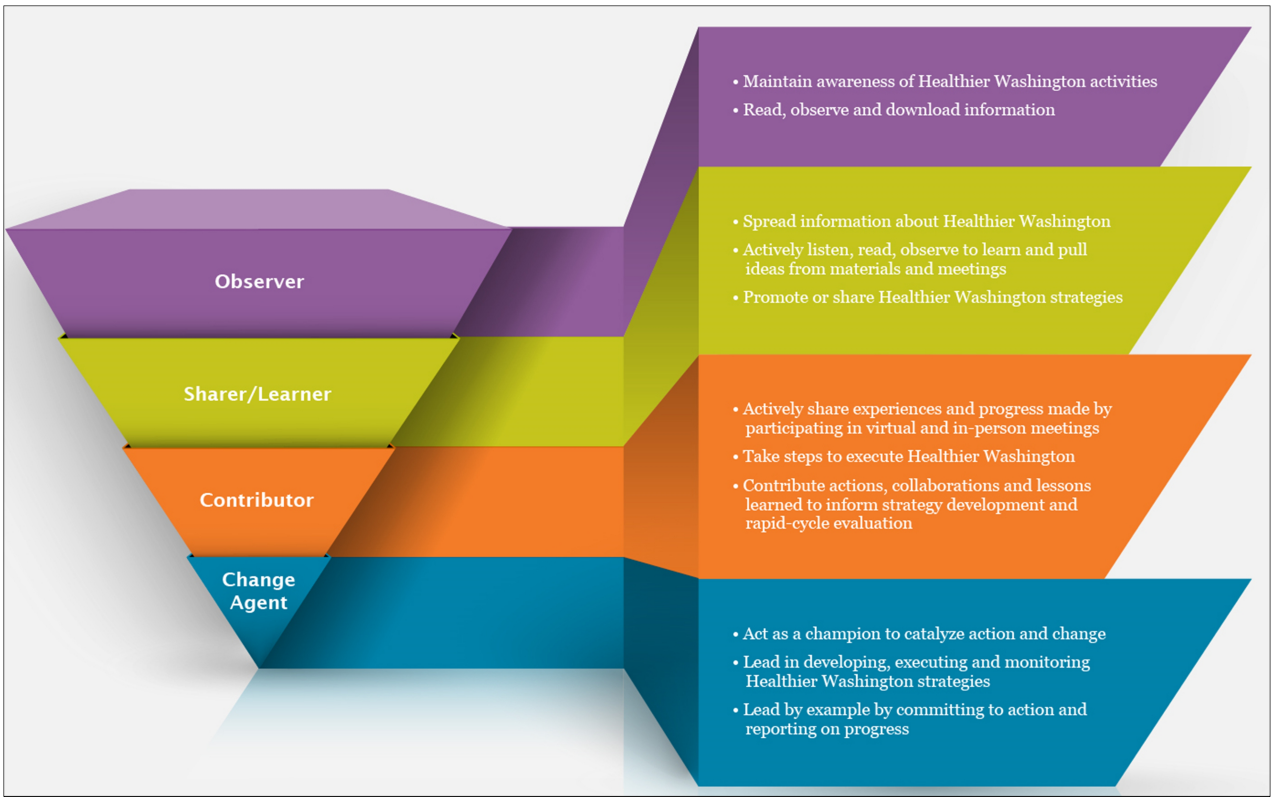
By their very nature, the interdependent elements of the Healthier Washington initiative necessitate community, health system and marketplace engagement. As such, Healthier Washington partners go beyond payers, providers, purchasers, public health, policymakers, consumers, and tribes, and reach into communities and to those that impact the social determinants of health such as housing, education, philanthropy, and social service providers. Healthier Washington's multi-sector approach is reflected in most workgroups and advisory bodies that have been formed under the initiative.

Foundational principles of Washington's 2013 State Health Care Innovation Planning process and the resulting Healthier Washington initiative is that the work be transparent and inclusive. Public and private leaders across the state have been and continue to be engaged in an intensive stakeholdering and communications effort, with thousands of stakeholders engaged throughout the state.

Ongoing activities will heavily rely on stakeholder support, interest, and commitment to transformation. A key component of Healthier Washington is broad engagement of interested stakeholders in order to promote bi-directional dialogue and feedback; connect stakeholders in action to further augment, accelerate and amplify the effort; and encourage momentum and sustainability of the initiative. The opportunity to engage in the initiative is open to all and allows for various levels of engagement—from listening, observing, and learning to actions as leaders and champions to promote change.

While some partners, such as members of the initiative's public-private leadership network, are expected to work as change agents and lead the charge in this work, there are many ways for interested stakeholders to engage. Contributors to Healthier Washington may be participants in Healthier Washington payment model tests or serve as partner communities; sharers and learners may take part in public comment opportunities and project-specific convenings; and interested stakeholders may simply observe the efforts by accessing the web meetings and resources in order to stay informed about work in the field. Our goal is to move stakeholders along the continuum of engagement and activate many Washington partners as change agents by the end of the model test.

Levels of Engagement



While many stakeholder groups recognize the value of their engagement in Healthier Washington, in order to activate a majority of stakeholders Washington has and will continue to be proactive about each stakeholder groups' role in the model test.

Government – State, County and Tribes

State, county and tribal governments have a key role as conveners, regulators, purchasers and policy makers. The state's policy makers in the legislative branch laid the foundation for many Healthier Washington efforts through the bi-partisan passage of House Bill 2572 and Senate Bill 6312.

Through Healthier Washington's collaborative efforts, state agencies are leading by example to act across traditional siloes. Entities at the state and community levels are working to bring the appropriate players to common tables and embrace a Health in All Policies approach. At the state level, this is reflected in the active ongoing engagement of agencies such as Commerce, which administers housing resources; the Superintendent of Public Instruction, Early Learning and the Board of Community and Technical Colleges, which bring education and workforce perspectives and resources; the Insurance Commissioner and Exchange, which ensure the consumer is represented and protected; and Labor and Industries, which focuses on the workplace.

The state maintains a government-to-government relationship with tribes. Tribes' ongoing involvement with Healthier Washington is and will continue to be essential for achieving the aims of the initiative as a whole. Healthier Washington is collaborating with tribes in a number of ways, including ongoing consultation on Medicaid purchasing and transformation. We have engaged the American Indian Health Commission to provide recommendations to the state and ACHs on how the tribes want to be engaged in the ACHs. In addition, the state will work with tribes to help determine how they wish to engage with the transformation of the non-tribal system. There also have been ongoing conversations in the pre-implementation year about how to best communicate with tribal members, and we are exploring communicating Healthier Washington stories and updates in tribal newsletters.

Engagement at the county level has been of particular importance to the early implementation of Payment Model Test 1. Counties have a traditional role in the organization and delivery of behavioral health services to local populations. Model Test 1, with its emphasis on integration of physical and behavioral health services, creates an opportunity to think regionally and consider how other elements of the system can complement the achievement of whole person health. Counties are responsible for signaling to the state their readiness to transition to fully integrated managed care. Our initial experience in Southwest Washington served as an early learning opportunity for how the state will achieve its mandate to integrate physical and behavioral health services statewide by 2020.

Many local public health jurisdictions have strong capabilities related to assessment, communications, and community partnership development. Local health jurisdictions also serve as connection points to community partners who influence the 80 percent of health that happens outside of clinic walls since they often have histories of working on policy issues or delivering interventions in collaboration with these entities. Examples of these partners include retailers, housing units, schools, jails, transportation planners, and community-based organizations.

Purchasers and Payers

Purchasers and payers alike play a key role in Healthier Washington as both directly and indirectly influence payment and delivery of services. Active engagement and participation of both stakeholders is necessary in order to achieve Healthier Washington's paying for value goal: Drive 80 percent of state-financed health and 50 percent of commercial health care to value-based payments by 2019.

The state is now regarded as "first mover" with the implementation of Model Test 3 and other payment and delivery system transformational elements and reforms such as the set of common performance measures, shared decision making, adherence to Bree Collaborative recommendations, participation in the Foundation for Health Care Quality improvement programs, and participation in Accountable Communities of Health. In partnership with the Washington Health Alliance, HCA will convene other purchasers to share its story and educate purchasers on the importance of moving away from fee for service to activate them to spread and scale strategies and reforms that align with the state's effort. HCA will partner with the Alliance to expand their current purchaser group, the Purchaser Affinity Group (PAG). C-suite leaders from current PAG members as well as other large purchasers such as Microsoft and Costco will be invited to attend quarterly meetings. In addition, HCA along with King County, the Alliance, and the Washington Roundtable will sponsor an annual purchaser conference aimed at educating and providing tools to benefit managers.

HCA is wielding its purchasing power to engage payers in transformation strategies. The three commercial plans under the state employee program have agreed to report on the common measure set. In addition, the Medicaid MCOs are actively participating in the ACHs and community engagement work.

MCOs and behavioral health organizations (BHOs) are central to the organization, financing and delivery of integrated behavioral and physical health services under Model Test 1. MCOs have participated as key stakeholders in the development of the "early adopter" approach to fully-integrated managed care in the Southwest Washington service area; and two have been selected as the first plans to deliver such care to their Medicaid enrollees in April 2016. The plans not only have incorporated behavioral health providers in their networks, but have reached out to the providers of crisis services in order to fully coordinate services. As active participants in the regional Accountable Communities of Health (often as members of governing boards), the MCOs are attentive to community health concerns and opportunities that extend beyond their managed care agreements with the state.

BHOs will be implementing managed care for the first time for substance use disorder (SUD) services. They are responsible for integrating SUD services with the current managed care delivery system operated by county-based Regional Support Networks for mental health services. BHOs are in the process of responding to the detailed plan request (issued by DSHS). The plan must detail each BHO's transition of SUD services from fee for service and into managed care in their respective regions. BHOs will contract with state licensed and certified behavioral health agencies for their Medicaid members. By 2020, all regions will have fully-integrated Medicaid managed care. The transition will be accomplished in close coordination with both MCOs and BHOs in order to assure seamless services to Medicaid beneficiaries throughout Washington.

Providers

The aims of Healthier Washington cannot be achieved without active provider engagement. With the consolidation of clinics and small group practices into larger systems, Washington has the opportunity and the challenge to drive health care delivery transformation through a systems approach. Not only are individual providers and provider systems participating in the fulfillment of Healthier Washington's aims, but their associations are as well. Those groups actively involved in Healthier Washington initiatives include but are not limited to the Washington State Hospital Association, Washington State Medical Association, Washington Association of Community and Migrant Health Centers, Rural Health Clinic Association of Washington and many others. Providers are engaged in every element of Healthier Washington, as illustrated by the following:

Accountable Communities of Health: Health care providers are included as participants in every ACH and participate actively in the organization and development of those entities. The ACH readiness demonstration criteria established by HCA address balanced membership in the governance structure, including health care system representation.

Payment Model Test 1: Providers of mental health and substance use disorder services, as well as primary care providers, have been working closely with HCA and community representatives in the development of the fully-integrated managed care model in Southwest Washington. Leadership of this initiative has come from within the provider community, most notably from the Regional Support Network which has historically provided mental health services to the local community. The state is fortunate to have other champions of physical and behavioral health integration as active partners, including such well-known providers as Kitsap Mental Health Services—whose director co-chairs the Physical and Behavioral Health Integration Accelerator Committee of our Health Innovation Leadership Network.

Payment Model Test 2: Because the success of Model 2 depends on the acceptance of new payment arrangements by community clinics and rural hospitals, establishing and maintaining effective working relationships with those providers is essential. HCA not only has direct relationships with many of these clinics and hospitals, but is working closely on model design and evaluation with their representative associations, including the Washington State Hospital Association, Washington Association of Community and Migrant Health Centers, and the Rural Health Clinic Association of Washington.

Payment Model Test 3 and 4: The introduction in 2016 of value-based payment under Model 3 is the result of successful recruitment and negotiation with two accountable care provider systems, the Puget Sound High Value Network and the University of Washington Accountable Care Network. These two systems represent a significant proportion of physician and hospital systems in the five-county Puget Sound area. Not only will these provider groups be actively engaged in the pursuit of Healthier Washington goals, but others—especially in other regions of the state, where Model 3 will next be introduced—will be closely monitoring and participating in the model design and roll-out. Under Model 4, leveraging a claims and clinical data aggregation strategy will empower providers to enter into value-based payment arrangements and effectively engage in care coordination and population health management. HCA is working closely with providers and their associations to assure that the tools and systems developed will be of greatest use to providers in making that transition.

Practice Transformation Support Hub: Health care and behavioral health care providers have been the core contingent for the Hub listening sessions, site visits, surveys and interviews. The results of our "listening tour" will inform the requirements of the Hub site and associated services. In the future, the extension model will extend a resource into each regional service area to support providers directly in their transformation to value-based care and quality outcomes. The Hub will also offer web resources, practice coaching and facilitation, trainings, networking events and learning collaboratives to help support and maintain linkages with providers. Also planned for early 2016, a Hub Advisory Board will be formed with internal and external partners who will help us leverage short and long term service delivery components. It will define and refine the services we will provide.

The Hub strategy intends to continue the collaboration among many state agencies that engage providers. It will be a forum for referral patterns and must be sustainable – which requires agency collaboration. For example, the Hub will work closely with the Office of Rural Health (regarding payment model 2) to work cross-sector to collaborate on practice coaching and training in rural health clinics. There is already a tremendous amount of knowledge and services to leverage throughout Washington State, including through associations, practice transformation grant receipients and more.

Community Health Worker Task Force: The task force has a diverse, statewide membership that includes those who do community health work, as well as broader representatives from communities and throughout the health sector. Provider representatives include physical and behavioral health care delivery systems, community-based programs, health plans, and regional support networks.

Shared decision making: Washington is currently working with national and state experts to develop a process to certify decision aids and will use the Practice Transformation Support Hub and providers within Accountable Care Networks to spread the use of shared decision making as a practice, as well as the use of certified patient decision aids. Working with members of the International Patient Decision Aids Collaborative (IPDAS), HCA, along with state stakeholders will finalize certification criteria, drawing from 10 years of IPDAS research. We are leveraging current efforts of organizations who are working to implement shared decision making into practice, such as Group Health Research Institute, learning from their experience. Key stakeholders, including providers, payers, purchasers, state legislators, IPDAS, developers, academics, AHRQ, and The Gordon and Betty Moore Foundation convened to provide input into the development process and will continue to be engaged, as appropriate to implement the certification process, and spread of shared decision making in Washington.

Interoperability: Washington is conducting a statewide assessment of the EHR capabilities and needs of behavioral health providers who do not qualify for Meaningful Use incentives, and is exploring solutions to increase the capacity of these providers to connect with the state's clinical data repository.

In the meantime, managed care plans are stakeholders and funding partners for the clinical data repository through a multi-year performance improvement project. They are helping advance the electronic exchange of care summaries through the state HIE through their contracts with provider organizations across their delivery network. They are partnering with HCA to require that provider organizations with certified EHR systems export a care summary to the clinical data repository each

time an Apple Health consumer assigned to them is seen. HCA will reinforce requirements through meaningful use program and EHR incentives.

Common measures: The Statewide Common Set of Measures is a core element of Healthier Washington and provides the foundation for accountability and measuring performance across all areas of Washington. In May 2014, Governor Inslee appointed a Performance Measures Coordinating Committee (PMCC). The Committee includes broad representation from the provider community, including physicians and hospital systems, mental health providers, rural health care and public health. On January 31, 2015 the PMCC finalized a plan for the ongoing evolution and evaluation of the statewide common measures set. The committee will continue to convene quarterly through 2018 to consider recommendations for evolving the measure set.

Community

Accountable Communities of Health follow a cascading engagement strategy that balances the need for a nimble decision-making structure with meaningful multi-sector engagement of community leaders. Examples of community sectors that are included in one or more of the multiple layers of ACH engagement include delivery system providers, insurers, philanthropy, business, housing, Area Agencies on Aging, criminal justice, emergency medical services, and tribes. These partners are engaged for the purpose of identifying common health priorities across sectors to align measures and commit to mutually reinforcing activities.

Local health jurisdiction capabilities have allowed them to be valuable partners at ACH tables, in some cases serving in leadership roles. ACHs draw upon local health expertise regarding assessments and community health improvement planning, as well as specific services and resources around data. In some cases, local health jurisdictions are working within regional boundaries across county lines to pool expertise and align resources. For example, local health jurisdiction assessment coordinators from the five counties that comprise the North Sound ACH joined forces to identify regional health needs and develop a regional health improvement plan; sharing of expertise allowed for improvement of the quality of community health planning in each county.

Consumers

The principles of transparent engagement, continuous learning, and collaboration will continue through established workgroups and communication outlets, such as the Healthier Washington website and quarterly initiative webinars. The Healthier Washington initiative will prioritize resources for communications and outreach needed across all efforts to ensure success and transparency at the state and community levels. Healthier Washington also is telling the story of people and their families through videos and other communication vehicles that demonstrate the intended impact of the initiative.

Healthier Washington recognizes we cannot improve health care quality and reduce avoidable costs without engaging people and their families. A key activity in this arena includes a focus on engaging patients and their health care providers more actively in preference-sensitive decisions through the phased deployment of certified patient decision aids. During the pre-implementation year, consumer groups were engaged in identifying the process to certify decision aids, and will continue to be key contributors to this consumer-facing effort.

As part of their cascading engagement strategies, ACHs are expected to engage consumers within their multiple communities. Health is local and the identification of local issues and corresponding solutions requires authentic local engagement. ACH membership includes consumers and consumer advocates. In addition, individuals and families are engaged in a variety of formats, including county forums and existing community-based convenings that are now leveraged to inform regional ACH efforts. ACHs are also testing different mechanisms to include the consumer voice in the decision-making process, including public comment during ACH meetings, specific consumer and equity committees, and web-based feedback mechanisms. As we move forward, state leaders are interested in how we better engage consumers including opportunities to leverage complementary resources. For example, the Northwest Office of Health Law Advocates and the Washington Community Action Network are currently funded by a Robert Wood Johnson Foundation grant to partner with ACHs and Healthier Washington leads to identify existing gaps and opportunities to support transparency and broader engagement.

Under Model 3, patient engagement is foundational. Both networks are at financial risk for timely access and patients' experience as a number of CG-CAHPS measures are included in the quality improvement model (which determines the network's savings or deficits). Also, both are required to participate in shared decision-making pilots (for obstetrics, total joint replacement and end of life care), offer timely and convenient access to both primary care and specialty providers, as well as expanded service hours for primary care, urgent care, and 24/7 consulting nurse and tele-urgent care services. Moreover, both networks are required to provide enhanced communications to members, including plan-specific websites, dedicated contact centers for scheduling, prescriptions, and additional support services, and proactive member engagement through printed and electronic materials.

At the same time, HCA has worked to encourage healthy behaviors of state employees through educational tools like the annual wellness assessment. For example, state employees received a lower annual deductible if they completed the wellness assessment and follow up activities. Follow up activities included completing an advance directive to align with strategies implemented on the supply side. HCA will continue to develop and promote additional consumer tools as consumer engagement is the number one priority of PEBB for 2016.

State and Local Engagement for Sustainability

Healthier Washington is engaging stakeholders in a manner that empowers them to own and drive change within the initiative. This approach is predicated on the belief that while the state has a role in health systems transformation, leaders exist across the public and private sectors who are passionate about achieving change in their organizations and for the people of Washington State. This ownership is a prerequisite for Healthier Washington to endure. We are already seeing this ownership demonstrated in two forums in particular.

Health Innovation Leadership Network. Key to success during Innovation Planning was the commitment of a cross-agency leadership group that included the Governor's office, HCA, DOH, DSHS, Commerce, Early Learning, the Health Benefit Exchange, Community and Technical Colleges, Labor and Industries, Financial Management, Insurance Commissioner, and the Superintendent for Public Instruction. In its pre-implementation year, Washington evolved this group to a public-private Health Innovation Leadership Network (HILN) to accelerate Healthier Washington efforts. The leadership network—comprised of providers, business, health plans, consumers, community entities, governments, tribal entities, and other key sectors—monitors,

informs, and accelerates progress, as well as identifies barriers and opportunities for alignment, scale, and spread.

HILN is Healthier Washington's state-level recognition that transformative, lasting changes requires focused and collaborative engagement of the public and private sectors working toward mutual goals. In addition to HILN's overarching role as accelerators of culture change and as Healthier Washington ambassadors, HILN has developed subcommittees, called "accelerator committees." The HILN Accelerator Committees focus on specific and timely efforts that directly impact and drive toward the achievement of Healthier Washington's aims.
HILN Accelerator Committees will:

- Accelerate the goals and objectives of Healthier Washington versus advise on policy and operational components of the initiative.
- Evolve, expand and disperse over time as Healthier Washington itself evolves in response to rapid-cycle learning and improvement.
- Build upon existing efforts and groups already in place.
- Be reflective of the HILN structure in public-private, multi-sector membership.
- Be championed by HILN members, with membership including leadership from HILN and non-HILN organizations.

The initial Accelerator Committees are:

- **Healthier Washington Clinical Engagement Accelerator Committee**: Accelerate provider commitment to and adoption of Healthier Washington aims and strategies.
- **Healthier Washington Communities and Equity Accelerator Committee**: Elevate and act on Healthier Washington's commitment to every Washingtonian getting a fair chance to lead a healthy life.
- **Healthier Washington Integrated Physical and Behavioral Health Accelerator Committee**: Accelerate the transition to fully integrated care systems by leveraging cross-sector action.
- **Healthier Washington Rural Health Innovation Accelerator Committee**: Accelerate the uptake and spread of value-based payment and delivery models in the state's rural communities, and influence the uptake of rural health innovations that support these models.
- **Healthier Washington Collective Responsibility Accelerator Committee**: Promote the concept of shared accountability and collective impact in achieving the aims of Healthier Washington through the development and implementation of an education campaign.

The work of HILN and its accelerator committees will evolve and advance throughout the Test period.

Accountable Community of Health Leadership. In addition to the engagement activities occurring within each ACH, leaders from the ACHs are collaborating with each other and the state through various engagement opportunities. Early on in ACH development the state recognized the need for a collaborative space for ACH leaders to come together to discuss key challenges and opportunities with each other and state partners. This ACH Development Council has been an

essential part of communication and collaboration across the state and has served as an open space for other SIM program leads to communicate with ACHs and receive feedback. In addition to the Development Council, ACHs coordinate formally through the ACH technical assistance effort (e.g., through statewide convenings) and informally through self-organized meetings to discuss common issues and promising practices. The state recognizes the value of learning and maturing together and will continue to support the strong partnerships that exist statewide.

Plan for Improving Population Health

The Revised Code of Washington (RCW 43.70, 70.05) declares that "the social and economic vitality of the state depends on a healthy and productive population" and charges government with the "life and health of the people," granting authority and responsibility for organizing public health services. The public expects Washington's public health network to work with health care providers, tribes, communities, and others to do what it can to improve health and reduce costs. The agency that oversees this work and is ultimately accountable is DOH, under the leadership of the Secretary of Health.

As DOH and the public health system work with partners to create a statewide population health plan, we also continue to work to strengthen the public health system that would sustain the plan over time. This work on Foundational Public Health Services (FPHS) defines a basic set of capabilities and services that must be present in every community in order to efficiently and effectively protect all people in Washington. Foundational capabilities (such as assessment, communication, policy development and support, community partnership development) and foundational programs (such as chronic disease and injury prevention, access to clinical care, and maternal, child and family health) will align with the components of the Plan for Improving Population Health. The FPHS work is now entering the final phase of implementation, which is to develop a statutory and funding framework that can be implemented legislatively and operationally. Public health partners are working to develop a legislative policy proposal targeting the 2017 legislative session.

As a state agency, DOH is creating alignment of organizational structures and funding to strengthen support of a Health in All Policies approach and the work of the Accountable Communities of Health. These alignments include the following:

- In October, 2015, DOH launched its Center for Public Affairs. The Center will provide support to the agency to better integrate data, science, economic analysis, health promotion, individual relationships and community partnerships to lead policy change and improve the health of people in the state. The Center will allow the agency to prioritize attention to issues, including Healthier Washington priorities, and maintain a focus on health equity.
- By the end of 2015, DOH will launch its Informatics Roadmap (in alignment with the Healthier Washington AIM initiative) that demonstrates commitment to building better ways to get public health data out of the Department and into the hands of partners (such as ACHs) that need it to prioritize health issues and measure progress.
- DOH will look for opportunities to align the federal funding it receives to support the priorities of communities.

The History of the Plan for Improving Population Health

The Plan for Improving Population Health is a key systems component that complements the many levers of Healthier Washington. We're changing payment. We're changing delivery. Population health improvement strategies are another critical component to achieving transformation. As called out in the County Health Rankings, population health is impacted 20 percent by clinical care access and quality, and 80 percent by social and economic factors, health behaviors, and the physical environment. This Plan is about person and family engagement and activation, in the context of the environments where those persons and families reside. The approach aligns with CMMI'S expectation that strategies to improve population health include:

- Policy, systems and environmental changes
- Strategies to support and reinforce healthy behaviors (evidence-based practice and environmental approaches);
- Health systems interventions and clinic-community linkages

Foundational steps for the P4IPH were taken upon completion of Washington's State Health Care Innovation Plan, when the state led the creation of a public-private multi-sector Prevention Framework committee to begin work on a plan for addressing population health. This effort forged stronger linkages between public health and the delivery system. Core elements were informed by state health data, review of public health and hospital community health needs assessments, and existing state health improvement plans. The resulting Framework prioritizes prevention and management of chronic disease and behavioral health issues, while addressing root causes, and identifies four initial focus areas:

- Cardiovascular Disease and Diabetes
- Healthy Eating, Active Living, Tobacco Free Living, and Obesity Prevention
- Mental Health, Substance abuse/use (opioids)
- Trauma informed practices (e.g., Adverse Childhood Experiences or ACEs)

Our Prevention Framework manifests a shared vision for influencing the health of the people of Washington. It includes a vision, goals, principles, measurable objectives, and core strategies. It is widely considered to be a groundbreaking piece of work and public-private partnership.

The objectives are:

Objective One: By December 31, 2018, Washington State will increase the proportion of the population who receives evidence-based clinical and community preventive services that lead to a reduction in preventable health conditions.

Objective Two: By December 31, 2018, Washington State will increase the proportion of the population with better physical and behavioral health outcomes by engaging individuals, families, and communities in a responsive system that supports social and health needs.

Objective Three: By December 31, 2018, Washington State will increase the number of communities with improved social and physical environments that encourage healthy behaviors, promote health and health equity.

Objective Four: By December 31, 2018, Washington State will increase the number of integrated efforts between public health, the health care delivery system and systems that influence social determinants of health to lower costs, improve health, improve the experience of care and contribute to the evidence base.

Our core strategies are:

- Engage and influence health and other systems to improve health, quality, reduce cost and improve experiences for both people and providers;
- Align funding and resources to incentivize prevention and health improvement; and
- Foster and engage people, communities and systems in health promotion activities that enable them to exercise control over their health and environments.

The Plan for Improving Population Health takes the Prevention Framework from the "what" to the "how" – including how strategies and interventions are implemented so that we align as a state, allow for local flexibility, apply the latest evidence, quantify return on investment, and ensure sustainability. Healthier Washington has tasked DOH with this effort, and ultimate accountability resides with the Secretary of Health.

The Plan project lead and staff have convened an Interagency Advisory group with members from DOH, HCA and DSHS representing the identified investment areas of Healthier Washington. Additionally, DOH is in the process of convening an External Advisory council, chaired by a public health leader in Washington's North Sound region who served as the co-chair of the Prevention Framework work group, and comprised of representatives from each of the nine Accountable Communities of Health (ACHs), as well as other key sectors such as tribal health. Guidance from this group will be critical as we work to align public health, health care delivery systems, and social determinants of health in diverse communities to achieve improvement in population health in our state.

Getting it done will require strong governance and leadership from the Secretary of Health and DOH. Our advisory and interagency councils are a strong foundation. The inclusion of the Plan for Improving Population Health in the Healthier Washington portfolio is intended to ensure the alignment of public health, health care delivery system, and social determinants work.

The P4IPH will guide community activities while also serving as a strategic plan for state population health priorities and efforts—particularly at DOH—moving forward. The Plan for Improving Population Health will align population health efforts across state agencies, with priorities informing direction of existing and emerging resources, alliances, policy initiatives, and funding opportunities. The Plan will provide the language and taxonomy for public and private partners to speak to one another about population health across systems, agencies and sectors. Common priorities and a structure to guide the effort will allow for all necessary partners to "lean in," and to increase Collective Impact at both the local and state level. Multi-sector engagement will amplify population health priorities and help ensure the return-on-investment of population health strategies and interventions is shared with decision makers.

In addition to making Health in All Policies our approach to population health, health equity is a foundational priority of Healthier Washington. The Plan for Improving Population Health is a primary lever for that goal. The Plan will address social determinants of health and the need for an upstream focus. The Prevention Framework targets housing, employment, literacy and other

services that address social needs which impact outcomes and costs. As the Plan is developed, input and guidance will be provided by health equity partners at the state and local level, so that the completed Plan reflects necessary considerations of access, environment and life stress within specific populations and communities.

Integration of P4IPH across Healthier Washington

Accountable Communities of Health (ACHs). The Plan for Improving Population Health will serve as a resource to further ACH implementation of regional health improvement projects while not prescribing what ACHs focus on. Across Washington, ACHs prioritize the Triple Aim, including access, coordination and integration of care. The Cascade Pacific Action Alliance (CPAA) offers a good example of the type of projects ACHs across the state will be working on. CPAA found a need within its region for earlier identification and treatment of children with mental health or chemical dependency issues. They facilitated a formal work group, including representatives of school districts, social service organizations and health care providers. The work group selected behavioral health screening tools, inventoried relevant treatment resources within the region, discussed the proper role of school staff and treatment providers, and mapped how these roles would be coordinated on behalf of these children. CPAA then identified four project test sites through a process that included developing selection criteria, researching potential school partners, designing a scoring matrix, and reaching out to selected schools.

Using the example above, the Plan for Improving Population Health toolkit will not only further the efficiency of project selection, but also ensure that the design and implementation of ACH regional health improvement projects emphasize equity, return on investment, and sustainability.

Payment Redesign. Healthier Washington's four payment model tests focus on value-based purchasing. Central to the definition of "value" is improvement in the health of the population served. Model Test 1 recognizes that those with serious mental illness are at risk of dying decades earlier from preventable chronic disease than those without such a dual diagnosis. If, for example, a population health plan of a given population includes addressing an elevated incidence of diabetes, it is essential that the health system serving that population seamlessly integrates behavioral health services into the provision of diabetic care. By establishing fully-integrated managed care agreements, together with coordinated MCO/BHO contracts, Washington will, beginning in April 2016, firmly establish a delivery and payment system that advances whole-person care.

As the largest health care purchaser in the state, HCA is in a position to influence the focus of provider systems toward care that can much more consciously align with population health needs. All four payment test models move along a continuum away from fee-for-service reimbursement toward incentives for improved health outcomes. These arrangements encourage not only a better use of health care resources, but also create opportunities and incentives for greater engagement of individuals in their own health. For example, if a provider system redeploys resources to promote healthier behaviors and is rewarded through retaining a share of savings realized, the benefits accrue both to the provider system and to the population served. Such rewards are made possible through a combination of alternative payment relationships, the accountability of a health system for a defined population, and agreement on a common set of outcomes-focused performance measures.

Common measures. In an effort to align and standardize the way we approach performance measurement, draft population health measures from the Prevention Framework influenced the

development of the "starter" set of statewide common measures. It is however recognized that the current set of common measures are clinical in nature and there is a need, as we continue to evolve the common measures, to incorporate measures that address a broader population health approach. As the Plan for Improving Population Health is developed and the common measure set continues to evolve, efforts will be made to align, where possible, the common measures with priorities and strategies included in the plan, including goals to address health equity.

Alignment with Related Initiatives

CDC Grant. DOH's CDC Grant 'State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke' is focused on strategies across the continuum of the health care delivery system and public health on improving the control of high blood pressure and improving the screening and management of pre-diabetes. It aligns with Healthier Washington in its regional approach and supports some ACHs in developing partnerships across multiple sectors in the region to implement population health interventions.

SmartHealth. SmartHealth is Washington's voluntary wellness program that incentivizes state public employees to engage in their health and wellness. Eligible employees who track activities such as completion of a well-being assessment or steps walked in a day qualify for wellness incentives in 2016 in the form of a reduction to their medical deductible or a deposit into their health savings account.

ACEs. DOH is working with both state and local partners to address social determinants of health and upstream factors that impact health outcomes, particularly with the Adverse Childhood Experiences (ACEs) initiatives. DOH and the Department of Early Learning lead the Washington State Essentials for Childhood Initiative, and work closely with the Foundation for Healthy Generations and multiple community coalitions across the state. DOH awards Maternal Child Health Block Grant (MCHBG) funds to each county in the state; over half of these counties are choosing to invest and leverage MCHBG funds in strategies and interventions to address Adverse Childhood Experiences, including trauma-informed practice and toxic stress reduction.

Health Care Delivery System Transformation Plan

In Washington State, we are pursuing delivery system transformation in various ways: by leveraging new financial models, collecting data and creating new mechanisms to deliver critical information.

Healthier Washington and the broader health care environment are shifting the physical and behavioral health care landscape toward rewarding value, rather than the volume of services provided. Although this shift is still unfolding, many health care organizations are adopting population health approaches and forging new cross-agency relationships that expand their focus beyond acute, episodic care, to ensure that relevant community services and supports, post-acute and primary care are available in a coordinated fashion to meet the needs of patients across the care continuum.

However, creating effective linkages across the care continuum requires overcoming challenges related to the historic fragmentation of physical and behavioral health care service delivery within most communities, in which provider organizations may not share a common mission, orientation to

the goals of care, or up-to-date information exchange platforms. The Healthier Washington practice transformation investment in services to support physical and behavioral health care organizations will focus on priorities and efforts to bolster organizational capacity to meet whole-person care needs across the continuum. Our goal is to strengthen clinical provider practices and their participation with communities. The desired outcome is to achieve better health, better care and reduced costs. This requires a variety of transformational strategies to strengthen the diverse primary and behavioral health care practices in the state, support their readiness for payment reform, and to address complex problems that cut across delivery systems, social supports and community environments.

The Practice Transformation Support Hub

The Practice Transformation Support Hub will accelerate regional and statewide health improvement activities. It will strengthen capacity, improve health outcomes, and increase the overall health of the community. The Hub will support local quality improvement efforts by connecting health care providers with tools, training, and hands-on technical assistance to advance whole person care.

The key aims of the Healthier Washington clinical practice transformation strategy are to support primary and behavioral health providers and their engagement with local ACHs to:

- Stimulate and accelerate the uptake of integrated and bidirectional behavioral health and primary care.
- Support payment reform readiness and progress toward value-based payment systems .
- Advance community linkage priorities by supporting practice efforts to identify, connect, and align community-based services to strengthen whole-person care.

The purpose of the Practice Transformation Support Hub is to accelerate regional and statewide health improvement activities that strengthen capacity, improve health outcomes, and increase the overall health of the community. The Hub will support local quality improvement efforts by connecting healthcare providers with tools, training, and hands-on technical assistance to advance whole person care.

Formative Stakeholder Activities

The Practice Transformation Support Hub engaged in an environmental scan of primary and behavioral health providers and practice dynamics. The intent of this scan was to

- Identify evidence-based best practices and innovative strategies to achieve the three Hub aims;
- Optimize clinical provider alignment with Hub aims and gather feedback on Hub service delivery model prototypes;
- Capture insights, needs, and preferences for Hub offerings as well as aspects of care coordination workflow that the Hub's three aims may most likely impact; and
- To inform strategic design priorities for the Hub.

The complexity of a statewide practice transformation initiative warranted a pre-project formative evaluation to improve the design and performance of the Healthier Washington practice transformation investment. A variety of stakeholdering activities informed the formative evaluation

activities to ensure that the Hub service's initial design is intentionally shaped by the clinician community it will serve and align with provider and community service provider needs. The formative evaluation activities have provided a better understanding of the process of change in Washington's primary and behavioral health care practices, and identified what works, what doesn't and why. This diverse clinician input is especially important because of the policy, workforce development (training, certification and licensing), state and federal codes and payment reform state-specific context. The Hub sponsored a variety of intentional, standardized stakeholder engagement activities including:

- A 14-stop listening tour
- Site visits to 11 small to medium primary and behavioral health practice settings
- Twenty-five key informant interviews
- Data analysis
- Market survey

What we learned

Throughout this engagement, clinical providers and leadership shared their ideas and examples of assets, successes, challenges and intervention priorities to leverage and achieve Healthier Washington's practice transformation aims. For each of the Hub aims, and the extension agent service delivery network, a framework was populated with provider's ideas of current practices and resources, challenges to achieving each aim, and training, technical assistance and information resource intervention ideas. This information will inform the three key strategies of the Hub, and be directly translated into fourth quarter 2015 RFP development. Some key themes that emerged in these discussions include

- Providers and other stakeholders expressed significant and repeated concern about transforming practice to be better aligned with certification and evidence-based protocols (and sustaining changes they have made in their practices) without meaningful payment reform.
- Privacy regulations (real or perceived) make it difficult to share clinic information to improve continuity of care.
- We have the opportunity to align resources and referral practices so practices can avoid being invited to participate in a multitude of (often duplicative or competing) initiatives. Conversely, we need to align our direct coaching/facilitation resource dollars in service to those practices where we know there are gaps in best practices.
- Technical assistance providers agreed that the needs of practices vary significantly and that small practices have difficulty implementing a multidisciplinary model. They can be financially constrained, and often challenged, to support time off for staff to participate in learning and planning. The Healthier Washington technical assistance funds will focus on small to medium size primary care, mental health and substance use disorder practices.
- Communities struggle to connect across organizations, especially with social service agencies offering critical mental health or basic need services, specialists and hospitals. Care coordination varies from clinic to clinic and by sector (payers, providers, programs, contracts). Effectively defining a cost effective care coordination role that meets the needs of an individual obtaining care across multiple systems remains a challenge.

- Demonstration projects that fund integrated clinical and external partner workflow, Health Information Technology, and actionable policy strategies have proven successful. However these innovations were not sustainable once funding ended. We have learned how difficult it is for providers to deliver care in a way they are desirous to move to when they get paid for a different model.
- There is considerable demand for the state entities engaged in health care to coordinate internally. Collaboration across agencies is lacking.
- The payers interviewed and engaged in listening sessions reported having made significant investments over the past few years in supporting primary care practices in medical home development, and have seen some significant progress, but believe there is substantial variability in the level of transformation among practices. There are several alternative payment arrangements in place. However, there is currently limited collaboration among payers in support of primary care and behavioral health practices.
- Behavioral health practices have not benefited from federal and state practice transformation investments as evidenced in primary care related support for meaningful use, PCMH certification, etc. Great need exists for comprehensive external practice support to build quality improvement capacity within these practices.

Translating what we heard to what we will do

The state will leverage SIM funding to support capacity building for provider practice transformation, focusing on support of small to medium primary care, mental health and substance use disorder provider practices. Practice transformation activities will build on existing clinical practice assets and priorities, and provide access to new strategies, training and coaches, as well as tools, evidence-based literature and both expert and peer 'faculty' to foster success factors for organizational achievement of the three aims.

To develop tailored strategies to address the challenges, Hub extension agents will be trained in the Theory of Change process. They will engage with their local ACH to participate with and (in some cases) convene large and small group meetings to answer the question: *What infrastructure would best support primary care and behavioral health practices to take on the transformation challenge of improved population health?* The result will be a Theory of Change[5] package that describes what the right infrastructure would include, and strategies for building it. It will simultaneously recognize the importance and complexity of the large-scale changes the delivery system must make to achieve the broader Triple Aim goals of Healthier Washington. Other SIM-funded initiatives have identified some of the defining features that would help primary care and behavioral health infrastructure deliver on the Triple Aim:

- **Technical assistance** for primary care and behavioral health practices and communities to build relationships, make transitions, and strengthen systems of care

[5] "Theory of Change is a rigorous yet participatory process whereby groups and stakeholders in a planning process articulate their long-term goals and identify the conditions they believe have to unfold for those goals to be met." H. Clark and D. Taplin (2012). *Theory of Change Basics: A Primer on Theory of Change.*

- **Community-based connections** that bridge siloed systems, like public health and social service organizations; we know that change within primary care practices is not enough
- **Integration** of essential behavioral health services that address the health of the whole person
- **Innovative models** that can be tested, scaled and sustained
- **A strong workforce** prepared for team-based care, optimizing each discipline working at the top of their license, and staff time to support the emergence and sustainment of new quality improvement inspired organizational workflows
- **Visible physician, mental health and clinician leadership** that champions fully integrated care and a vision that inspires change
- **A local approach that is connected to and informed by state and national efforts** related to supportive policy, aligned metrics, availability of data, and new payment methodologies
- **A payment system** to support robust primary care homes and health neighborhoods that is based upon outcomes and value rather than fee-for-service

The Practice Transformation Support Hub investments will focus on three key strategies:

1. Development of a Web-based Clearinghouse Resource Portal Hub for Primary Care and Behavioral Health Practice Transformation
2. Launch and phased-in implementation of a regional Extension Program with nine extension agents geographically located in regional service areas to support primary care and behavioral health practices at the local, community level.
3. Formal alignment of practice transformation initiatives related to behavioral health integration, strengthening community-clinical linkages, value-based payment reform and data capabilities.

Strategy 1: Web-based Clearinghouse Resource Portal

The Practice Transformation work plan will support the development of a number of approved TA partners and content experts. The web-based resource portal will be designed to become a key vehicle for reaching practices and other stakeholders across the state. Applying best practices from other SIM and practice transformation efforts, a combination of in-person and web-based opportunities, as well as events focused on both content delivery and peer-learning will be used. A high-functioning resource portal help disseminate best practices, support clinical practice interaction and use rapid-cycle learning to refine high-value features such as:

Ease of access. Making vetted and curated information available through a variety of mediums in a way that allows users to access information on demand makes it easier for them to take advantage of resources while balancing the demands of running a busy practice. We are aiming for a high level of interactivity, including web design features that allow for regional web page customizing to strengthen relevancy to local clinicians interests and needs. In addition, publicly available resources that may have otherwise been available only to those in a nested medical group or health system will be made available. This is important for practices and organizations with limited time and resources available to seek out information or participate in webinars offered by other organizations. The Hub will make resources available to the practitioner "public" at no cost.

Resources will include: recorded webinars, self-paced online learning modules and a library of downloadable and editable change packages and tools.

Local Context. Webinar presenters and blog post authors will be asked to share important stories and ideas about things that have worked in Washington. These "Profiles for Change" stories will highlight and celebrate success, share barriers and efforts to mitigate these challenges, help people feel less alone in their challenges, provide opportunities for curbside consults, and build relationships and credibility for individuals serving as change agents in their organizations and communities.

Communication Pathways. The Practice Transformation Support Hub investments will serve as an important communication gateway. Given the close working relationship between HCA, DOH and DSHS, up-to-date messages relating to state activities, relevant code, funding, policy and program opportunities will position the clearinghouse to be a go-to information resource. State messages and alignment with the other Healthier Washington investment areas will be incorporated into Practice Transformation Support Hub sponsored educational materials and events. A network of TA partners, context, and peer experts will also serve as important messengers; their close relationships with the practices they work with allow them to not only provide information, but also to help practices consider the impact of changes on their work.

The site will strategically use vetted links to leverage internal and external agency practice transformation resources and include:

- Web mechanisms to support the provision and dissemination of best practices ideas and turn-key resources for implementation
- Dedicated web access to technical practice referral and support services and telephone access via extension agents
- Webinars (regional and statewide)
- Regional and statewide learning collaboratives
- Subcontracted subject matter experts and peer learning colleagues to support the training and technical expertise needed for strong execution of quality improvement imperatives

Strategy 2: Primary Care and Behavioral Health Extension Program

Health care is impacted by factors that vary from region to region (e.g., payers, delivery systems, provider affiliations) and each community has unique assets and challenges; a one-size-fits-all approach for primary care and behavioral health transformation will not be effective. An Extension Program model has been adopted in a number of states as a means to develop a regional or community based approach to realign resources and develop a sustainable infrastructure to accelerate primary care and behavioral health transformation. The concept is new and has been used in 18 different states to meet varying needs. What all of them have in common is a recognition that health and health care is impacted by factors that vary from region to region. This extension center delivery model for practice transformation support, increases the likelihood that this support will be locally relevant and useful. The Healthier Washington Primary Care and Behavioral Health Extension Centers will align with the regional service areas that are aligned with Accountable Community of Health boundaries. The agent in each region will maintain a primary focus on

achieving the Hub's three aims: behavioral health integration, strengthening community-clinical linkages and supporting clinical practice uptake of payment clinical reform.

The Practice Transformation Support Hub will monitor, evaluate and report progress on the impact of the extension agent program regularly. With the University of Washington evaluation team, the extension agents will collect and maintain information about participation in practice facilitation, learning events and community collaborative meetings, as well as assess participant satisfaction and feedback to continue to strengthen their region's portfolio of services supporting local clinical practices.

Strategy 3: Alignment of Resources: Practice Coaching and Facilitation

The Practice Transformation Support Hub will identify and develop opportunities to align, coordinate and integrate transformation efforts that maximize existing resources and diminish the deleterious impacts of duplication of efforts. Using the Collective Impact[6] model as a guiding framework, the Hub will provide strategic guidance, a joint plan of action and coordinated communication among partners to optimize alignment and collaboration across these diverse initiatives. An active CQI strategy will be used to strengthen this collaborative design for coordinating and integrating clinical practice transformation initiatives, and will be adaptive to change with the evolving health care landscape.

A Practice Transformation Support Hub Advisory Board comprised of internal and external partners will be convened in Q2 2016 to provide oversight, monitor implementation milestones, provide guidance on strengthening the fidelity of the core services throughout the duration of the grant, and provide adaptive recommendations in accordance with emergent changes in the health care environment. This group will serve also advise on designing a sustainability plan for practice transformation support in Washington State.

Person and Family Engagement and Activation

The use of shared decision making as an evidence-based strategy is not only supported in Washington legislation, but the use of certified decision aids is an innovative practice that Washington has an opportunity to lead.

Shared decision making in Washington has its foundation through key legislation that supports the use of shared decision making in practice, outlined further in section six "leveraging regulatory authority."

Washington will spread the use of shared decision making as a practice, as well as the use of certified patient decision aids through the SIM grant. In early 2016, HCA, along with the Washington Health Alliance and Group Health, will host a shared decision making 101 with the Agency for Healthcare Research and Quality (AHRQ). The two-day training, based on the SHARE curriculum[7], uses a train-the-trainer approach, giving us an opportunity to spread the use of shared decision making across Washington by targeting participants from all regions.

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[6] *Collective Impact*, Stanford Social Innovation Review http://www.ssireview.org/articles/entry/collective_impact

[7] http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

The promotion of shared decision making as a practice, including the use of certified decision aids, is embedded into each investment area of Healthier Washington. Providers within the Accountable Care Programs, for example, are required to participate in SHARE training and will pilot the use of certified decision aids that address maternity health.

Furthermore, Healthier Washington will offer targeted technical assistance and coaching to providers who are participating in payment model tests, as well as offer scholarships or negotiated reduced fees for providers in need to spread the use of certified patient decision aids.

Implementation of Evidence-Based Practices

In 2011, the Washington State Legislature established the Dr. Robert Bree Collaborative to identify specific ways to improve health care quality, outcomes and affordability in Washington State. The Governor-appointed members of the collaborative include private health care purchasers, health plans, physicians and other health care providers, hospitals and quality improvement organizations. Each year, the Bree Collaborative identifies and develops evidence-based recommendations for up to three health care services with high variation.

Healthier Washington champions the implementation of the Bree recommendations through many elements of its model test:

- Healthier Washington's initiative to spread shared decision making draws upon Bree recommendations regarding the certification of patient decision aids.
- Payment model tests 3 and 4 require providers to implement Bree recommendations.
- One of the priorities of the Practice Transformation Support Hub is to spread the use of evidence-based guidelines, based on Bree recommendations.

Approaching its fifth year of work, Bree now has recommendations around maternity care, addiction and dependency treatment, hospital readmissions, knee and hip replacement, low back pain and spine surgery, cardiovascular health, and end-of-life care. However, adoption of Bree recommendations is unstudied. Under Healthier Washington, the Bree will survey the spread of its recommendations throughout Washington State, develop an implementation model based on implementation science, and adopt a roadmap for more strategic uptake of its evidence-based recommendations.

Alignment with Other Initiatives

Washington State recently received two additional CMMI funding opportunities, through the University of Washington Medical Center and the Department of Health, that promote the development of practice transformation networks, within a multi-state region, as well as pediatric practices. The Hub will align efforts, where possible, to ensure the spread of participation and support for providers, while reducing duplication of efforts. Furthermore, the Hub will build upon the work of other practice transformation initiatives, such as the McColl Institute's Healthy Hearts Northwest project and the Washington Healthcare Improvement Network's efforts to build capacity for quality improvement within practices.

Payment and Service Delivery Models

Paying for Value

Washington aims to drive 80 percent of state-financed health care and 50 percent of the commercial market to value-based payment by 2019. In achieving this vision, Washington's annual health care cost growth will be two percent less than the national health expenditure trend. Paying for value is key to achieving the Triple Aim and—most importantly—ensuring systems contribute to the health of the whole person. Meeting this goal will require shifting reimbursement and delivery system strategies away from a system that rewards volume of service to one that rewards quality and outcomes as measured by the common measure set. Washington State will use its position in the marketplace to drive transformation as both a "first mover" and "market convener."

Washington purchases health care coverage for more than two million people through Medicaid and for public employees (through the Public Employee Benefits Program). The state will leverage its purchasing power to lead by example and accelerate the adoption of value-based reimbursement and alternative payment strategies.

This strategy is exemplified by the Healthier Washington initiative's four payment redesign strategies. All of these model tests are reflective of stages of readiness that vary geographically. Starting April 2016, Washington will purchase Medicaid services in 10 regional service areas throughout the state. For public employees, our movement toward value begins in the Puget Sound region.

Payment Model Test 1

Critical to advancing the health of the whole person is the integration of behavioral health and physical health services in a seamless delivery and payment system. Building upon the commitment by the governor and legislature in House Bill 2572 and Senate Bill 6312, Washington has initiated a phased approach to achieving this transformed system. Starting in Southwest Washington, this takes the form of fully integrated Medicaid managed care contracts and agreements for the delivery of crisis services to the region's entire population. In the remainder of the state, care will be delivered through separate but closely coordinated behavioral health and physical health managed care contracts.

By 2020, Medicaid beneficiaries in every service area in Washington will be served by managed care systems providing a fully-integrated set of physical and behavioral health services.

The transition will be accomplished in two stages. The first, effective April 1, 2016, will consist of the fully-integrated managed care system in Southwest Washington and the coordinated, capitated managed care and behavioral health contracts in the remainder of the state. As the managed care systems gain experience with the integrated model in the Southwest region, the remaining regions will be given the opportunity to convert in subsequent contracting cycles; but all will be converted by 2020. In the meantime, and regardless of service area, residents will have access to the same set of behavioral and physical health services during the progression from current state to full managed care integration in 2020.

Incorporation of behavioral health services into the state's contracts with MCOs is consistent with Washington's Medicaid purchasing strategy under our Apple Health program. Nearly all of the state's Medicaid beneficiaries are enrolled in managed care delivery systems for the majority of covered services. The MCOs are responsible for providing accessible, coordinated and appropriate health care for their members, including a comprehensive array of preventive and treatment services through their provider networks. In submitting proposals to offer a fully-integrated set of physical and behavioral health services in Southwest Washington, MCOs have taken the first and very important step toward our 2020 mandate.

In both the fully-integrated and the managed care/behavioral health organization regions, the set of physical and behavioral (including mental health and substance use disorder) services will be reimbursed on a per capita basis.

Our experience in Southwest Washington has demonstrated the possibilities and the impact of community involvement in planning and executing the transition to fully-integrated managed care. With leadership from the counties and active engagement by the Southwest Washington Regional Health Alliance (the region's ACH), SW Washington became the state's first "early adopter" of the integrated managed care model. The ACH has served as an important partner in helping to convene stakeholders and to reinforce communications with a broad audience of providers, consumers, local government and the public at large. This experience will help inform the role of ACHs as other service areas transition to full integration.

The leadership shown by the counties and ACH in Southwest Washington has also set the stage for longer-term sustainability of the fully-integrated model. Their investment of time, talent and local resources in convening partners and confirming a commitment to the success of the Early Adopter model not only helps assure continuation of services to their own residents, but sets an example that the other regions can follow.

The transition to a fully-integrated managed care system in 2020 will be informed not only by the experience gained in the first Early Adopter region but by the efforts of the Practice Transformation Hub. The Hub has designated primary care and behavioral health integration as one of its areas of focus and has been collaborating in Southwest Washington, as well as examining models from around the country for tools that can be brought to practices throughout the state.

Knowing whether we are successful in meeting our goals of better health and better value through integration will require that we identify and apply appropriate outcome measures. To that end, driven by the establishment of our first Early Adopter region, the performance measures incorporated into managed care and BHO contracts will include the following:

- Alcohol or Drug Treatment Retention
- Alcohol or Drug Treatment Penetration
- Mental Health Treatment Penetration
- Psychiatric Hospitalization Readmission Rate

These measures are in addition to—and closely coordinated with—the state's Common Measure Set developed under Healthier Washington.

Payment Model Test 2

Federally qualified health centers, rural health clinics and critical access hospitals are essential providers of care to Washington's Medicaid population. These providers offer some of the most innovative and integrated delivery models in the state yet their reimbursement structure stifles further care delivery innovation. In these settings, payment changes are especially difficult given statutory and regulatory barriers and business models that rely on encounter-driven, cost-based reimbursement. Payment Model Test 2 aims to move these providers to a value-based payment system that allows them the flexibility to achieve better care, better health and lower costs for the populations they serve.

Federally Qualified Health Centers and Rural Health Clinics

More than 41 percent of Medicaid beneficiaries and 1 in 10 Washingtonians are served by federally qualified health centers (FQHCs) or rural health clinics (RHCs). Recognizing the critical role these centers play in delivering primary care to their patients, and in an effort to assure a baseline level of funding, they have been operating under a cost-based reimbursement system that calculates payments based on historical costs per visit. Unfortunately, this encounter-based reimbursement system focuses on the volume of services provided, offering little in the way of incentive for innovation in the delivery of care. It is also cumbersome and costly to administer, requiring annual, retrospective reconciliation of assumed to actual costs. Model 2 is intended to reform the payment system for FQHCs and RHCs in a way that provides the flexibility and sustainability to meet changing community needs.

Model 2 aims for a payment system that is simple, fair, transparent, and inexpensive to administer. It will link gain sharing and risk to quality and provide the opportunity for shared savings. It will also address the burdensome reconciliation process. Ultimately, the payment model developed will pave the way for a true population-based pay for performance system.

At present we are in the design phase of payment modeling. HCA has identified an apparently successful bidder to provide technical assistance for working session facilitation and model development. This assistance will be carried out through early 2016. HCA is also assembling the data analytic capacity to support model development and testing. Operational components are being identified and mapped to support the facilitation of a new payment model.

Specific to payment model design, a suggested approach has been offered by the Washington Association of Community and Migrant Health Centers (WACMHC), demonstrating their commitment to collaborating with the state in moving this work forward. Together with the technical assistance contractor, WACMCH and the Rural Health Clinic Association of Washington, we intend to accomplish the development, testing and introduction of a new payment model in CYQ1 2017. During the remainder of the SIM test, we intend to expand the model to the full contingent of FQHCs and RHCs, increasing the opportunities for value-based reimbursement over time.

Critical Access Hospitals

Critical Access Hospitals (CAHs) serve as a point of access to essential health services and a hub of care delivery within the rural communities they serve. Past regulatory efforts, including the establishment of Public Hospital Districts and formal designation as CAHs, have helped to prevent the closure of many rural hospitals; but the current payment and delivery system is unsustainable in

the long-term. Healthier Washington recognizes the importance of the preservation of access to essential health services in rural Washington. Under Model 2, we are seeking to create a new facility type designation that allows CAHs to scale their services and care relationships to the needs and care patterns of the communities they serve. In the long-term we are leveraging the initiative and Model 2 to maintain Washington's acute and primary care backbone for rural communities.

Washington's rural population tends to be older, with higher mortality rates and greater challenges in accessing primary and acute care than their urban counterparts. The CAHs in rural communities are faced with managing this population across geographically vast and varied regions. Linking rural populations to care can be costly and resource intensive. The communities, in turn, recognize the importance of backbone health care institutions. As Public Hospital Districts, many rural communities have moved to increase levy revenue to maintain these access points. Without redress of the payment and delivery systems on which the CAHs rely, however, many of these institutions are not sustainable on the long-term.

Washington's CAH infrastructure is tasked with supporting the rural population while maintaining a payer mix averaging 50 percent Medicare and 16 percent Medicaid. At present CAHs are reimbursed on a cost-basis, with Medicare covering an estimated 97 percent of cost and Medicaid covering 93 percent. Given these dynamics it is difficult for these facilities to maintain operations and access; however, it is clear that allocating additional funding for these facilities in their current form is unlikely.

Through the formative work of the Washington Rural Health Access Preservation (WRHAP) Project, a collaborative effort by DOH and the Washington State Hospital Association, and supported by the goals of Healthier Washington, a unique window of opportunity is available for Washington State to address the challenges faced by CAHs. Under the work of Model 2 we are seeking to create a new facility type designation that meets the needs of both payers and providers and offers the opportunity for care to be organized and delivered in ways that are responsive to the health needs of rural communities. A dozen CAHs facing the most serious fiscal challenges have submitted letters of intent to collaborate in the development of a new approach to facility designation and reimbursement. We have engaged the help of the hospital association in convening those CAHs and facilitating high-level model design. This design work, in conjunction with data analysis and financial modeling undertaken by HCA and our partners in DSHS, will result in a proposed alternative model for the definition, organization and financing of services to be provided by the hospitals to their communities.

Because Medicare is a majority payer in rural communities, changes to Medicaid alone under the initiative will not be sufficient to ensure sustainability in rural health systems. With CMMI support, Medicare’s participation in this payment model will be needed to fully address reimbursement and delivery model challenges in rural health systems.

Hospitals are not necessarily motivated to innovate or cut costs because cost reductions can lower hospital revenues. Payment Model 2 needs the ability to pilot new approaches that will move hospitals away from this model while sustaining access to essential health services in low volume settings.

In developing that model, we intend to work not only with the hospitals and their association representatives, but with the Accountable Communities of Health in the affected service areas in

order to assure that we are being responsive to community needs. We will also coordinate the hospital work with the modeling for Rural Health Clinics as described above. In addition, we intend to leverage the resources of the Practice Transformation Support Hub in working directly with providers.

Payment Model Test 3

HCA is a major purchaser of health care in Washington. We interact daily with other major purchasers. Together, we are all moving this concept forward. The Model Test 3 will test accountable care delivery and payment strategies first for public employees in Western Washington, and then spread statewide and work with other public and private purchasers to adopt similar risk-based and value-based strategies.

Accountable Care Benefit offered to state employees in 2016

Under this Model Test, providers will be paid based on value of care delivered, including state employees' satisfaction with their health care experience, and improved health outcomes. In November 2014, HCA released a Request for Applications for HCA to contract directly with clinically integrated delivery systems to manage and be accountable clinically and financially for the care of enrolled state employees and their families.

In June 2015, Puget Sound High Value Network and the University of Washington Medicine Accountable Care Network were selected as the two 'UMP Plus' networks offered to public employees in the five county Puget Sound region starting in 2016. Regence BlueShield, the third-party administrator of the state employee preferred provider option, will perform claims administration and preauthorization services for both networks.

Both UMP Plus networks have agreed to the following health transformation requirements:

- **Coordinating and standardizing care: Improving outcomes and lowering costs (care transformation).** UMP Plus Networks and their partners are accountable for managing all aspects of their members' care. Both networks are required to participate in Healthier Washington initiatives including shared decision making pilots (maternity care, total joint replacement, and end of life care) and Accountable Communities of Health; produce Quality Improvement Plans documenting their progress on implementing Bree Collaborative recommendations for various high cost, high utilization, and high variation procedures annually; participate in established community quality improvement programs for obstetrics, cardiology, and spine care; adopt certified health information technology infrastructure, including electronic health records, and participate in the Washington State Health Information Exchange; and invest in infrastructure to advance primary care medical home (PCMH) standards across all network partners (as defined by NCQA PCMH Level III standards or equivalent).
- **Member access and experience.** Both networks will offer timely and convenient access to both primary care and specialty providers, as well as expanded service hours for primary care, urgent care, and 24/7 consulting nurse and tele-urgent care services. The networks will provide enhanced communications to members, including plan-specific websites, dedicated contact centers for scheduling, prescriptions, and additional support services, and proactive member engagement through printed and electronic materials.
- **Integrated financial and quality improvement model.** The networks are risk-based contracts; In other words, within set parameters there are potential financial consequences to

both HCA and the accountable care network plans if financial, quality, and member experience targets are not met. Each accountable care network has agreed to annual targets for financial trend guarantees. If the network exceeds its trend guarantee target – resulting in more savings than the target would have created – HCA will pay the network a share of the savings. If the network does not achieve its trend guarantee target – resulting in less savings than the target would have created – the network will pay HCA a share of the deficit. The deficit can be mitigated or savings shared could increase depending on the network's performance (improvement and movement toward achieve measure target for each measure) in the quality improvement model (QI model). The QI model includes 19 quality measures, a subset of measures from the Washington Statewide Common Measure set in the following five categories: chronic conditions; behavioral management; client experience; medical screenings and immunizations; and obstetrical care.

To incent state employee participation, the networks will offer a unique benefit design to further improve member experience and promote the use of high quality health care services. Features include 30 percent lower monthly premiums than the UMP Classic plan, lower medical and prescription drug deductibles, and no cost-sharing for office visits to primary care network providers. Plus, members who complete a wellness assessment and earn a wellness incentive will pay no or a reduced medical deductible. In addition to these benefits, the UMP Plus network plans offer the same monthly out-of-pocket limits, inpatient and emergency coinsurance rates, and covered services as the current PPO plan.

While appearing targeted, this Model Test will have effects on the broader Washington delivery system beyond state employees. To meet financial and health transformation contractual requirements, network partners are re-engineering their systems of care infrastructure, which will benefit all patients who receive care at the network and their partners regardless of payer.

After the two networks were selected, implementation planning efforts began immediately. Focus groups were conducted with state employees to inform messaging and communication efforts and a marketing firm was hired to craft messages and produce promotional materials (video and print materials) to educate state employees on value-based options and maximize enrollment in the new networks as well as existing HMO plans. HCA staff also produced an educational webinar and made presentations to different state agencies and state sponsored groups to spread the word about the new value-based plans.

Open enrollment occurred during the month of November. As of November 25, 2015 the last week of open enrollment, approximately 6,775 eligible public employees and retirees have enrolled in the UMP Plus options.

Statewide expansion and multi-purchaser strategy

To further scale and spread the accountable care option, this model test will be expanded statewide in 2017. The strategy for statewide expansion is currently under review, but options include the growth of current partners' networks beyond the Puget Sound region and new partner selection. At the same time, as the geographic spread of the model occurs, public and private purchasers will be asked to replicate the test model and accountable care strategies (e.g., common measure set).

Historically, purchasers have been passive, typically relying on brokers and health plans to dictate health benefits. Educating purchasers (leadership and benefit managers) on accountable care

strategies through different avenues is a key cornerstone of the multi-purchaser strategy, which includes the following activities:

- **Engagement of senior purchaser leaders through the Washington Health Alliance Purchaser Affinity Group.** The Washington Health Alliance will expand its current purchaser group, the Purchaser Affinity Group (PAG) to include C-suite leaders and other large self-insured purchasers not currently members of the purchaser group. Chaired by the Director of the Public Employee Benefit Board current PAG membership includes benefit managers from Starbucks, King County, Eddie Bauer, and unions. To be held four times a year, the meetings will be a 'call to action' and a mechanism to engage and educate benefit decision makers at organizations.

- **Targeted presentations to purchaser groups and 1:1 meetings with public and private purchasers**. Healthier Washington staff will proactively select presentations and arrange individual meetings with public and private purchasers to further educate and spread the model test and accountable care tools. Or, in the case of public purchasers or political subdivisions (e.g., schools, water districts, cities, and counties), join the state employee plan and enroll in the Model Test directly (if risk requirements are met). In early December, the governor will speak about the importance of accountable care and paying for value at the Washington Roundtable board meeting. The Washington Roundtable is a public policy organization comprised of senior executives from major private sector employers throughout Washington State with complementary goals, such as fostering economic growth, generating jobs and improving quality of life for Washingtonians.

- **Annual purchaser conference sponsored by HCA, King County, the Washington Health Alliance, and the Washington Roundtable to increase awareness and provide tools to develop and implement accountable care strategies**. HCA, King County, Washington Health Alliance and the Washington Roundtable will co-sponsor a statewide purchaser conference on value-based purchasing. HCA will lead a session on the model test and steps purchasers can take to replicate the model.

Payment Model Test 4

Healthier Washington Payment Model Test 4: Greater Washington Multi-Payer seeks to accelerate the adoption of value-based purchasing by increasing providers' access to patient data across multiple payers and health systems. The resulting multi-payer network will have the capacity to coordinate care, share risk, and engage a large population comprising commercial, Medicaid, public employee, and Medicare beneficiaries. Claims and clinical data integration and aggregation will provide a unified view of patient care and timely feedback to providers, regardless of payer, facilitating improved care coordination and population health management.

Multiple innovative efforts around sharing data from payers that empower providers to take on new forms of reimbursement are emerging across Washington State. This payment model leverages state data (Medicaid and PEBB) and aims to accelerate capacity through a Lead Organization (LO).

In September 2015, HCA released a Request for Applications (RFA), seeking applicants with demonstrable leadership skills and successful experience convening payers and providers, to serve as the LO, advance an existing data aggregation solution, and increase the adoption of value-based reimbursement strategies. The purpose of the RFA was to provide resources and state data to the selected lead organization to accelerate an existing strategy in the lead organization's operation while, at the same time, incorporating care transformation strategies from Model 3, including the Quality Improvement models, Quality Improvement plans that integrate Bree Collaborative recommendations, Shared Decision Making, active participation in Accountable Communities of Health, and the Washington State Common Measure Set.

Applications were due in mid-October, however, no bids were received despite receiving two Letters of Intent from potential applicants. HCA is currently re-visiting the development and discovery process and gathering more information to identify the appropriate path forward. For example, Healthier Washington staff spoke with Colorado SIM staff to learn more about their Rise Health multi-payer initiative, and has participated in various NASHP technical assistance conference calls.

Model participation metrics intended to capture data on participation from beneficiaries, providers, and provider organizations in the four SIM payment test models were identified. Accountability targets were set for each payment test model. These metrics were determined based on original grant application estimates. Model development and implementation design is in the preliminary stages making it difficult to estimate the accountability target. As model development and implementation design progresses, adjustments may be made to reflect the updated accountability targets of each payment model. See Appendix A: Porfolio of Reporting Metrics for the model participation metrics by payment model and the corresponding accountability target.

Leveraging Regulatory Authority

Washington has the authority in place to implement Healthier Washington. The state has taken full advantage of expanding Medicaid enrollment. This brought additional populations into the Medicaid managed care system, covering more than 550,000 new enrollees. Washington State's rate of uninsured adults is now only 6.4 percent, down from nearly 17 percent.

In 2014, to implement the Innovation Plan, the Governor requested two landmark pieces of legislation, which passed with bipartisan support. House Bill 2572 adopted key recommendations from the Innovation Plan, including Accountable Communities of Health, the Practice Transformation Support Hub, developing and reporting on the common measure set, and directing the state to increase value-based purchasing for Medicaid and public employees. Senate Bill 6312 set the path for the phased approach to fully integrated managed care by 2020.

E2SHB 2572 – "Better Health Care Purchasing"
• Creates legislative oversight • Establishes and funds first two Accountable Communities of Health • Establishes statewide performance measures committee • Creates practice transformation support hub • Establishes all-payer claims database and creates a safe harbor • Directs HCA to increase value-based contracting for Medicaid and public employees

2SSB 6312 – "Treating the Whole Person"
• Medicaid purchasing for physical, mental health and chemical dependency services must be fully integrated by 2020 • Creates behavioral health organizations by 2016 to integrate chemical dependency and mental health services administration • Medicaid purchasing will be aligned in regional service areas by 2016 • Incentives for early-adopters of full integration • Incentives for outcome-based performance • Reciprocal contracting arrangements required for co-located services

This built upon Washington's history of legislation that supported innovation.

- **Shared decision making.** In 2007, the state passed the Blue Ribbon Commission bill that promoted a shared decision-making pilot within the state. Additionally, it provided that if a patient signs an agreement to use a "certified decision aid" as part of the informed consent process, there is a presumption that the patient has given his or her informed consent. Consequently, in 2012, the state passed legislation that grants HCA's chief medical officer the authority to certify patient decision aids.

- **State Health Information Exchange (HIE).** In April 2009, the Washington State Legislature passed Substitute Senate Bill 5501 designed to accelerate the secure electronic exchange of high value health information within the state. SSB 5501 directed the HCA to designate a private sector organization to lead implementation. In October 2009, the HCA designated OneHealthPort to serve as the Lead HIE Organization. New services to address interoperability challenges in sharing health information across delivery systems are now being tested for the Medicaid population.

- **All Payer Claims Database (APCD)**. Earlier this year the Washington State Legislature passed Chapter 246, Laws of 2015 (Engrossed Substitute Senate Bill 5084), which directs the Office of Financial Management (OFM) to establish a statewide all payer health care claims database (Washington-APCD) to support transparent public reporting of health care information. The Medicaid program, the Public Employees Benefits Board program, all health insurance carriers operating in the state, all third-party administrators paying claims on behalf of health plans in the state, and the state Labor and Industries program will be required to submit medical, pharmacy, and dental claims to the Washington-APCD. In late October, OFM released the Request for Proposals to procure the lead organization to coordinate and manage the database. OFM anticipates selection of the lead organization will be completed by January 2016 and expects reporting from the Washington-APCD will begin in 2017.

- **Telehealth**. The 2015 legislature passed Senate Bill 5175 which broadens the scope of telemedicine to enable its use in urban and underserved areas in addition to rural areas. It also enables payment for both the originating and the distant site in a telemedicine transaction beginning in 2017. This will encourage more extensive use of this growing technological toolkit to serve individuals and enhance provider capacity and resources.

Washington State has been striving for the Triple Aim by leveraging its purchasing influence for the past 30 years, beginning in 1986 when the state Medicaid agency was directed to contract with managed health care systems to provide services to recipients of aid to families with dependent

children. Recognizing opportunities to more effectively manage care and cost, Washington brought purchasing for Medicaid and public employees into the same agency and amplified the state's commitment to managed care in 2011. In addition to the adoption of E2SHB 2572 in 2014, recent statutory Medicaid managed care requirements include: performance-based managed care for the integrated delivery of medical and mental health services; compliance with network adequacy standards; incentives for chronic care management within health homes; comprehensive medication management; assessment of evidence-based practices utilization in children's services; outcome and performance measures to assess and improve mental health, long-term care, or chemical dependency services; outcome and performance measures developed by the statewide performance measures committee; and integrated managed health and behavioral health care for foster children (2015).

Over the last several years, the Legislature created avenues to move to quality and value. In 2011, the Washington State Legislature established the Dr. Robert Bree Collaborative (Bree Collaborative), a multi-stakeholder consortium charged with identifying specific ways to improve health care quality, outcomes, and affordability in Washington State. Stakeholders are appointed by the Governor as Collaborative members and represent public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. Since its inception the Bree Collaborative has convened and published evidence-based recommendations including alternative payment models recommendations to improve the quality of care and reduce variation for the following topics: obstetrics, readmissions, total joint replacements, low back pain, spinal fusions, end-of-life care, and addiction and dependence treatment. HCA's Care Transformation strategies in the Model 3 contracts center on the Bree Collaborative recommendations. Both networks are required to demonstrate implementation and adherence to the Bree recommendations through annual Quality Improvement plans. This approach will be replicated in the other payment models, most notably Model 4.

Washington State eased administrative barriers to mental health and substance use disorder treatment integration at the delivery level for agencies that provide behavioral health services by creating behavioral health administrative and service rules. In July 2013, these rules were finalized and they provide streamlined administrative guidance in support of treatment agencies wishing to provide mental health, substance use disorder, and/or problem and pathological gambling treatment. Additional regulatory changes in 2014 broadened the venues where chemical dependency professionals may practice if those chemical dependency professionals are also licensed mental health counselors, psychologists, advanced or independent clinical social workers, advanced registered nurse practitioners, marriage and family therapists, osteopathic physicians, osteopathic physician assistants, physician assistants, or physicians, as defined by state law. These licensed and certified healthcare professionals may now practice in settings that are not also licensed and certified by the Division of Behavioral Health and Recovery.

There are some avenues where Washington State will pursue additional authority to advance its Model Test. The designation of Critical Access Hospitals (CAHs) is an area that will receive attention as part of the Payment Model Test 1 initiative under the SIM grant. The Critical Access Hospital designation was established under the federal Balanced Budget Act of 1997. In Washington, authority to license and regulate CAHs is under the DOH. A collaborative effort by DOH and the Washington State Hospital Association led to a series of recommendations regarding the future of CAHs—one of which is to consider a modification of state licensing laws that would

allow CAHs flexibility in the set of services they provide. Under the Model Test 1 work, HCA, DOH, the hospital association and others will further explore possible regulatory and statutory changes that will aid in the development of value-based payment opportunities for these critical providers of care to rural communities.

Washington has an innovative and ambitious agenda to advance coordination of care and improve patient outcomes through development of a statewide electronic exchange of clinical information. The goal is creation of a clinical data repository which, when fully populated with clinical records, will provide near real-time access to integrated medical, dental, behavioral health and social service support data to authorized health providers at the point of care. Successful implementation of the clinical data repository requires identifying and overcoming legal barriers to exchanging protected health information. We are partnering closely with ONC to explore innovative avenues to facilitate the exchange of health information to support clinical care.

Outside of HIPAA, federal law imposes very stringent restrictions on sharing information in patient records that specifically pertain to substance use disorder treatment. Our approach to overcoming this barrier is to explore options for integrating client consent within the electronic data exchange to support seamless care while complying with federal law.

Quality Measure Alignment

Historically, providers and payers alike have expressed frustration over a lack of common, statewide quality and cost performance measures. Current efforts to measure performance are burdensome, overlapping, and often conflicting; in addition, they provide no consistent or comparable indication of health system performance and undermine forward momentum to value-based purchasing. In January 2015, the legislative directive to build aligned Medicaid and public-private measures of health system performance was realized.

The passage of E2SHB 2572 required the development of a statewide core measure set to inform health care purchasing. With the adoption of a "starter" set of 52 measures across the domains of prevention, chronic illness, and acute care, the Performance Measures Coordinating Committee will continue to evolve as state priorities evolve and will be consistent with other measure sets to reduce provider burden.

E2SHB 2572 builds upon legislation from 2013 that required a standard set of cross-system performance measures for use across Medicaid delivery systems that include physical health, mental health, chemical dependency and long-term services and supports. The legislation required focus on both traditional and non-traditional measures of performance including improvements in client health status, reductions in client involvement with criminal justice, appropriate utilization of emergency rooms and increases in stable housing. With the involvement of a broad range of stakeholders, 51 measures were selected across these domains; a subset of these measures is currently being implemented in state Medicaid contracts.

Additionally, the governor's data-driven, continuous improvement system, "Results Washington," is a key underpinning for this initiative's measurement efforts. It provides health and health care cost and quality targets that the Governor reviews with his cabinet and stakeholders every quarter, resulting in a public report.

The common measure set, as the measurement foundation for all Healthier Washington tests, will measure all aspects of the Triple Aim, including health, quality, access and costs. As such, Washington has already begun and will continue to incorporate the common set into its model tests.

For example:

- ACHs are using 26 cross-cutting measures as a subset of the common set to measure long-term outcomes in communities.
- All Medicaid contracts, including those for payment model tests 1 and 2, include key common measures. These allow for comparability across both the fully integrated region and other regions.
- A subset of 19 measures from the common measure set is included in the ACP shared savings model. Performance on these measures will determine the amount of savings the networks will receive or the deficits they will owe HCA.
- The Plan for Improving Population Health measures will include measures that align where possible with the common set. Once the Plan is complete, it will inform the ongoing evolution of the common measure set.

During the pre-implementation year, the common measure set has already evolved. Based on the state's focus on behavioral health, the multi-sector Performance Measures Coordinating Committee—comprised of payers, providers, purchasers, public health and others—asked an ad hoc committee to research and recommend additional measures. As a result, at least one behavioral health measure is expected to be added to the common measure set. This is an indication of work and progress that will occur annually and emphasizes the state's commitment to aligning Results Washington and the cross-system Medicaid measures with the common measure set. As the science of measurement evolves, as well as our ability to access clinical data sources, the common measure set will be outcomes-based and better linked to community goals that address whole person health.

Payers and providers are equally committed to reducing the administrative burden of overlapping measure requirements and are active participants on the Performance Measures Coordinating Committee. Commercial payers have voluntarily committed to participating in public reporting of the common measure set. Additionally, the state is investing in a campaign that targets purchasers to promote the adoption of the measure set. These efforts will result in a measure set that can be effectively used by multiple payers, clinicians, hospitals, purchasers, and communities for health improvement, quality improvement, provider payment system design, benefit design, and administrative simplification efforts, as appropriate.

The common measure set will be used to regularly assess and report performance at the community, health plan, clinical practice, and/or hospital level. Results will be publicly reported in an unblinded manner when numerators and denominators are sufficient to produce results that are statistically valid.

SIM Alignment with State and Federal Initiatives

Because of the broad interagency and stakeholder engagement in the development of Washington's State Health Care Innovation Plan, which served as the foundation for Healthier Washington, many health care innovation activities are already well coordinated with the SIM grant. Even with close coordination, SIM funding neither duplicates nor supplants federal or state funds that support such activities. Specific instances of coordination are described below and throughout this section of the Operational Plan.

Federal-Specific Initiatives	Aligned with…
1115(a) Medicaid Demonstration	*See below.*
CMMI Innovation Awards Health Care Innovation Awards Health Care Innovation Awards Round Two Community-based Care Transitions Program Bundled Payments for Care Improvement (BPCI) Models 2 and 3 Transforming Clinical Practice Initiative Medicare Care Choices Model	*See Practice Transformation below.*
Medicaid-led transformation efforts, such as Health Homes, ACOs, and Patient-Centered Medical Homes	*See Health Homes below.*
Meaningful Use and HITECH	HCA has purchased a service to collect, share and use integrated health data through a community clinical data repository. Participation can help eligible hospitals and providers meet meaningful use objectives for sharing clinical summaries and medication reconciliation.
Initiatives from related agencies such as CDC, ONC, SAMHSA, HRSA and AHRQ	HCA is driving the adoption of health information exchange using national standards via the State HIE through purchasing efforts and meaningful use incentive payments.

Medicaid Transformation Waiver

Washington has applied for a Section 1115 Medicaid Transformation Waiver that builds upon—but does not duplicate—the work initiated under the SIM grant. The Medicaid Transformation Waiver, if granted, will leverage Accountable Communities of Health as coordinating entities, overseeing the selection, implementation and evaluation of regional transformation projects. As Coordinating Entities under the waiver, the ACHs will, in collaboration with the state, build upon such SIM-initiated activities as value-based purchasing; and will make greater use of performance assessment and other tools created under SIM.

Practice Transformation Network

Washington is fortunate to have the opportunity to participate in numerous federal initiatives that offer practice support for providers, while transforming the way we deliver health care. For example, five organizations within Washington have received a CMMI Transforming Clinical Practice Initiative (TCPI) award, which is designed to help clinicians achieve large-scale health transformation. We recognize that with each new opportunity we also need to ensure that providers are not so overburdened with opportunities that they experience transformation fatigue.
The Practice Transformation Support Hub has conducted an inventory of practice transformation activities in Washington, and along with several partners created a statewide practice transformation network. The Practice Transformation Support Hub will regularly convene a consortium of organizations leading practice transformation initiatives to ensure ongoing alignment of efforts to reduce duplication and identify gaps. By understanding where the gaps and resulting opportunities are, we can direct Healthier Washington resources to address those gaps. In partnering to develop and regularly convene a network of organizations providing practice transformation activities, we can leverage resources and ensure universal transformation of our health care systems across Washington.

Regional Alignment Through Accountable Communities of Health

One of the strengths of the ACH model is the fact that it leverages and aligns existing resources and programs at the community level. ACHs provide a unique opportunity to coordinate efforts within non-traditional partnerships, including a regional perspective that aligns the efforts of multiple communities. One of the early deliverables, and an ACH requirement prior to designation, is a Regional Health Needs Inventory, which includes a summary of existing health improvement projects/resources within each region. These inventories are just a starting point but they represent the state's commitment to aligning rather than supplanting.

Building an All Payer Claims Database

In September 2013 and September 2014, the Office of Financial Management received grant awards under the Health Insurance Rate Review Grant Cycle III and Cycle IV Programs from the CMS Center for Consumer Information and Insurance Oversight to establish data collection and disseminate health pricing information. The grant programs were the third and fourth rounds of funding to support health insurance rate review and insurance transparency in the pricing of medical services. Cycle III grant activities included seeking legislation. With the passage of Engrossed Substitute Senate Bill 5084 in April 2015, Cycle III and IV funds are being used to support and the establishment of the Washington-APCD activities in compliance with Chapter 231.371 RCW.

Alignment with the State Health Improvement Plan

In the implementation plan, a near-term goal related to “Access to Health Care” will be measured by the increased number of local health jurisdictions and tribes actively participating in Accountable Communities of Health. The long-term “shift” in the implementation plan includes several broad-based efforts, one of which is to “broaden health care to promote health outside of the medical system”; this item makes reference to the Prevention Framework and the Plan for Improving Population Health.

Alignment with Investments of State And Federal Dollars

The Department of Health received federal dollars from CDC for the Healthy Communities Obesity, Diabetes, Heart Disease, and Stroke Prevention Program (1422), and distribution of funding was aligned with ACH regions. State marijuana tax funding to support marijuana and tobacco community grants is being distributed in alignment with ACH regions. Upcoming distributions of funds (combination of state, CDC and HRSA) to support HIV community services will likely be distributed in alignment with ACH geography.

Alignment with Evidence-Based Health Home (HH) Program

The Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) have been collaborating on the Health Home (HH) program with federal partners for over two years, and have received strong support from beneficiaries, local health care providers, and advocates. The Health Home program is a unique person-centered care coordination program for high-risk Medicaid and Medicare/Medicaid beneficiaries. It provides both intensive care coordination and comprehensive care management with improved health outcomes and a reduction in service costs for some of Washington's highest need beneficiaries.

As part of the HH program, the state has been participating in the Center for Medicare and Medicaid (CMS) Managed Fee-for-Service (MFFS) Financial Alignment Demonstration for Medicare/Medicaid beneficiaries. The demonstration is an unprecedented opportunity available for states to benefit from Medicare and Medicaid savings resulting in improvements in health care quality while reducing costs. For the first time, direct performance payments from CMS based on achieving statistically significant savings and meeting or exceeding quality requirements is possible.

Initial demonstration qualitative measures have shown a reduction in Medicare inpatient hospital admissions, avoidable emergency room visits, Medicare inpatient psychiatric admissions, and all cause readmissions. It has also been shown to be a factor in decreasing the need for nursing admissions. CMS has confirmed the HH program has achieved preliminary actuarial Medicare savings for the first year of the demonstration payable during this fiscal year.

Health homes are closely aligned with payment models 1 and 2, and also demonstrate the state's general readiness and capacity for further interaction with Medicare, particularly on model 2.

Prescription Drug and Opioid Addiction Project

In August 2015, the Department of Social and Health Services received SAMHSA grant funding for the Washington State Medication Assisted Treatment-Prescription Drug and Opioid Addiction Project (Washington-MAT-PDOA). The Washington-MAT-PDOA will expand access to integrated medication assisted treatment (MAT) with buprenorphine for individuals with opioid addiction. Using a proven office-based opioid treatment (OBOT) model implemented in both a large urban safety net primary care clinic and two Opioid Treatment Program sites serving a predominantly rural population, this project provides new tools to replicate integrated MAT statewide. This grant-funded initiative seeks to increase the use of an evidence-based treatment for individuals with opioid dependence seen in primary care settings and uses telehealth as one aspect of the model, which align well with efforts under Healthier Washington.

Workforce Capacity

Healthier Washington aims to maximize all resources by ensuring the health and health care workforce is working at the top of their scope and we're ensuring the right people are delivering the right services, including those outside traditional health care services. This includes considering family members, social service providers, those who do community health work, and health systems leadership. This also considers consumers themselves as members of the workforce through empowering people and families to be contributing members of the health care team.

There is increased demand on the health workforce because more people, including single adults, now have health coverage and expect care as a result of the Affordable Care Act. There is increased draw on a wide array of mental health providers as a result of mental health parity implementation. In addition, Americans are older and have worse health than they used to. This creates conditions that entail more care such as obesity, asthma, and COPD.

Workforce challenges include shortages of providers in key areas as well as assessing the adequacy of the mix of providers.

Projected Healthcare Personnel Shortages[8]

Occupational Title	New Supply	Projected Annual Net Job Openings 2017-2022	Annual Gap Between Supply and Projected Demand
Vocational Rehabilitation Counseling	25	298	-273
Clinical Laboratory Science/Medical Technology/Technologist	26	212	-186
Health Unit Coordinator/Ward Clerk	228	400	-172
Physical Therapists	118	259	-141
Medical Doctors (all)*	222	340	-118
Dentists, General	85	200	-115
Dental Hygienists	225	336	-111
Emergency Medical Technicians and Paramedics	69	158	-89
Opticians, Dispensing	24	86	-62
Pharmacists	199	256	-57
Respiratory Therapists	30	77	-47
Dental Laboratory Technicians	17	56	-39
Occupational Therapists	87	124	-37
Registered Nurses**	2,367	2,384	-17

[8] **Source: Health Workforce Board 2014 Annual Report**

*Medical doctors at completion of medical school. MDs still have 3+ years of residency training before they can begin to practice.

**US Department of Labor data provides aggregate data on demand for registered nurses. Nursing demand numbers are not broken down by degree attainment. The registered nurses category for this table includes ADNs, BSNs and NPs

Medical Transcriptionists	82	82	0
Physician Assistants	100	95	5
Radiologic Technologists	216	158	58
Substance Abuse Counselors	381	133	248
Licensed Practical Nurses	1,110	393	717
Medical Assistants	2,419	686	1,733

Healthier Washington is addressing health care workforce requirements through its multiple levers including purchasing, payment and legislation. It also is establishing innovative mechanisms that build upon work in the state, and also redefining what we mean by an "adequate" informed health workforce. Adequate doesn't just mean increasing the numbers of providers, but appropriately matching the skillset demanded to serve the state's transformed system. We have two specific investments under Healthier Washington that focus on CHW and pipeline data.

Community Health Worker Task Force

Community Health Workers, Community Health Representatives (tribal), peer support specialists, doulas, "promotores de salud" (promoters of health), and myriad others have been working in various paid and unpaid capacities throughout Washington for years. They have worked in clinics, hospitals, housing projects, local social service centers and other locations to draw on their connections to and linkages with local community members to increase individuals' success in navigating and accessing health services, increasing successful care transitions and managing previously debilitating health conditions such as asthma. They have helped to organize improved health behaviors, safer environments and a health workforce that has a better understanding of and relationship with the diverse Washington population.

During the pre-implementation year, Washington convened a Community Health Worker task force to develop actionable policy recommendations around roles, skills and capacity of those who do community health work, and how they will align with Healthier Washington and be incorporated into a transforming and transformed delivery system. The discussion of the task force includes the work of doulas, tribal community health representatives, promotoras, peer supports and others as well as those with the actual title of CHWs. This task force includes more than 50 representatives including broad representation of workers, health plans, employers, hospitals, clinics, educators, community based organizations for physical and behavioral health, housingand tribal representatives. This task force is developing recommendations in December 2015, which may include topics around CHW definition, intersection with ACH activities, and common qualities, skills and principles.

Washington stakeholders plan on considering these recommendations as well as those initiatives already in place, to evaluate whether and how to implement. We anticipate annual review of action on the implementation of the actionable policy recommendations as aligned with Healthier Washington to achieve its goals.

Industry Sentinel Network

In the rapidly growing and evolving health care landscape we need to have rapid turnaround workforce information from the leaders in community and site-based care and those striving to

improve population health. The Industry Sentinel Network will draw from rapid periodic polling from employers such as hospitals, clinics, community based organizations, and from workforce organizations. It will assess the workforce and areas of additional focus areas in training needed. These areas could include how to work effectively in teams, function well in in a cross disciplinary environment, use IT tools, and increase individual client engagement and client ownership of effective personal health management. This, in addition to information about workforce shortages, can be analyzed and shared with educators, associations, other employers, ACHs, the Hub and state and local entities. It may be used to develop education and training to improve the effectiveness of the current workforce, enable professional development and provide support for workers and employers. The Health Care Authority has developed an interagency agreement with the Workforce Training and Education Coordinating Board/Health Workforce Council. They will subcontract with the University of Washington Health Workforce Center to develop a survey, establish a portal and begin gathering information for sharing in the autumn of 2016. The portal will be developed and information is scheduled to begin flowing in Q3 2016.

Access and Redefining Adequacy

In addition to these workforce needs, we also have requirements under our payment model tests around network adequacy:

- **Model Test 1**: Before signing contracts to provide fully-integrated physical and behavioral health coverage in Southwest Washington, MCOs must demonstrate network adequacy and the ability to provide all required physical and behavioral health services within time and distance standards as identified in the contract. HCA will review network submissions to ensure that each MCO's contracted provider network can ensure timely access to all covered services and meet the expected utilization capacity in the region. This network adequacy review includes the number of providers, their geographic distribution relative to the population to be served, and timeliness of appointments. MCOs are also required to routinely monitor provider accessibility and network adequacy.

  Additionally, because specialty mental health services and substance use disorder services have not previously been provided through Medicaid MCOs, HCA has established an Essential Behavioral Health Provider Network list, specifying essential behavioral health provider types (e.g. evaluation and treatment services, substance use disorder residential treatment, detoxification services) that must be present in an MCO's network in order to receive a contract from HCA.

- **Model Test 2**: The provision of services to Medicaid beneficiaries by federally qualified health centers, rural health clinics and critical access hospitals is by contract with managed care organizations and is therefore subject to the network adequacy standards and review process set forth in the MCO contracts. As new value-based payment models are introduced and adopted under Model Test 2, we will monitor closely for their effect on availability of and access to providers. One goal of this model development is to more closely match the availability of services to community needs, especially in rural areas. For example, it may make sense for a given CAH to alter the mix of services it provides to place more emphasis on long-term care or behavioral health. Guided both by the established network adequacy standards and the common performance measures established under Healthier Washington, enhanced access to the appropriate mix of providers and services is anticipated.

- **Model Test 3:** The Model 3 contract will measure network adequacy differently than Models 1 and 2. As outlined in the contract, each network is required to provide a comprehensive clinically integrated network that includes adequate geographical coverage across multiple contiguous counties, starting with the five county Puget Sound region in 2016. Each network is required to disclose its agreements with partner providers (its network of providers and facilities that are critical to the success of the network and that satisfy network requirements because of the number state employees receiving primary care in one of the five counties), affiliate providers (network of providers and facilities that are individually contracted with to ensure access to providers), and ancillary providers (non-hospital providers that are the third party administrator's network), and are required to provide notification to HCA of any changes (additions or deletions) to the network. In addition, the contract has timely access to care clauses. Both networks must provide appropriate and timely access to care for state employees, offer and provide appropriate telephone consultations, virtual visits (including electronic messaging), telemedicine, home monitoring, after-hours access to care, and administrative and clinical assistance/services (a HCA dedicated contact center with extended hours of operation, dedicated contact center advocates, and website/portal). For 2016, the University of Washington Medicine Accountable Care Network is offering telemedicine free of charge (no co-pay or other payment) to enrolled state employees. Both networks are required to submit a member access and member experience report annually, reporting on their performance on CG-CAHPS measures, adherence levels for each of the services outlined above, corrective action plan for where standards are not met, show evidence of compliance.

- **Model 4:** Model 4 contract will leverage Model 3 contract language and lessons learned from Model 3 implementation.

An Expanded Definition of Workforce Development

In addition to developing the workforce of those who provide services directly to people and families, Healthier Washington is developing its health and health care leaders at the community and state levels in order to accelerate and sustain the initiative, and to ensure leadership is representative of Washington's communities.

Accountable Communities of Health, combined with the tools and resource under Practice Transformation and Plan for Improving Population Health, will be the primary vehicle to strengthen non-traditional partnerships and build the capacity of community and health system leaders, including the organizations they represent.

The Health Innovation Leadership Network (HILN) is reflective of our Accountable Community of Health model, but at a state level. This multi-sector public-private network is accelerating the efforts of Healthier Washington to assure a diverse and adequate workforce representative of the needs of the communities they serve. HILN will accelerate Healthier Washington's aims through culture change, broad communication around what Healthier Washington is trying to achieve, and by providing a bi-directional feedback loop on progress of the initiative.

Key members of the HILN include the cabinet members and leaders from a dozen state agencies and organizations, who have been working together on this initiative since 2013 and recognize the power of working across sectors and breaking down silos to achieve change. These state agencies have not only been working with private-sector partners to accelerate leadership and action, but this year have focused on ensuring the state government workforce is prepared to deliver equitable and

culturally appropriate services representative of those we serve. The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards) are a comprehensive set of guidelines that inform and facilitate the provision of culturally and linguistically appropriate services. The goals of the standards are to advance health equity, improve quality of services, and work toward the elimination of health disparities. The standards can be implemented by any entity wishing to provide services that are responsive to the diverse cultural, language, literacy, and other needs of the populations it serves.

Recently the Governor's Interagency Council on Health Disparities adopted CLAS as a priority and member agencies have been working to raise awareness of CLAS and obtain agency support to implement CLAS policies and practices. Following are four examples, which highlight different approaches agencies are taking.

1. HCA has adopted an agencywide approach to developing and implementing a CLAS policy. In February 2014, the agency created the "Health Equity: Culturally and Linguistically Appropriate Services Initiative." The initiative is supported by 12 workgroup members representing different divisions and offices. To date, the workgroup has developed a charter, implemented an agency CLAS policy, conduct an organizational self-assessment, implement CLAS practices in every division, and educate staff and partners on the importance of cultural competency and language services. The Agency incorporated CLAS into the agency's strategic plan to ensure sustainability and integration of CLAS into all agency activities.

2. DSHS adopted an agencywide policy on cultural competence with guidelines for implementation within each administration in September 2011. The stated purpose of the policy is to create and maintain an environment within that values and supports cultural competence and embraces respect for the individual differences of employees and clients. Currently, administration workgroups are reviewing alignment of their existing plans with the CLAS standards.

3. DOH has adopted an agencywide approach to developing and implementing CLAS policies and procedures. In January 2014, the agency convened a health equity workgroup with representatives from across the agency. The agency's Chief of Health Equity serves as the executive sponsor for the workgroup and has appointed a lead manager to oversee CLAS planning and integration efforts. Current activities include reviewing existing agency policies and communications standards to identify opportunities to align with the CLAS standards, and developing an overall strategy with immediate actions and long-term initiatives.

4. At the Office of Superintendent of Public Instruction (OSPI), information on CLAS was presented to a few staff members in December 2013, which was followed by a presentation to the OSPI Cabinet in January 2014. Agency leadership approved an approach to explore the creation of a CLAS policy and implementation of CLAS strategies at the division level. In March 2014, agency sector directors received a presentation on CLAS and have been invited to participate in the CLAS project in ways that meet the needs of their sections.

Supporting Initiatives

In addition to direct interaction with SIM, there are many other activities occurring across the state that support a transformed workforce.

Telemedicine. The contracts for both Medicaid and PEBB include the ability for benefits to be provided utilizing telemedicine tools. Several health plans are currently utilizing those tools.

Various health licensing boards and commissions such as the Board of Psychologists are considering guidelines for their respective workforces to increasingly engage individuals through Telemedicine. We have seen presentations that that Speech Therapists and Physical Therapists are currently utilizing Telemedicine to extend their workforce to provide personalized care while avoiding time consuming travel for providers and clients in rural and urban areas. In addition the University of Washington has a Telehealth Center to do consultations with rural providers. These consultations serve two purposes; they increase the timeliness and sophistication of services available outside urban areas and they reduce professional isolation among rural practitioners. In another venture, DOH is hosting an ongoing telemedicine workgroup including HCA and DSHS in an effort to provide a coordinated approach to increased interest in the topic, and to increasing professional engagement of this emerging care force.

Paramedicine. Throughout Washington there are enclaves of effort to use paramedics and other first responders to increase the engagement of and subsequently the health of individuals with chronic health conditions. Many of these individuals use a lot of ambulance and emergency department services. To this end, Kent, Tacoma, Prosser, Spokane and other fire/EMS districts, in conjunction with hospitals, are looking at ways to reduce unnecessary use of the emergency department.

They are looking at a minimum of two approaches. The first approach is to use community paramedics to further engage with these individuals, people who they are likely to already know, to check in on them between emergencies to see if they understand their medication and how to use it, to encourage safe and healthy physical environments and to see if the individuals understand and are following up on the care directions.

The second approach is to divert people with lower acuity needs from going to emergency departments when a more basic level of care is more appropriate. This effort is buoyed by 2015 legislation (HB 1721) that allows emergency personnel to be paid when they transport clients, after appropriate assessment, to urgent care clinics or mental health or chemical dependency services instead of hospital emergency departments. This is in the planning stages, with the HCA required to provide guidelines by July 2016 for inclusion in regional EMS and trauma care plans.

Familiar Faces. In King County (the most populous county in Washington), a program called "Familiar Faces" recognizes that certain individuals with complex physical, behavioral and social health needs are served by a broad array of professionals—some of whom may not ordinarily be considered when defining "health care providers." Familiar Faces mapped the many services and facilities that serve as points of contact with this high-need population, including not only physical and behavioral health services providers in clinic and hospital settings, but first responders, emergency departments, criminal justice, schools, employers and the faith community. Working from such a map, the program has begun to define a future state in which a more coordinated care plan could be developed and accessed by the broader care community in betterment of the health status of the individual, regardless of where in that community the individual may first present. Healthier Washington helps to provide a context in which such collaborative thinking can be encouraged and supported.

Education. Starting in January 2016, the Pacific Tower will serve as a satellite campus for Seattle Central College to house its growing Allied Health programs including dental hygiene, respiratory care, nursing and surgical technology. The Seattle Central Health Education Center will occupy five floors in the tower and provide students with new medical and computer labs and state-of-the-art equipment in order to train with the latest medical technology. One of the strengths of this campus is the potential for students to collaborate with health-focused organizations located within the tower. For example, Neighborcare Health will open a community dental clinic in the Health Education Center, enabling dental hygiene students to practice skills learned in the classroom.

Central Supply Processing and Certified Nursing Assistant programs give those with no experience in healthcare the opportunity to earn certificates and launch careers relatively quickly. And many of Seattle Central's programs include day, night and online classes that provide those with work and family commitments the opportunity to advance their education.

Additionally, SCC's Workforce Services programs provide required tuition, fees, books and transportation to qualifying students. Academic planning, job placement assistance and emergency financial assistance is also available.

Workforce education programs include: Basic Food Employment and Training Program (BFET); WorkFirst for students receiving Temporary Assistance for Needy Families (TANF); Worker Retraining for students who receive or have exhausted unemployment benefits, individuals who are "displaced homemakers," veterans, or the formerly self-employed; and Opportunity Grants are available to low–income adults pursuing an approved program.

New Medical School with Rural Focus. Although Healthier Washington is not focused on continuing existing efforts such as health career student loans, it is looking at increasing capacity for training all levels of health care professionals and paraprofessionals. Washington State University will launch its medical school in Spokane with the first classes planned for the fall of 2017, with the anticipated graduation of its first class of medical students in the spring of 2021. The medical school will seek to produce family practitioners and will seek to increase the number of graduates willing to work in rural areas, in part by recruiting students from rural areas.

Health IT Plan

As part of the Model Test implementation and operation, Washington has a well-considered vision for optimizing its existing and planned Health IT to support the collection, storage, protection and dissemination of information needed to achieve the aims of the SIM. This section is comprised of tables requested by CMMI to outline our strategy, governance, staffing and planning approach. Sections include:

Table 1. Our Strategy / Rationale / Metrics and the Driver Diagram
The HIT elements in Washington State are designed to achieve health care transformation by virtue of involving multiple state agencies and multiple stakeholders, with particular attention to common data definitions, safeguards for privacy, and meaningful use of health care information.

Tables 2-4. Governance
To coordinate data integration and analytical resources, Washington will leverage its governance team, the AIM Steering Committee, to lead HIT activities under Healthier Washington. Governance bodies have been comprised of policy, technology leaders from WaTech, DSHS, HCA and DOH. The steering committee will direct the planning, oversight and implementation.

Tables 5-9. Health IT Organizational Capacity

Tables 10-12. Health IT Stakeholder Engagement

Tables 13-15. Leveraging Existing Assets

Washington State has implemented the policy and regulatory foundation for our HIT Plan. The state legislature has established a foundation for accelerating a standards-based health care information technology adoption. For example, House Bill 2572 laid the groundwork for APCD, with recent legislation expanding the mandate. We have set ourselves up well to be early and great adopters across providers, hospitals and payers in HIT. Washington State has implemented Substitute Senate Bill 5501 passed in April 2009, designed to accelerate the secure electronic exchange of high value health information within the state. SSB 5501 directed the HCA to designate a private sector organization to lead implementation of the act. In October 2009, the HCA designated OneHealthPort to serve as the Lead HIE Organization. We leveraged the HITECH act to establish the state HIE and establish the EHR Incentive Program to advance adoption of certified EHRs above the national average. All of our eligible hospitals are using certified EHR.

We are exercising existing authorities through managed care contracts to require that all health care delivery systems with certified EHR's to export a care summary using a CCDA via the state HIE to the clinical data repository each time a Medicaid consumer is seen beginning no later than February of 2017.

We are also requiring for our state employees program that accountable care organizations offer electronic access to patient medical records; to providers for purposes of care, and to activate patients as engaged participants in their own care. We are organizing ourselves so as to be careful about duplicating investments. It is one swimming pool – but we have carefully established multiple swim lanes.

Table 16. State Regulatory and Policy Levers

Table 17. Medicaid Waivers

Table 18. SIM Health IT Alignment with other federal, state, regional and local investments in IT

Tables 19-20. State Methods to Improve Transparency and Encourage Innovative Uses of Data

Table 21. Promotion of Patient Engagement and Shared Decision Making

Table 22: Multi-Payer Strategies

Tables 23-24. Analytical Tools

Table 25. Plans to use Standards-based Health IT to Enable Electronic Quality Reporting

Tables 26-27. Public Health IT Systems Integration and Electronic Data to Drive Quality Improvement at the Point of Care

Table 28. Health IT to Support Fraud and Abuse Prevention, Detection and Correction

Tables 29-30. Technical Assistance. Under Healthier Washington, the state is planning on providing technical assistance to providers in multiple ways. We are currently doing an assessment of EHR and interoperability capacity for those who are unable to qualify for MU incentives and may invest in a solution to link to the Link4Health CDR.

Table 1: Health IT Support for Data/Information for Driver Diagram (Workbook Tab 1)

Metric: What data will be used to track progress (how much and by when)? ***(copy from Operational Plan Driver Diagram-Tab 1)***	**Who needs the data?** **(1) state** **(2) HC delivery systems/managed care entity** **(3) providers** **(4) patients/enrollees**	**What Health IT is needed to support data collection, retention, aggregation, analysis, dissemination? (what and by when)**	**What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?**	**Identify and explain policy levers that will be used (if applicable): (1)statutory/regulatory (2) Leveraging State Purchasing - Medicaid (managed care contracting/MMIS/MU Program) (3) Leveraging State Purchasing - State Employees (4)Leveraging Private Financing**	**Identify challenges and additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item**
Program-wide Outcomes					

1.a.1 Program-wide Outcomes Behavioral Health: % of Adults Reporting 14 or more Days of Poor Mental Health Plan All-Cause Readmission Rate Psychiatric Hospitalization Readmission Rate Potentially Avoidable ED Visits Adult Access to Preventive/ Ambulatory Health Services Child and Adolescents' Access to Primary Care Practitioners Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) Childhood Immunization Status Patient Experience: Provider Communication (CG-CAHPS) Patient Experience: Communication about Medications and Discharge Instructions (HCAHPS) Well-Child Visits (two rates) Annual Per-Capita State-purchased Health Care Spending Growth Relative to State GDP Medicaid Spending per Enrollee First Trimester Care Tobacco: % of Adults who Smoke Cigarettes Mental Health	The state needs this data for reporting to legislature and for gauging impact of the various interventions on the service delivery systems. Positive results for each of these measures would be shared with providers via the Practice Support Transformation Hub, as well as the ACHs, to cement improvements in care delivery and access. Further, the state can use these levers as negotiation data with the MCOs.	The state is currently producing ALL of the measures captured in the program-wide outcomes section. As part of the Results Washington and Results HCA initiatives, outcome goals and measures have been in development for several years and are currently available on a dashboard monthly.	N/A All system and process changes have occurred to produce this data set.	N/A	N/A

ACHs					
1.a.2 Intermediate: Project-specific process and outcome measures tailored to measure ACH's individual projects Long term: Each ACH selects measures from a subset of the official Healthier Washington Common Measure Set aligned with its project-specific goals, which many include: -Child/adolescent health - Adult primary/preventive care - Adult behavioral health - Adult ED visits and readmissions - Health care costs	The state needs this data to measure the formative measures of the ACH development in the intermediate term. Longer term, as the ACHs set their agenda and goals, the entities will pick measures from a subset of the Common Measure set.	Currently the ~52 measures in the state common measure set are tracked and produced by data provided to the Washington Health Alliance – a long-time state partner. In the intermediate term, Washington has contracted with an organization called Providence CORE to provide formative and evaluative data elements related to the ACHs – inclusive of geo-mapping and data related to multi-sector social determinants data. Longer term, AIM will be playing a larger role in supporting ACH development and outcomes measurement.	The WHA is continuing to deliver data to support the common measure set. Contracting with Providence CORE is complete. No further policy, technical or operational changes are required.	N/A	N/A

1.b.1 - Assess the extent to which the ACH's play an active and productive role in delivery system transformation - Specific measures to be developed once the ACH role in Healthier Washington activities is further developed	Clearly both the state and the accountable community of health (ACH) require advanced data and analytics to establish their contribution to delivery system transformation.	The AIM roadmap has prioritized the data needs of the ACHs to include implementation of a logical data warehouse and various presentation tools for the use of the ACHs.	Washington is in the early stages of understanding its procurement needs. Some TA may be useful. We are also leveraging the state OCIO office and their technical services as available.	N/A	N/A
Hub					

1.b.2 Hub Number of practices participating List of peer mentors; number of mentor/mentee interactions; satisfaction with interaction Counts of sessions and number by type of stakeholders involved; summary of results Committee charter; meeting minutes Website analytics; user satisfaction Number of trainings; satisfaction with trainings; changes in practice -Number of sessions, satisfaction with sessions; changes in practice -By January 2019 connect 80% of primary care, mental health, and substance use disorder providers in small to medium practices with Hub-sponsored transformation services Proportion of ACH regions with an extension center agent; satisfaction with agents; changes in practice	Both the state and the stakeholder groups (primarily physicians) engaged in Hub utilization will require extensive data. The Hub's future sustainability is wholly dependent on its quality and utilization. Measuring utilization and impact will be essential to its long-term existence.	Though the Hub is early in its procurement process, we know this: We will need a comprehensive internet-based portal. We will need to leverage a portal with analytics capabilities so we can track utilization and trends. We will need a mechanism to track user engagement and satisfaction. We will need to leverage the data in section 1.A to determine any impacts on clinical outcomes.	Since the Hub is a new entity at the state level and a new player in the clinical practice support market, both technical and operational changes will occur. The state will have competitors in the Hub marketplace, entities who are providing practice support services today. We will need to determine how to compete or collaborate. We will have the opportunity to learn from others. The state will have a new technology partner or be a site administrator itself. Operationally, the state will need to help operate aspects of the Hub or it will need to contract for support services.	The legislative framework is in place which calls for a state-sponsored Hub. The biggest issue here is that of sustainability. The Hub will need to develop a business model that enables a sustainable future; it is possible that long-term vision may require a policy change.	N/A
Payment Model Redesign					

2.a.1 Model 1: Health care use and costs: - Inpatient admissions - ED visits -Total $ per member per month – Nursing home - Home and community-based services - Total long term services and supports ($) Quality of care outcomes: - Antidepressant medication management - Adherence to anti-psychotic medications for persons with schizophrenia - Comprehensive diabetes care - Follow-up after hospitalization for mental illness (7 and 30-day) - 30-day plan all-cause and psychiatric inpatient readmission rates - Initiation and engagement in alcohol and other drug dependence treatment Social outcomes (labor market, housing stability, and criminal justice involvement): - Unemployment rate - Annual earnings level - Homelessness - Arrests - Jail bookings	The state needs data from the MCOs as well as Medicaid/Medicare to gauge the impact of the Early Adopter program on fully-integrated managed care. The MCOs will need data from the state – though primarily they are a provider of data. Patients certainly need data to evaluate the positive impacts of the plan and make enrollment decisions.	The state's Provider One system will provide the data necessary to evaluate the impact of the model test. By 4/1/2016, Provider One will be expected to process benefits and provide outcome data to evaluate the metrics at left.	The legislative and policy framework is in place to empower fully-integrated managed care.	Legislative mandate to have fully integrated services by 2020 – 6312. Legislation around statewide measure set is to inform purchasing HB 2572	N/A

2.a.2 Model 2: Cost: Total cost of care per member per month (pmpm) Utilization: ED visits and plan all-cause readmissions Quality: subset of HEDIS clinical quality metrics and patient experience metrics (e.g., HCAHPS publicly reported hospital-based surveys[9]) Population health: -Screening for clinical depression -Blood pressure control - BMI screening and follow-up	The state will need both MCO and hospital/HEDIS reports to evaluate the impact of this transformational payment redesign pilot.	AIM will be a key supporter and enabler of Model 2 data capture. By 12/30/16, AIM will be expected to report out on quality measures to evaluate quality of Model 2.	Policy levers for Model 2 is built on work done by the WHRAP – collaboration between DOH and WSHA.		

[9] See the following reference for HCAHPS:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html

Model 3: 19 quality metrics from the HCA's own QI model (a subset of the Washington Statewide Common Measure Set) in the following categories: - Chronic conditions - Behavioral health management - PEBB member experience - Medical screenings and immunizations - Obstetrical care - Total cost of care (pmpm)	The state needs data to determine the progress of the Accountable Care Program (Model 3). The ACP has been extended to the public employees of Washington State. State operational staff administer the program and evaluate quality data submitted from the MCOs	Currently the ~52 measures in the state common measure set are tracked and produced by data provided to the Washington Health Alliance – a long-time state partner. Additionally, the MCOs are contractually obligated to provide quality data at specific intervals.	Extensive operational changes are required at the state Health Care Authority to begin support of the Model 3 test in service to the public employees – by January 1, 2016.	The genesis of APM Model 3 is statutory/regulatory and leveraging state purchasing. Development of APM Model 3 was driven by the Legislature through E2SHB 2572. The Legislature directed the Health Care Authority to "increase the use of value-based contracting and alternative quality contracts for Medicaid and public employee purchasing." All of the Payment Model work can be mapped back to 2572 which was a mandate to link state purchasing to value.	

Model 4: Implementation measures: - Payer/provider commitments and readiness to incorporate ≥ 25 K enrollees from state-purchased programs and ≥ 25 K commercially insured by year 1 (2016), expanding significantly, including Medicare enrollees, by years 2 and 3 (2017 and 2018) - All partners of LO to adopt value based purchasing (VBP) for 80% of covered lives by end of year 3 (Jan 31, 2019) Process/Outcomes: Performance on the Statewide Common Measure Set (52 measures[10]): -Population health (5 measures) -Clinical processes or outcomes for health plans only (4 measures for children and adolescents; 9 for adults); primary care medical groups (4 measures for children and adolescents; 17 for adults; 10 for hospitals) - Cost of care (3 measures)	Model 4 is unique in that a lead organization will be providing a data aggregation platform for use of the providers who are engaged in value-based care. Providers need data to support decision-making and comply with value-based contracts. The state needs data on outcomes.	The state is currently searching for a Lead Organization to use existing technology and leverage the state HIE in support of improved data sharing (aggregation) and distribution. The technical solution has not been identified but will receive up to $1M in services to ensure the right data gets into the right provider's hands.	Technical and operational changes will, no doubt, be required to embrace a new vendor into the benefits and healthcare administration environment.		

[10] http://www.hca.wa.gov/hw/Documents/pmcc_final_core_measure_set_approved_121714.pdf

Domains of the Health Information Technology Plan

A. Governance

ORGANIZATIONAL STRUCTURE AND DECISION-MAKING AUTHORITY RELATED TO HEALTH IT

Table 2: Organizational Structure(s) related to Health IT (Workbook Tab 10)

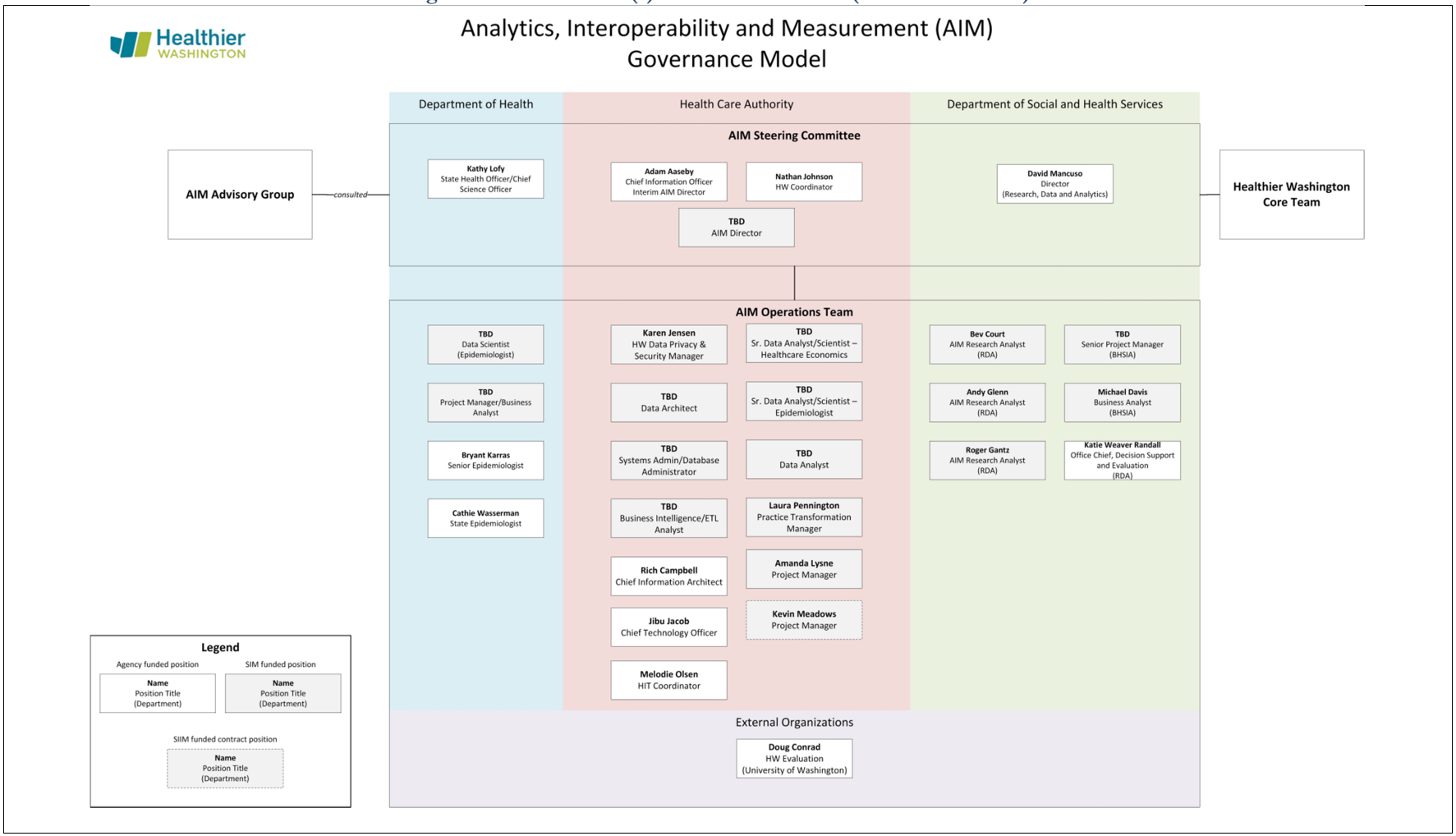


Table 3: Health IT Related Positions (Workbook Tab 6)

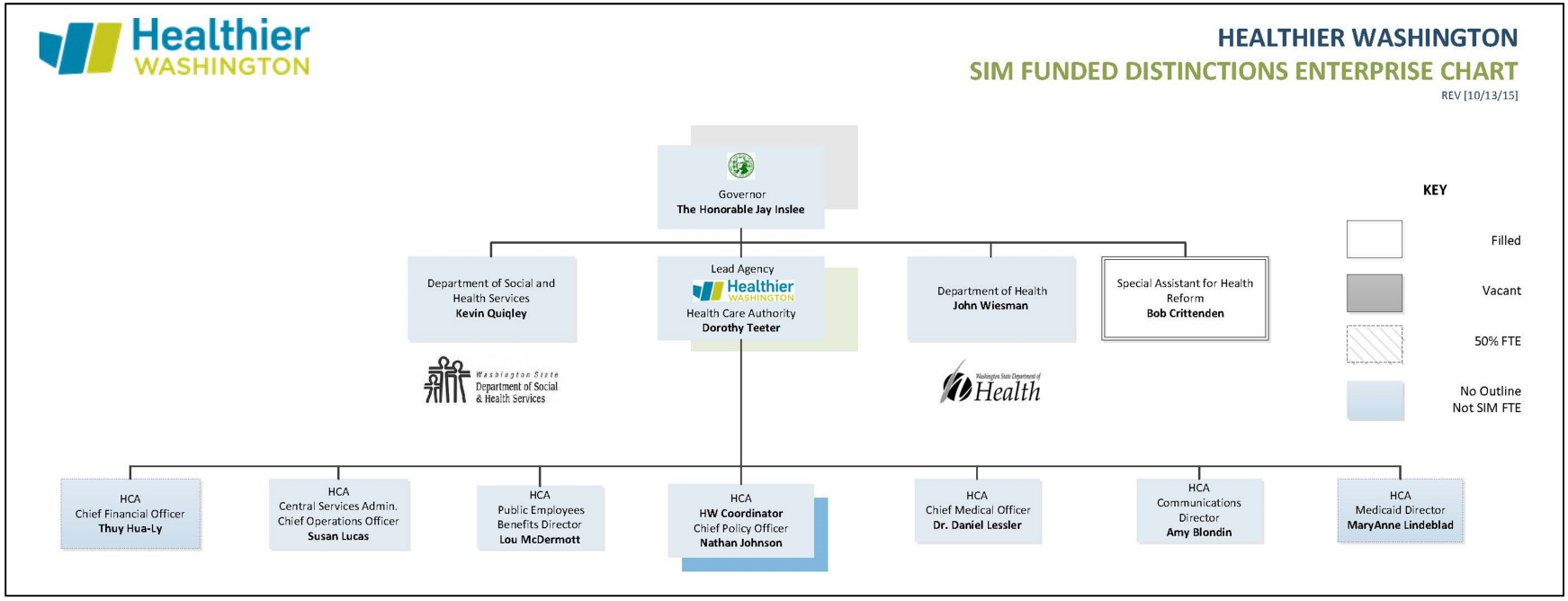
HIT Lead					Contact Information	
Health IT Activity	**Position/Title (including Government Agency)**	**State Appointed Staff (AS), State Hired Staff (HS), Contracted (C), Appointed (A)**	**First Name**	**Last Name**	**Phone Number**	**Email Address**
HIT Leadership	Chief Information Officer Health Care Authority	AS	Adam	Aaseby	360-725-1241	Adam.aaseby@hca.wa.gov
HIT Leadership	Analytics, Interoperability and Measurement Director Health Care Authority	HS	TBD	TBD	TBD	TBD
Data/Information Governance	Data Privacy and Security Manager Health Care Authority	HS	Karen	Jensen	360-725-1887	karen.jensen@hca.wa.gov
Data Architecture and Management	Data Architect Health Care Authority	HS	TBD	TBD	TBD	TBD
IT Infrastructure	Systems Administrator/Database Administrator Health Care Authority	HS	TBD	TBD	TBD	TBD
Data Analysis, BI and Reporting	Business Intelligence/ETL Analyst Health Care Authority	HS	TBD	TBD	TBD	TBD
Data Analysis, BI and Reporting	Sr. Data Analyst – Epidemiologist focus Health Care Authority	HS	TBD	TBD	TBD	TBD
Data Analysis, BI and Reporting	Sr. Data Analyst – Healthcare Economics focus Health Care Authority	HS	TBD	TBD	TBD	TBD
Data Analysis, BI and Reporting	Data Analyst Health Care Authority	HS	TBD	TBD	TBD	TBD

Data Analysis, BI and Reporting	Data Analyst Health Care Authority	HS	TBD	TBD	TBD	TBD
Performance Measurement	Practice Transformation Manager Health Care Authority	HS	Laura	Pennington	360-725-1231	Laura.pennington@hca.wa.gov
Project Management	Management Analyst 3 Health Care Authority	HS	Amanda	Lysne		Amanda.lysne@hca.wa.gov
Project Management	Project Manager Health Care Authority	C	Kevin	Meadows	206-552-9526	Kevin.meadows@hca.wa.gov
HIT Leadership, HIE, Link4Health CDR	State HIT Coordinator Health Care Authority	AS	Melodie	Olsen	360-725-1983	Melodie.olsen@hca.wa.gov
Data Architecture and Management	Chief Data Officer Health Care Authority	AS	Rich	Campbell	360-725-1146	Richard.campbell@hca.wa.gov
IT Infrastructure	Chief Technology Officer Health Care Authority	AS	Jibu	Jacob	360-725-0792	Jibu.jacob@hca.wa.gov
HIT Leadership	Director Department of Social and Health Services – Research, Data and Analytics department	AS	David	Mancuso	360-902-7557	David.mancuso@dshs.wa.gov
Data Analysis, BI and Reporting	AIM Research Analyst - Epidemiologist Department of Social and Health Services – Research, Data and Analytics department	AS	Bev	Court	360-902-0726	Bev.court@dshs.wa.gov
Data Analysis, BI and Reporting	Senior Research Manager Department of Social and Health Services – Research, Data and Analytics department	AS	Andy	Glenn	360-902-7790	Andy.glenn@dshs.wa.gov

Data Analysis, BI and Reporting	AIM Research Analyst Department of Social and Health Services – Research, Data and Analytics department	AS	Roger	Gantz	360-902-0268	Roger.gantz@dshs.wa.gov
Data Analysis, BI and Reporting	AIM Business Analyst Department of Social and Health Services – Behavioral Health Services Integration Administration	HS	Michael	Davis		
HIT Leadership	State Health Officer Department of Health	AS	Kathy	Lofy	206-418-5510	Kathy.lofy@doh.wa.gov
Data Analysis, BI and Reporting	AIM Research Analyst – Epidemiologist Department of Health	HS	TBD	TBD	TBD	TBD
Data Analysis, BI and Reporting	AIM Info Tech Specialist Department of Health	HS	TBD	TBD	TBD	TBD
Data Analysis, BI and Reporting	Senior Epidemiologist Department of Health	AS	Bryant	Karras	206-418-5540	Bryant.karras@doh.wa.gov
Data Analysis, BI and Reporting	State Epidemiologist for Non-Infectious Conditions Department of Health	AS	Cathie	Wasserman	360-236-4250	Cathie.wasserman@doh.wa.gov

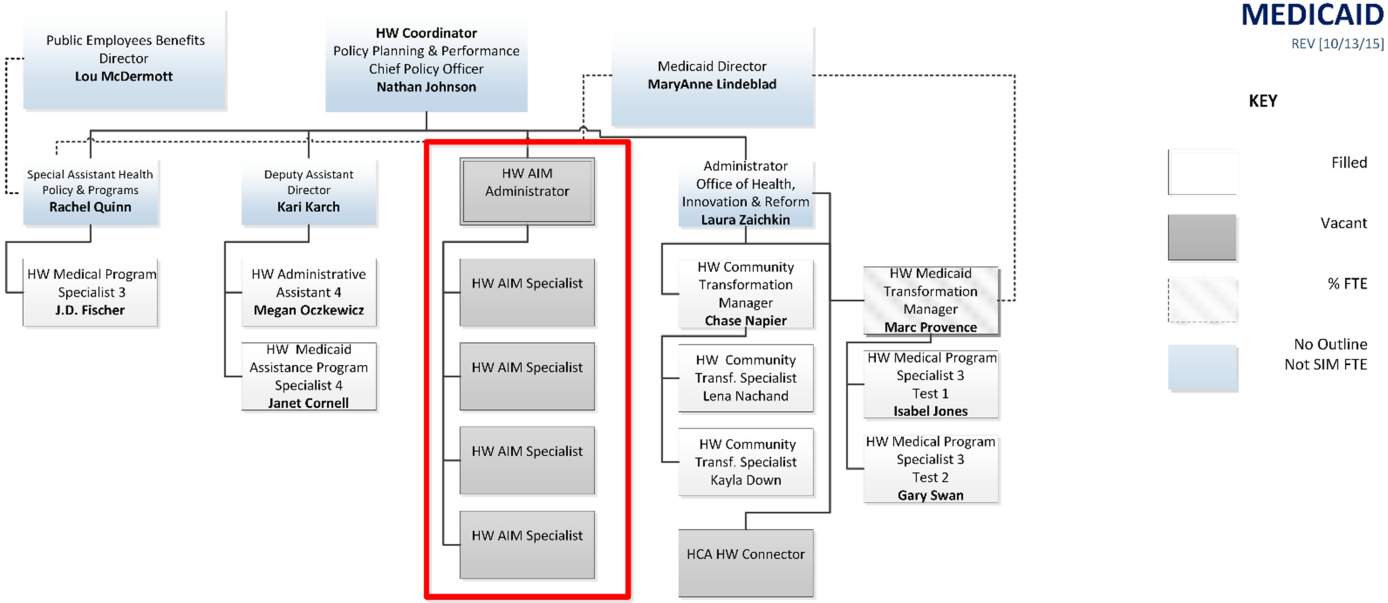
Table 4: Description of How Health IT Organizational Structure(s) Incorporated into Overall Organizational Chart
(May include diagram(s) and/or narrative- Workbook Tab 10)

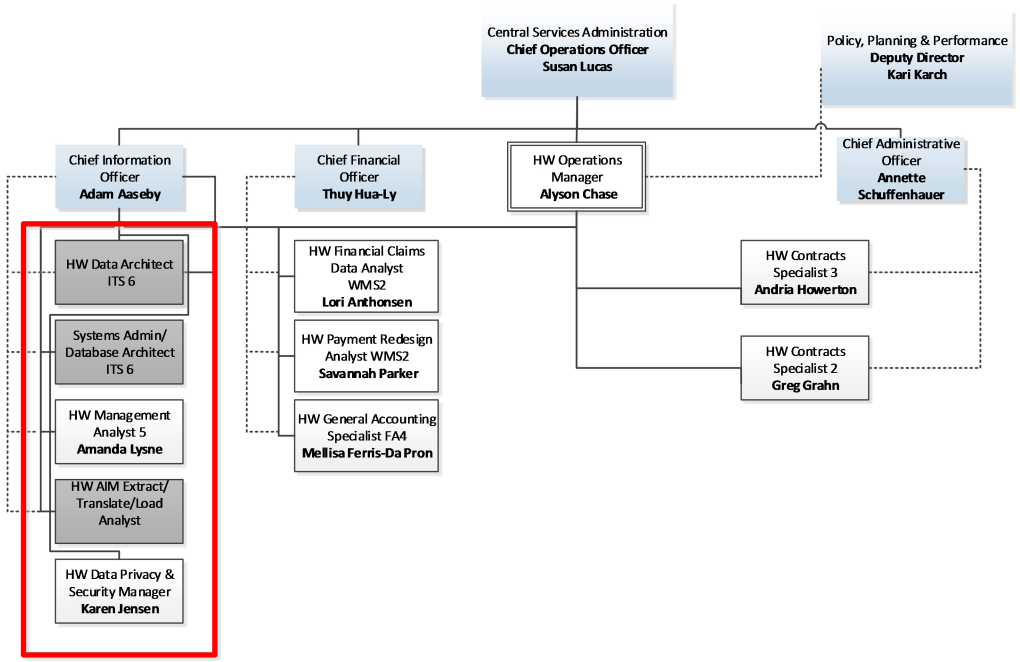
SIM funded Health IT roles are spread across several Washington State agencies and departments. The following organizational charts highlight these positions, and where they reside in each agency's organizational structure. SIM funded Health IT roles are highlighted in red boxes.

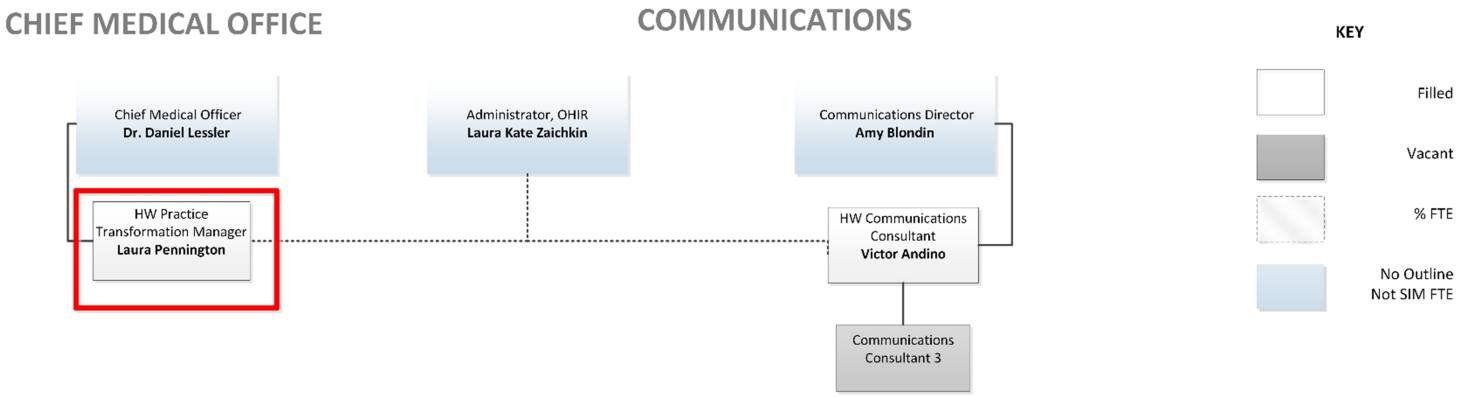


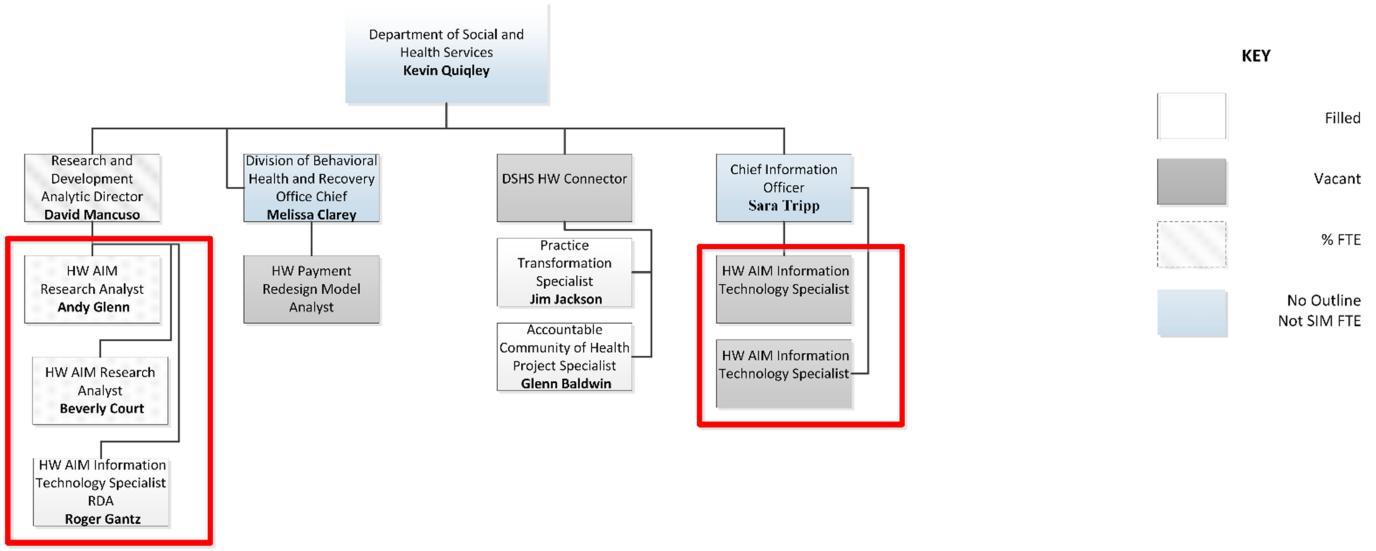
HEALTHIER WASHINGTON
HEALTH CARE AUTHORITY
POLICY, PLANNING & PERFORMANCE
PUBLIC EMPLOYEES BENEFITS
MEDICAID

REV [10/13/15]




Central Services Administration
Chief Operations Officer
Susan Lucas
Policy, Planning & Performance
Deputy Director
Kari Karch
Chief Information Officer
Adam Aaseby
Chief Financial Officer
Thuy Hua-Ly
HW Operations Manager
Alyson Chase
Chief Administrative Officer
Annette Schuffenhauer
HW Data Architect ITS 6
Systems Admin/ Database Architect ITS 6
HW Management Analyst 5
Amanda Lysne
HW AIM Extract/ Translate/Load Analyst
HW Data Privacy & Security Manager
Karen Jensen
HW Financial Claims Data Analyst WMS2
Lori Anthonsen
HW Payment Redesign Analyst WMS2
Savannah Parker
HW General Accounting Specialist FA4
Mellisa Ferris-Da Pron
HW Contracts Specialist 3
Andria Howerton
HW Contracts Specialist 2
Greg Grahn
KEY
Filled
Vacant
% FTE
No Outline
Not SIM FTE


CHIEF MEDICAL OFFICE
COMMUNICATIONS
Chief Medical Officer
Dr. Daniel Lessler
Administrator, OHIR
Laura Kate Zaichkin
Communications Director
Amy Blondin
HW Practice Transformation Manager
Laura Pennington
HW Communications Consultant
Victor Andino
Communications Consultant 3
KEY
Filled
Vacant
% FTE
No Outline
Not SIM FTE


Department of Social and Health Services
Kevin Quigley
Research and Development Analytic Director
David Mancuso
Division of Behavioral Health and Recovery Office Chief
Melissa Clarey
DSHS HW Connector
Chief Information Officer
Sara Tripp
HW AIM Research Analyst
Andy Glenn
HW AIM Research Analyst
Beverly Court
HW AIM Information Technology Specialist RDA
Roger Gantz
HW Payment Redesign Model Analyst
Practice Transformation Specialist
Jim Jackson
Accountable Community of Health Project Specialist
Glenn Baldwin
HW AIM Information Technology Specialist
HW AIM Information Technology Specialist
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HEALTHIER WASHINGTON
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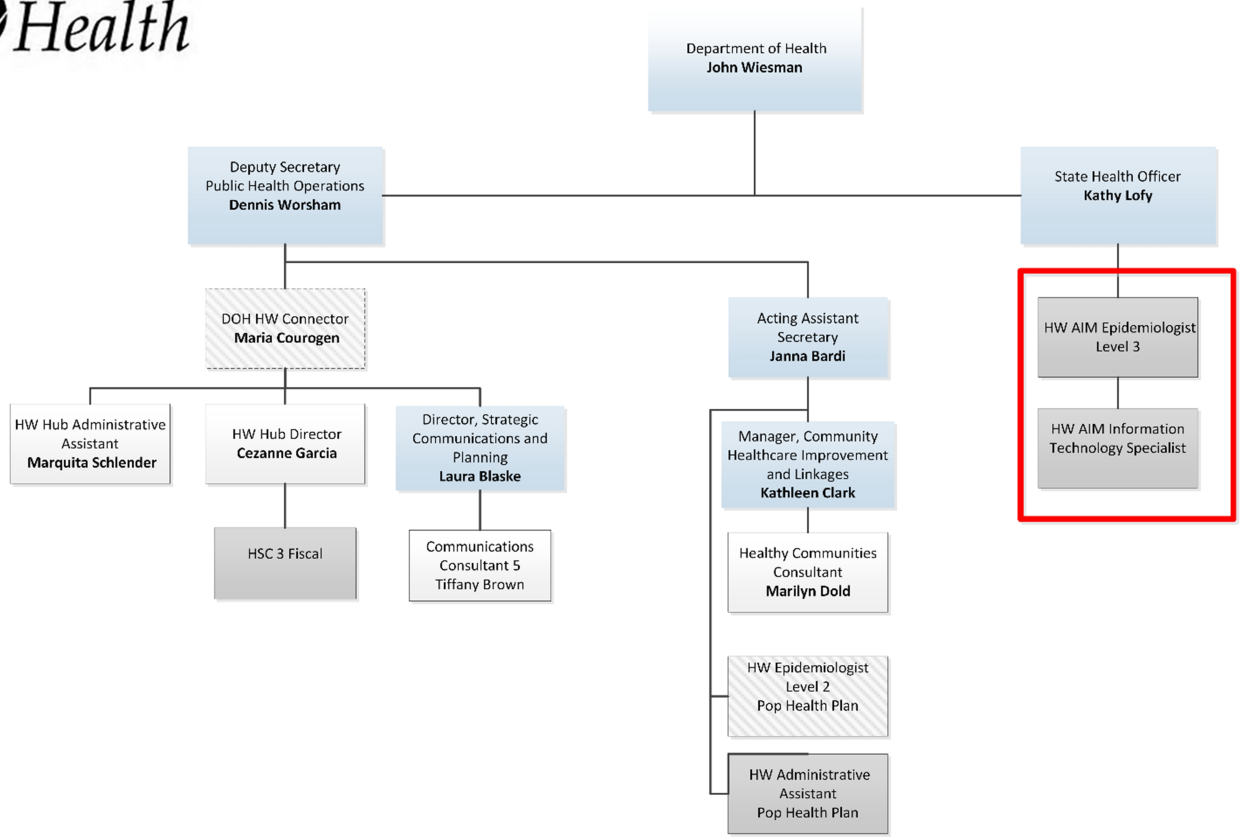

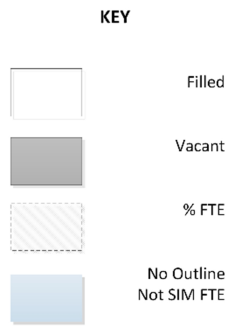

In addition to SIM-funded HIT staff, Healthier Washington will rely on several members of HCA's existing HIT staff. The org chart below shows in red these positions.

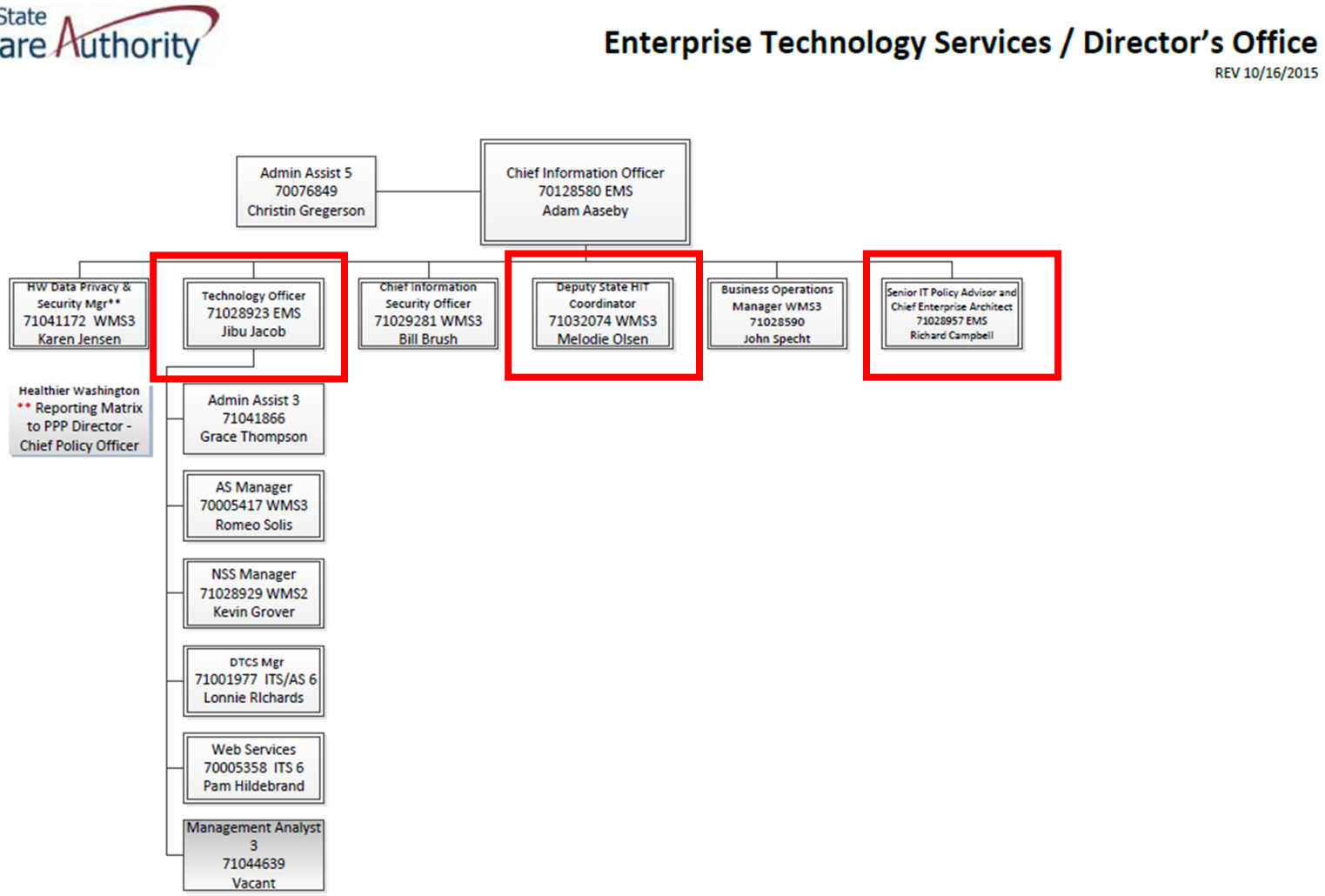

Table 5: Health IT Organizational Capacity –Staffing (Workbook Tab 6)

HIT Activity *(Repeat this column from first column in previous table)*	**Staffing Resources and Roles** *(beyond "lead" which is identified in previous table)*		**Recruitment Mechanisms** *(narrative if any special efforts or N/A)*	**Training** *(indicate staff (S) or contractor (C) or both (B)) (indicate new (N) existing (E) or both (B)) (Indicate if mandatory training (M) or optional training(O) and if training type/content)*			
	Number	**Roles**		**S/C/B**	**N/E/B**	**M/O**	**Type/Content**
Examples: HIE Infrastructure for Driver X; Health IT Data Repository; Identity Management; Privacy and Security; etc.	***Examples: actual or estimated number***	***Examples: technical; managing contracts; business analysts; policy; etc.***	***Examples: link to community colleges); special newspaper advertising; special training; etc.***				***Examples: web; one-on-one; classroom internal; community college training; etc.***
HIT Infrastructure (Lead: Healthier Washington System Admin/DBA, Jibu Jacob interim)	2	ETL/BI Reporting Analyst (HCA) RDA Analyst (Gantz)	We anticipate having some challenge in recruiting these highly technical positions. Strategies include: Website postings, college job fairs, in-house training, look at hiring community college instructors, use recruiting firms.	S S	N N	O O	
Data Architecture and Management (Lead: Healthier Washington Data Architect, Rich Campbell interim)	2	Business Analyst (DOH) Business Analyst (DSHS/BHSIA)	We anticipate having some challenge in recruiting these highly technical positions. Strategies include: Website postings, college job fairs, in-house training, look at hiring community college instructors, use recruiting firms.	S S	N N	O O	

HIT Activity *(Repeat this column from first column in previous table)*	Staffing Resources and Roles *(beyond "lead" which is identified in previous table)*		Recruitment Mechanisms *(narrative if any special efforts or N/A)*	Training *(indicate staff (S) or contractor (C) or both (B))* *(indicate new (N) existing (E) or both (B))* *(Indicate if mandatory training (M) or optional training(O) and if training type/content)*			
Data Analysis, BI and Reporting (Lead: AIM Director, Adam Aaseby interim)	5	Data Scientist (HCA) Data Scientist (HCA) Epidemiologist (DSHS/RDA) Senior Research Manager (DSHS/RDA)	We anticipate having some challenge in recruiting these highly technical positions. Strategies include: Website postings, college job fairs, in-house training, look at hiring community college instructors, use recruiting firms.	B	B	O	
Data/Information Governance (Lead: AIM Director, Adam Aaseby interim)	1	Healthier Washington Privacy and Security Manager	N/A	S	E	O	
Performance Measurement (Lead: Laura Pennington)	1	Practice Transformation Manager	N/A	S	E	O	

HIT Activity *(Repeat this column from first column in previous table)*	**Staffing Resources and Roles** *(beyond "lead" which is identified in previous table)*		**Recruitment Mechanisms** *(narrative if any special efforts or N/A)*	**Training** *(indicate staff (S) or contractor (C) or both (B)) (indicate new (N) existing (E) or both (B)) (Indicate if mandatory training (M) or optional training(O) and if training type/content)*			
Clinical Data Repository (Physical and Mental/Behavioral Health) Lead: Melodie Olsen	9	Project Manager Project Coordinator HIT Stakeholder Engagement and Communications Manager Communications Consultant HIT Business Integration Manager (Vacant) HIT Technical Manager Technical Analyst HIT External Change Management Lead (Vacant) HIT Curriculum Manager (Vacant)	N/A	C S S S S S S S S	E E E E E E E E E	O O O O O M O O O	HL7 Certification
All Payer Claims Database (Lead: Lead organization TBD, OFM interim)	TBD						

HIT Activity *(Repeat this column from first column in previous table)*	Staffing Resources and Roles *(beyond "lead" which is identified in previous table)*		Recruitment Mechanisms *(narrative if any special efforts or N/A)*	Training *(indicate staff (S) or contractor (C) or both (B))* *(indicate new (N) existing (E) or both (B))* *(Indicate if mandatory training (M) or optional training(O) and if training type/content)*			
Health Information Exchange (Lead: Lead org – OneHealthPort)	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Table 6: Health IT Organizational Capacity –Project Management

Relationship of Health IT Project Management to Overall SIM Project Management (Workbook Tab 11)

Individual Health IT Project Management by HIT Activity *(Repeat this column from first column in previous table)*	Project Management by Individual Health IT Activity Currently Exists (Y), Being Developed (D) Does not exist (N)	Document (Attach and Indicate Attached)	Additional Comments and Clarifications
HIT Infrastructure	Y		Healthier Washington AIM project manager is responsible for managing this HIT Activity
Data Architecture and Management	Y		Healthier Washington AIM project manager is responsible for managing this HIT Activity
Data Analysis, Business Intelligence and Reporting	Y		Healthier Washington AIM project manager is responsible for managing this HIT Activity
Data/Information Governance	D		Healthier Washington AIM plans on procuring contract services for implementing an Information Governance program. Project management of that effort will be provided by that vendor, though monitored by the Healthier Washington AIM project manager. Additionally, the

			Healthier Washington Privacy and Security Manager will also play a primary role in managing this activity.
Link4Health CDR	Y		Link4Health Clinical Data Repository Project Manager is responsible for managing this HIT Activity.
APCD	D		Lead Organization and OFM will be responsible for managing this HIT activity.
HIE	Y		Lead Organization is responsible for managing this work activity.
Overall Health IT Project Management	**Yes/No**	**If Yes Document (Attach and Indicate Attached)**	**Additional Comments and Clarifications**
HIT activities to support a specific SIM effort are included in the related SIM Project Management Plan	Yes	Included in Section B (AIM section)	HIT activities to support SIM are included in the overall (SIM) Healthier Washington project management plan, and specifically in the Healthier Washington AIM project plan.
HIT Overall Project Management Plan that combines Individual HIT Project Plans into Comprehensive HIT Project Management Plan	Yes	State Medicaid HIT Plan (SMHP) available on request	HIT activities (Link4Health CDR and Meaningful Use) to support SIM funded by HITECH and MMIS are included in the State Medicaid Health IT Plan and specifically in the Link4Health project plan

Table 7: Health IT Organizational Capacity –Project Management

Health IT by SIM Component/Project Implementation Gantt chart (Workbook Tab 11)

SIM Component/Project Area (***Repeat from Column A from SHSIP Tab 3 Master Timeline)***	**Health IT Activity Supporting the SIM Component/Project Area** ***(If more than one list each one separately)***	**Year 1**				**Year 2**				**Year 3**				**Milestone(s) with Due Dates** ***(1) State HIT Operational Plan Completed and Item Identified in State HIT Plan (2) RFP/RFI Release Date (3) Contract Awarded (4) Project/Activity Initiated (5) Contract Milestones as Identified in Contract Completed (6) Other - explain***
		Q 1	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	**Q 1**	**Q 2**	**Q 3**	**Q 4**	
(***Repeat from Column A from SHSIP Tab 3 Master Timeline***	***Examples: Technology-EHR, Data Repository, system integrator, etc.; TA-to BH providers or substance use providers; other-explain***													***Examples: State HIT - 12/1/15; RFP for systems integrator – 3-1-16; Contract award for systems integrator – 5-1-16; first milestone of systems integrator contract – 6-1-16; other – explain; etc.***
Healthier Washington Dashboard Reporting Tool	IT Infrastructure, Data Architecture and Management, Data Analysis, BI and Reporting	X	X	X	X									1st release of Healthier Washington Dashboard Reporting Tool Q1 2016 2nd release of Healthier Washington Dashboard Reporting Tool Q2 2016 3rd release of Healthier Washington Dashboard Reporting Tool Q3 2016
Healthier Washington Information Governance	Data/Information Governance	X	X	X	X	X	X	X	X	X	X	X	X	Healthier Washington Information Governance service contract approved Q1 2016 Healthier Washington Information Governance Charter approved Q3 2016

SIM Component/Project Area (*Repeat from Column A from SHSIP Tab 3 Master Timeline)*	Health IT Activity Supporting the SIM Component/Project Area *(If more than one list each one separately)*	Year 1				Year 2				Year 3				Milestone(s) with Due Dates *(1) State HIT Operational Plan Completed and Item Identified in State HIT Plan (2) RFP/RFI Release Date (3) Contract Awarded (4) Project/Activity Initiated (5) Contract Milestones as Identified in Contract Completed (6) Other - explain*
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
AIM Project Quality Assurance	Project Management	X	X	X	X	X	X	X	X	X	X	X	X	Healthier Washington AIM Project Quality Management plan approved Q1 2016 Healthier Washington AIM Project Quality Assurance Initial Report Q1 2016 Healthier Washington AIM Project Quality Assurance Quarterly Progress Report Q2 2016 Healthier Washington AIM Project Quality Assurance Quarterly Progress Report Q3 2016 Healthier Washington AIM Project Quality Assurance Quarterly Progress Report Q4 2016

SIM Component/Project Area (*Repeat from Column A from SHSIP Tab 3 Master Timeline)*	Health IT Activity Supporting the SIM Component/Project Area *(If more than one list each one separately)*	Year 1				Year 2				Year 3				Milestone(s) with Due Dates *(1) State HIT Operational Plan Completed and Item Identified in State HIT Plan (2) RFP/RFI Release Date (3) Contract Awarded (4) Project/Activity Initiated (5) Contract Milestones as Identified in Contract Completed (6) Other - explain*
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
Healthier Washington AIM BI/Analytics Platform	AIM Data, Reporting and Analytics Infrastructure	X	X	X	X	X	X	X	X	X	X	X	X	AIM BI/Analytics Platform Procurement Strategy and Plan approved Q1 2016 RFPs for AIM BI/Analytics Platform released Q1 2016 Apparent Successful Vendors for AIM BI/Analytics platform selected Q2 2016 Contracts finalized for AIM BI/Analytics Platform and Implementation Support Q2 2016 AIM Data Acquisition Plans finalized Q2 2016 AIM BI/Analytics Platform Design Plans complete Q3 2016 • AIM BI/Analytics Platform Implementation Plans finalized Q3 2016 AIM data source Data Use Agreements finalized Q4 2016 AIM BI/Analytics Platform implemented Q1 2017 AIM data source acquisition mechanisms (e.g., ETL) built Q1 2017 AIM data sources added to Healthier Washington AIM Logical Data Warehouse Q1 2017
Healthier Washington Evaluation Support	Data Analysis, BI and Reporting	X	X	X	X	X	X	X	X	X	X	X	X	Assist with Healthier Washington Evaluation Plan Q1 2016 Refine Healthier Washington Evaluation metrics and supporting data collection plan Q2 2016 Evaluation data sources identified, Data Use Agreements (DUAs) in place Q4 2016 Evaluation data collection repositories designed, implemented and populated Q1 2017

SIM Component/Project Area (*Repeat from Column A from SHSIP Tab 3 Master Timeline)*	Health IT Activity Supporting the SIM Component/Project Area *(If more than one list each one separately)*	Year 1				Year 2				Year 3				Milestone(s) with Due Dates *(1) State HIT Operational Plan Completed and Item Identified in State HIT Plan (2) RFP/RFI Release Date (3) Contract Awarded (4) Project/Activity Initiated (5) Contract Milestones as Identified in Contract Completed (6) Other - explain*
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
BH Data Assessment	IT Infrastructure, Data Architecture and Management, Clinical Data Repository (Physical and Mental/Behavioral Health)	X												BH EHR Capabilities Gap Analysis and Alternatives Report Q1 2016
BH EHR Implementation	IT Infrastructure, Data Architecture and Management, Clinical Data Repository (Physical and Mental/Behavioral Health)		X	X	X	X	X	X	X	X	X	X	X	BH EHR Implementation RFP released Q3 2016 BH EHR Implementation project vendor chosen Q3 2016 BH EHR Implementation project kick-off Q4 2016
BH Data Consolidation Project	IT Infrastructure, Data Architecture and Management, Data Analysis, BI and Reporting	X	X											BHO Data Consolidation tool released – Q1 2016
Washington All Payer Claims Database	All Payer Claims Database													Washington APCD Vendor selected Q1 2016 Washington APCD project starts Q1 2016 APCD released Q3 2017
AIM Data Acquisition	Data Architecture and Management	X	X	X	X	X	X	X	X	X	X	X	X	2016 Q3 – Release initial (2015) enhanced Washington BRFSS survey sample

SIM Component/Project Area (*Repeat from Column A from SHSIP Tab 3 Master Timeline)*	Health IT Activity Supporting the SIM Component/Project Area *(If more than one list each one separately)*	Year 1				Year 2				Year 3				Milestone(s) with Due Dates *(1) State HIT Operational Plan Completed and Item Identified in State HIT Plan (2) RFP/RFI Release Date (3) Contract Awarded (4) Project/Activity Initiated (5) Contract Milestones as Identified in Contract Completed (6) Other - explain*
		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	
N/A NOTE: Though not SIM funded our Link4Health Clinical Data Repository is a key initiative to achieve our behavioral and physical healh information interoperability goals.	Link4Health Clinical Data Repository/Community Record (CDR)	X	X	X	X	X	X	X	X	X	X	X	X	Community record for 1.4M Medicaid managed care consumers established 10/1/2015 Care Summaries from provider EHR to Link4Health CDR starting 11/1/2015 Soft opening for controlled provider group January 2016 Full opening for all Medicaid providers no later than 6/30/2016 Community record for remaining Medicaid fee for service consumers 12/31/2016 Community record for full set of PEB lives 6/30/2017
	Link4Health Community Data Warehouse and mainstream dashboards	X	X	X	X	X	X	X	X	X	X	X	X	Core measures built into data warehouse - 9/20/2015 Analysis of Sandbox tool for large scale data extracts – 3/31/2016 Establish Sandbox tool – 9/30/2016
	Link4Health Care Assist Tools and Portal	X	X	X	X	X	X	X	X	X	X	X	X	Analysis of Care Assist tool for case management and decision support – 4/30/2016 Establish Care Assist tools – 9/30/2016
	Link4Health Metrix tools	X	X	X	X	X	X	X	X	X	X	X	X	Analysis of Metrix tools for reminder, notification and alters capabilities – 4/30/2016 Establish Metrix tools 12/30/2017

Table 8: Health IT Organizational Capacity –Project Management Budget Support (Workbook Tab 4)

Health IT Activity/Budget Item *(From the overall budget, separate out the Health IT budget items)*	**Description of Health IT Activities Budgeted**	**Vendor** *(If applicable and name vendor if known)*	**Expected Expenditures** *(If Health IT Component is funded by non-SIM funds indicate funding source)*
IT Infrastructure, Data Analysis BI and Reporting/ Providence CORE	Develop and implement a "Healthier Washington Dashboard Reporting Tool."	Providence CORE	900,566
Other/ IT Project Quality Assurance	Per Washington State Office of the CIO requirements, provide quality assurance reviews of the AIM project.	TBD - RFP	120,000
Data/ Information Governance/ Data Governance RFP	Plan and implement an Information Governance program to support Healthier Washington.	TBD - RFP	385,000
IT Infrastructure/ External IT Implementation and Support services	Assist the state in implementing the technical platform to support AIM	TBD - RFP	1,250,000
IT Infrastructure/ Cloud Based Storage Platform and Services	Provide AIM with cloud-based server architecture and platform	TBD - RFP	300,000
Data Architecture and Management/ Behavioral Health Data Assessment	Analyze BH data needs for Healthier Washington. Review alternatives for meeting these needs.	OTB Solutions	157,000
Data Architecture and Management/ Behavioral Health EHR Implementation	Provide BH providers with clinical data reporting per needs of Healthier Washington.	TBD – RFP	2,600,000
Data Architecture and Management/ Data Integration Engine application	Need to integrate data from multiple data sources into AIM logical data warehouse.	TBD - RFP	500,000
Data Architecture and Management/ Data Management and Data Warehouse application	Data warehouse and data repository	TBD - RFP	1,000,000

Health IT Activity/Budget Item *(From the overall budget, separate out the Health IT budget items)*	Description of Health IT Activities Budgeted	Vendor *(If applicable and name vendor if known)*	Expected Expenditures *(If Health IT Component is funded by non-SIM funds indicate funding source)*
Data Analysis, BI and Reporting/ BI/Analytics application	Provide business intelligence, reporting, data visualization and basic analysis tools.	TBD – RFP	500,000
Data Analysis, BI and Reporting/ Advanced Analytics application	Provide advanced analytics and modeling capabilities for Healthier Washington.	TBD – RFP	400,000
Data Architecture and Management/ Data Quality application	Provide data quality assurance and control over Healthier Washington logical data warehouse.	TBD – RFP	275,000
Data Architecture and Management Data Acquisition	Acquire and enhance data sources for Healthier Washington (e.g., Washington State Behavioral Risk Factor Surveillance System)	DOH – BRFSS	1,600,000

Table 9: Mechanisms to Coordinate Private and Public Health IT Efforts and Alignment with Health IT Legislative/Executive Authority (Workbook Tab 12)

Health IT Activity *(Repeat this column from 1st column in Table 5)*	Related Private Health IT Efforts *(Name and Explain or indicate N/A)*	Related Public Health IT Efforts *(Name and Explain or indicate N/A)*	Mechanisms to Coordinate SIM Health IT Activity with Related Private/Public Health IT Efforts	Statutory/Regulatory/ Executive Authority for Health IT Activity *(Current authority exists thru statute or regulation – Y; Needed and being pursued –P; Not Addressed –N)*

Health IT Activity *(Repeat this column from 1st column in Table 5)*	**Related Private Health IT Efforts** *(Name and Explain or indicate N/A)*	**Related Public Health IT Efforts** *(Name and Explain or indicate N/A)*	**Mechanisms to Coordinate SIM Health IT Activity with Related Private/Public Health IT Efforts**	**Statutory/Regulatory/ Executive Authority for Health IT Activity** *(Current authority exists thru statute or regulation – Y; Needed and being pursued –P; Not Addressed –N)*
IT Infrastructure	Most private entities are developing large data stores and the BI tools to engage with them meaningfully	HCA ProviderOne DSHS PRISM/Integrated Client Database (ICDB) DOH Washington Tracking Network (WTN) Community Health Assessment Tool (CHAT) WHA communitycheckup.org	Membership on AIM Steering committee includes sponsors of these public HIT projects Healthier Washington AIM BI/Analytics Roadmap involved analysis into these efforts to integrate where possible.	Current authority exists through SIM grant – Y
Data Architecture and Management	Most private entities are developing large data stores and the BI tools to engage with them meaningfully	HCA ProviderOne DSHS PRISM/Integrated Client Database (ICDB) DOH Washington Tracking Network (WTN) Community Health Assessment Tool (CHAT)	Membership on AIM Steering committee includes sponsors of these public HIT projects Healthier Washington AIM BI/Analytics Roadmap involved analysis into these efforts to integrate where possible.	Current authority exists through SIM grant – Y

Health IT Activity *(Repeat this column from 1st column in Table 5)*	**Related Private Health IT Efforts** *(Name and Explain or indicate N/A)*	**Related Public Health IT Efforts** *(Name and Explain or indicate N/A)*	**Mechanisms to Coordinate SIM Health IT Activity with Related Private/Public Health IT Efforts**	**Statutory/Regulatory/ Executive Authority for Health IT Activity** *(Current authority exists thru statute or regulation – Y; Needed and being pursued –P; Not Addressed –N)*
Data Analysis, Business Intelligence and Reporting	BI tools are common across the Washington healthcare landscape amongst the bigger players.	HCA ProviderOne reporting DSHS PRISM DOH Washington Tracking Network (WTN) Community Health Assessment Tool (CHAT)	Membership on AIM Steering committee includes sponsors of these public HIT projects Healthier Washington AIM BI/Analytics Roadmap involved analysis into these efforts to integrate where possible.	Current authority exists through SIM grant – Y
Data/Information Governance	Most private entities have information governance.	Link4Health Privacy and Security Workgroup	Link4Health Privacy and Security Workgroup provides foundation for Healthier Washington Information Governance program	Current authority exists through SIM grant – Y
Link4Health Clinical Data Repository (CDR)	Purchased through private sector lead organization for HIE. MCOs participate in shared payment model for community health record for Medicaid consumers assigned to them.	The Link4Health CDR is intended to query public health registries as it matures.	The Link4Health CDR is an essential piece of the AIM picture to collect share and use clinical information – and is part of the HCA roadmap.	Current authority exists through State Medicaid Health IT (SMHP) approval – Y
All Payer Claims Database (APCD)		Office of Financial Management has released the RFP to procure the Washington APCD lead organization and data vendor.		Current authority exists through SIM grant – Y

Health IT Activity *(Repeat this column from 1st column in Table 5)*	**Related Private Health IT Efforts** *(Name and Explain or indicate N/A)*	**Related Public Health IT Efforts** *(Name and Explain or indicate N/A)*	**Mechanisms to Coordinate SIM Health IT Activity with Related Private/Public Health IT Efforts**	**Statutory/Regulatory/ Executive Authority for Health IT Activity** *(Current authority exists thru statute or regulation – Y; Needed and being pursued –P; Not Addressed –N)*
Health Information Exchange	OneHealthPort has been chosen as the Lead Organization for the state HIE HIE capabilities exist within entities across Washington State – mostly regional or provider/system specific.	Department of health using HIE for public health reporting and meeting special registry requirements for meaningful use. HITECH funding through HCA is used to support these efforts.	Purchase services through state HIE fo create a community health record for Medicaid and PEB consumers, a community data warehouse with mainstream, care coordination workflow tools and alerts for patients outside the desired measures. HCA and DOH serve on oversight board for OneHealthPort as it relates to access, cost and security.	Current authority to appoint a private sector organization as the lead HIE exists through Substitute Senate Bill 5501 enacted in April 2009

Health IT Stakeholder Engagement

HCA understands there are elements of our HIT strategy that could be both transformative and challenging - both internally (within HCA and other state government agencies) and externally (among MCOs, provider groups and others in the community). We recognize that the success of Healthier Washington cannot be achieved without the engagement of a broad collaborative group of organizations and individuals. The approach to Healthier Washington outreach and communications draws on change management principles and communications best practices. These include the following important concepts:

- Supporting interagency collaboration
- Moving sequentially from awareness to commitment
- Ensuring consistent communications across audiences
- Focusing high touch outreach on the most critical audiences for each stage of implementation
- Engaging stakeholders with a variety of tactics.

The Healthier Washington Stakeholder Engagement Plan is intended to reach identified key internal and external audiences using a variety of potential tactics. Concise, common messages that inform these audiences about the development and staged implementation of Healthier Washington services will help achieve statewide understanding and acceptance, especially for AIM.

The tiers of target audiences are broadly defined as the following:

- State government, legislative and state agency leadership and personnel
- Key Healthier Washington partner agencies
- Medical and behavioral health providers under contract to the MCOs

The outreach and communications strategies and tactics are designed to:

- Identify target audiences
- Raise awareness of the initiative and the services that may be available from Healthier Washington
- Increase awareness, understanding, buy-in and commitment among targeted audiences
- Provide clarity about the initiative and answer questions that might arise.
- Contribute to the understanding federal and state funding partners have and increase their commitment to fund and staff the model test

- Generate excitement about the new strategies to ensure the key influential private and public sector leaders across the state recognize the potential benefits to the health care community and the critical role that Healthier Washington plays as a foundational element to the state's health care and payment reform.

An identity and messaging for Healthier Washington was developed and is used consistently. This included the simple logo, various templates, the public Healthier Washington website, brand guidelines, one-page informational documents, Frequently Asked Questions (FAQ), Glossary of Terms, PowerPoint presentations, information graphics, brochures, pamphlets, e-mails, trainings, webcasts, press releases, media briefings, and plans for a newsletter.

Effective communications for Healthier Washington means not only delivering messaging and communications materials to many stakeholder audiences; it means being able to measure whether we have successfully educated and engaged audiences. Multiple methodologies to measure results will be implemented at planned intervals during the rollout.

Table 10: Health IT Stakeholder Engagement (Workbook Tab 6)

Health IT Activity *(Repeat this column from first column in table above)*	**Stakeholders** *(name of the individual, organization, agency, non-profit or practice)*	**Entity Type** (*State Government/Fed. Government/ Local Government/HC Care System/ Commercial Purchaser/ Physical Health Provider/LTPAC-LTSS Provider/ BH Provider/PH Provider/Community/ Consumer/Tribal/REC/Other-Name*)	**How Stakeholder will be Engaged** *(Steering Committee/ Workgroup/ Other-Explain)*	**Stakeholder Role** *(Member/ SME/ Other-Name)*	**Timeframe for Engagement**
Examples: HIE Infrastructure for Driver X; Health IT Data Repository; Identity Management; Privacy and Security; etc.	*Examples: HIE Ex Director or Dept. of Health or xxx BH clinic or xxx FQHC or xxx Tribe*	*Examples: HIE, state government, BH provider, physical health provider, tribal, etc.*	*Examples: steering committee, workgroup xxxx, consultant to workgroup xxxx, other-explain*		*Examples: appointment for one year; appointment for duration of SIM award; etc.*
HIT Infrastructure	Washington State Agencies (DOH, DSHS, HCA) Leadership and Staff WashingtonTech Services (state CIO)	State Government	AIM Steering Committee, AIM Advisory Group Consulted Leadership Team (CLT)	Member /SME	Appointment for duration of SIM
Data Architecture and Management	Washington State Agencies (DOH, DSHS, HCA) Leadership and Staff	State Government	AIM Steering Committee, AIM Advisory Group, Consulted Leadership Team	Member /SME	Appointment for duration of SIM

	WashingtonTech Services (state CIO)		(CLT)		
Data Analysis, BI and Reporting	Washington State Agencies (DOH, DSHS, HCA) Leadership and Staff Healthier Washington Evaluation Teams ACHs Provider community WHA CMS	State Government Physical and Behavioral Health Providers Community / Consumer CMS Healthier Washington partner organizations/vendors	AIM Steering Committee, AIM Advisory Group Consulted Leadership Team (CLT) ACH AIM Delegates	Member /SME	Appointment for duration of SIM
Data/Information Governance	AIM Director Washington State Agencies (DOH, DSHS, HCA) Leadership and Staff WHA	State Government Tribal Government	Data/Information Governance Board (TBD)	Member	Appointment for duration of SIM
APCD	AIM Director WashingtonTech Services (state CIO) Washington State Agencies (OFM, DOH, DSHS, HCA) Leadership andStaff	State Government Physical and Behavioral Health Providers Community / Consumer CMS	Steering Committee (AIM), Consulted Leadership Team (CLT)	Member	Ongoing
Link4Health Clinical Data Repository (CDR) and Community Data Warehouse	AIM Director WashingtonTech Services (state CIO) Washington State	State Government	Steering Committee (AIM), Consulted Leadership Team (CLT)	Member	Ongoing

	Agencies (DOH, DSHS, DOC; LNI, HCA) Leadership and Staff CMS ONC County Emergency Response MCO Contract Managers Medicaid and PEB Consumers MU Program Participants – Hospitals and providers Early Adopter Full Integration Workgroup Tribal Health Clinics WSMA/WSHA WashingtonCMHC AWPHD Public Hospital Districts Multi Care Overlake Hospital Lacey Medical Center Tenino Family Practice Tumwater Family Practice Capital Medical Center Yelm Family Medicine Providence Health CHI Franciscan	Fed Government Local Government Managed Care Organizations Consumers Delivery Systems (Medical/ Dental/Rx) BH Providers and Managed Care/BHO Tribal Government Professional Organizations Round 1 Delivery Systems - Early clinical testing organizations Round 2 Delivery Systems - test	High touch outreach to recruit high volume Medicaid delivery systems Monthly meetings with Managed Care contract managers on multi-year Performance Improvement Project Direct engagement and support of EHR system users Quarterly statewide interagency meetings Workgroups for privacy and data segmentation General newsletters and webinars Participation in Monthly Early Adopter Workgroup Presentations at Association Meetings		

	Health Community Health Care Health Point Kadlec Peace Health Evergreen Clinic Proliance Surgeons	Link4Health CDR			
Health Information Exchange	OneHealthPort DOH, DSHS, LNI APD AdvanceMD Allscripts Amazing Charts AthenaHealth Care 360 Cerner CPSI Cenrix DigiChart EHR 24/7 eClinical Works Epic GE Healthcare Greenway HCS Health Sentry Healthland McKesson Meditech Nextgen Office Practicum Open Dental Practice Fusion Total Dental	State HIE lead Organization State Government Medicaid EHR Vendors - High Volume	Identify and plan for community wide technical solutions HCA and OHP high touch outreach to delivery systems with certified EHR systems and high volume Medicaid consumers HCA and OHP Vendor Outreach Meetings Technical assistance for use of Link4Health CDR services through OHP	HIE Subscriber and member of HIE oversight committee for access, pricing and privacy	Ongoing

Table 11: Health IT Stakeholder Engagement Process (Workbook Tab 6)

Process		Describe the Process ***(If meetings, how often and location, how input is incorporated into decision making, etc.)***
Communication and Outreach Process	*Examples: newspaper notices, community meetings, etc.*	Communication and outreach for the AIM initiative will generally be handled in conjunction with broader SIM communications. This includes: Healthier Washington Leadership status reports (weekly) CMMI Quarterly Reports SIM Operations Plan (annual) SIM Stakeholder Engagement Plan Link4Health Stakeholder Engagement Plan Most of our external stakeholders have an interest in all of the areas of SIM. Once our AIM roadmap is available, we will share that with a broad section of stakeholders (internal, cross-agency, staff, consultants and vendors). There is keen interest in understanding the different data stores planned for SIM (AIM, Model 4 data aggregation platform, APCD, Link4Health CDR, RDA @ DSHS, etc.) Additionally, we have planned two primary AIM communication channels to be handled by newsletter: Healthier Washington AIM Bi-Monthly Update/Newsletter – High level review of AIM status and accomplishments. Primary audience is our AIM Advisory group, specifically for the months that AIM Advisory Group does not meet. Healthier Washington AIM Quarterly Update – High level AIM update. Primary audience is the general public.

Process		Describe the Process *(If meetings, how often and location, how input is incorporated into decision making, etc.)*
Steering Committee Process	*Examples: Meetings monthly at location xx with public notice; agendas on the web;*	The AIM Steering Committee meets twice a month to evaluate progress, make decisions, and ensure the forward momentum of the initiative. The AIM Steering Committee is responsible for making all decisions for AIM related to scope, budget and schedule. When decisions affect or require input from other investment areas, they will be addressed at Healthier Washington Core team meetings. The formal AIM Steering Committee generally meets in-person at the Health Care Authority. Agendas are posted in advance, with meeting notes sent out following the meeting. In addition, we have an AIM Advisory Group which advises on strategic plans and execution. While they are not a decision-making body, they are an essential part of our strategy formation and buy-in process. The AIM Advisory Group will gather bi-monthly for updates and input gathering. The Healthier Washington SIM Core Team meeting meets bi-weekly to steer the program; the Consulted Leadership Team meets weekly for updates and escalations. The Healthier Washington Executive Steering meets ad-hoc.
Work Group Process, if applicable	*Examples: Meetings monthly at location xx with public notice; agendas on the web;*	Across Healthier Washington initiative, there currently is: Interagency workgroup on privacy and security (Link4Health Privacy and Security Workgroup). Interagency workgroup to segment and classify data elements (Link4Health Data Classification Workgroup). There are a number of other work groups for AIM, including: AIM Operations Team – Manage work activities, identify risks, address issues, and recommend decisions to AIM Steering. AIM ACH Delegates – Group of ACH representatives to inform AIM team on development of AIM tools and capabilities to meet ACH specific needs. Issue Specific Workgroups are formed and dissolve regularly to tackle key issues and problems.

Process		Describe the Process *(If meetings, how often and location, how input is incorporated into decision making, etc.)*
Ongoing Engagement Process	*Examples: listservs, newsletters, social media, phone calls*	We are committed to a high touch communication process with leadership. We run topic-specific communication campaigns (privacy, access, consent) We issue monthly newsletter on SIM, Link4Health CDR and Meaningful Use We have a Listserv for Meaningful Use, Link4Health CDR and SIM OneHealthPort manages EHR vendor communication re: HIE / newsletters/listservs/webinars We have a proactive communication strategy between the State and the Tribes. We offer quarterly webinars on the various components of SIM. We engage with our Health Innovation Leadership Network to advance and prepare the way for AIM initiatives over time. We make high touch leadership to leadership contact with organizations with high volume of Medicaid consumers as part of their patient panel.
Other: _____		AIM Director makes appearances in person and via webinars to broad audiences interested in learning more about the SIM initiative and AIM in particular. Health IT Team makes regular appearances at association meetings and on request to raise awareness and understanding of the Link4Health initiatives.

Table 12: Current State of Health IT for the Key Care Delivery Transformation and Payment Reform SIM Commitments (Workbook Tab 7)

(For Table 12 State Government is defined by state as a state system even if state has contractor operating)*

Focus: HIE and EHR Use in State

Health IT Item	Detail			If Y in Detail: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
HIE and EHR Use in State							
Statewide HIE	State Government*	Query: DIRECT: Both:	N N	P O Y	0		
	Non-State Government: Name of entity OneHealthPort	Query: DIRECT: Both:	Y Y Y	P O	1	2009	In April 2009, the Washington State Legislature passed Substitute Senate Bill 5501 designed to accelerate the secure electronic exchange of high value health information within the state. SSB 5501 directs the HCA to designate a private sector organization to lead implementation of the act. In October 2009, the HCA designated OneHealthPort to serve as the Lead HIE Organization.
Less-than-statewide HIEs	State Government*:	Query: DIRECT: Both:	N N N				
	Non-State Government: Name of entity: Collective Medical Technologies	Query: DIRECT: Both:	Y N N	O	1		CMT has implemented the Emergency Department Information System (EDIE) that connects EDs to identify high-risk complex needs patients in real-time. View of ED history available in the ED EHR when a patient registers.

Health IT Item	Detail	If Y in Detail: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
HIE and EHR Use in State					
The total number of Medicaid Meaningful Use-Eligible Professionals who have received a payment exchanging information through an HIE					
Percentage of all physical practices that have adopted any EHR		O	81%	2013	Exceeds National average of 78%
Percentage of all Physican Practices that have adopted basic EHR[11]s		O	61%	2013	Exceeds National Average 48%
Percentage of all Primary Care Physicians that have adopted basic EHRs'	Primary Care: general/family, internal medicine, obstetrics/gynecology, and pediatrics physicians.	O	56%	2013	Exceeds National Average 53%
Percentage of all rural practices that have adopted basic EHRs	Rural Practice: a physician practice in areas outside of a Metropolitan Statistical Area.	O	84%	2013	Exceeds National Average 46%

[11] Basic EHR: a system that has all of the following functionalities: patient history and demographics, patient problem list, physician clinical notes, comprehensive list of patient's medications and allergies, computerized orders for prescriptions, and ability to view laboratory and imaging results electronically.

Health IT Item	Detail	If Y in Detail: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
HIE and EHR Use in State					
Percentage of all small practices that have adopted basic EHRs	Small Practice: a physician practice consisting of 10 physicians or less.	O	44%	2013	Exceeds National Average 41%
Percentage of Physicians with Computerized Capability to View Lab Results		O	83%	2013	Exceeds National Average 77%
Percentage of Physicians with Capability to electronically send orders for lab results		O	56%	2013	Exceeds National Average 53%
Percentage of Physicians with an EHR that can automatically graph a patient's lab results over time		O	58%	2013	Exceeds National Average 47% Link4Health Clinical Data Repository will increase this significantly.
Percentage of Physicians with Capability to Exchange Secure Messages with Patients		O	58%	2013	Exceeds National Average 49%
Percentage of Physicians with Capability to provide patients with clinical summaries for each visit		O	73%	2013	Exceeds National Average 68% Link4Health Clinical Data Repository will increase this significantly.

Health IT Item	Detail	If Y in Detail: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
HIE and EHR Use in State					
Percentage of all hospitals that have adopted a basic EHR with notes[12]		O	85%	2014	Exceeds National Average 70%
Percentage of rural hospitals that have adopted a basic EHR with notes	Rural Hospital: a hospital in areas outside of a Metropolitan Statistical Area.	O	85%	2014	Exceeds National Average 70%
Percentage of small hospitals that have adopted a basic EHR with notes	Small Hospital: a hospital consisting of less than 100 staffed beds.	O	76%	2014	Exceeds National Average 70%
Percentage of all hospitals that have adopted a basic EHR without Notes		O	84%	2014	Exceeds National Average 83%
Percentage of all Rural Hospitals that have Adopted a Basic EHR without notes		O	92%	2014	Exceeds National Average 77%
% of small hospitals that have adopted a basic EHR without notes		O	86%	2014	Exceeds National Average 76%

[12] Basic EHR **with notes**: a system that has all of the following functionalities: patient history and demographics, patient problem list, *physician clinical notes*, nursing assessments, comprehensive list of patient's medications and allergies, computerized orders for prescriptions, view lab reports, view radiology reports, and view diagnostic test results.

Health IT Item	Detail	If Y in Detail: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
HIE and EHR Use in State					
Percentage of hospitals with capability to exchange summary of care record with any provider outside their health system		O	65%	2014	Exceeds National Average of 64% Link4Health Clinical Data Repository will increase this significantly.
Percentage of hospitals with capability to electronically share lab results with hospitals outside their health system		O	57%	2014	Exceeds National Average of 55% Link4Health Clinical Data Repository will increase this significantly.
Percentage of Hospitals with capability to electronically share lab results with ambulatory providers outside their health system		O	55%	2014	Below National Average of 63% Link4Health Clinical Data Repository will increase this significantly.
Percentage of hospitals with capability to exchange summary of care record with any providers outside their health system		O	65%	2014	Exceeds National Average 64% Link4Health Clinical Data Repository will increase this significantly.
Percentage of hospitals with capability to exchange summary of care record with		O	63%	2014	Exceeds National Average 55% Link4Health Clinical Data Repository will increase this

Health IT Item	Detail	If Y in Detail: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
HIE and EHR Use in State					
hospitals outside their health system					significantly.
Percentage of Hospitals with capability to exchange summary of care record with ambulatory providers outside their health system		O	56%	2014	Below National Average 57% Link4Health Clinical Data Repository will increase this significantly.
Percentage of hospitals with capability for their patients to electronically view, download, and transmit their personal health and medical information		O	42%	2014	Below National Average 64%
Percentage of hospitals with capability for their patients to securely message with their providers		O	52%	2014	Below National Average 64%
Total number of Medicaid MU-EPs who have received a payment with 2014 Certified System		O	5,522	10/26/2015	

Health IT Item	Detail	If Y in Detail: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
HIE and EHR Use in State					
Total number of Medicaid MU-EHs who have received a payment with 2014 Certified System		O	88	10/26/2015	
The total number of Medicaid MU-Eligible Hospitals who have received a payment exchanging information through an HIE	Achieved Stage 2 Meaningful Use	O	303	10/26/2015	This will increase significantly when Link4Health CDR is fully implemented.
Total number of Medicaid Long Term Post Acute Care (LTPAC)/Long Term Services and Supports (LTSS) providers with EHR (certified or not)		P	Unknown	11/12/2015	Not eligible for Meaningful Use and no relevant survey information available. Area for future exploration
The total number of Medicaid LTPAC/LTSS providers exchanging information through an HIE		P	Unknown	11/12/2015	Not eligible for Meaningful Use and no relevant survey information available. Area for future exploration
The total number of Medicaid Mental Health providers exchanging information through an HIE		P	Unknown	11/12/2015	Analysis under way

Health IT Item	Detail	If Y in Detail: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
HIE and EHR Use in State					
Total number of Medicaid MH provider with EHR (certified or not)		P	Unknown	11/12/2015	Analysis under way
Total number of Medicaid substance use providers exchanging information through an HIE		P	Unknown	11/12/2015	Analysis under way
Total number of Medicaid substance use providers with an EHR (certified or not)		P	Unknown	11/12/2015	Analysis under way

Table 12- continued: Current State of Health IT for the Key Care Delivery Transformation and Payment Reform SIM Commitments (Workbook Tab 7)

Focus Health-IT Infrastructure in State

Health IT Item	Detail	For Detail indicate: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
Health-IT Infrastructure in State					
All Payers Claims System (Name if applicable _____ _____)	Access to Data	HPs/CCOs/ACOs :			
		State:			
		Providers:			
	Types of Data	Encounter:			
		Medical Claims:			
		Eligibility:			
		Dental:			
		Pharmacy:			
	Sources of Data	Medicaid :			
		Medicare:			
		Medicaid Encounter:			
		Third Party Administrators/ Self-Funded:			
		Commercial Payer:			
Data Repository, excluding APCD that is listed above Name (if applicable):	Non-State Operated: Claims and Clinical (CCO)	P	1	11/12/2015	Purchased software as a service and HCA is sponsoring Medicaid covered lives in the Link4Health Clinical Data Repository.

Health IT Item	Detail	For Detail indicate: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
Health-IT Infrastructure in State					
Link4Health Clinical Data Repository (Medicaid lives) Includes: Community Master Patient Index Patient Matching Record Locator Service Community Master Provider Locator/Index Entity Master Locator/Index (Directory) User Directory: Authentication Consent Management Community Record Portal to Community Record HIE ATNA compliant Log of system access and Use Attribution of clinic and	Access to Individual Data	Health Care Providers Case Workers Public Health Care Coordinators	1		Initial scope of Medicaid consumers is 1.4M enrollees assigned to managed care. Scope will expand overtime to include FFS population. Other payers and health care organizations can purchase this service from OneHealthPort.
	Access to Aggregate Data	Public Health Managed Care Organizations State Analytics Teams			
	Types of Data	Medicaid Claims Medicaid Encounters Medicaid Medical Medicaid BH Medicaid Dental Medicaid Pharmacy Medicaid Eligibility			
	Sources of Data	Provider EHR Systems MMIS Laboratory Systems			
	Data Transactions	Care Summaries			

Health IT Item	Detail	For Detail indicate: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
Health-IT Infrastructure in State					
provider to Managed Care Plan					
PopHealth Use					
Statewide Provider Directory	e-addresses	O/P	Over 150 participating medical groups/systems	2003	OneHealthPort, the state's HIE, has an operational statewide provider directory. They use an ISO approved Organization Identifier (OrgID) for messages routed between trading partners who are both using the OHP HIE.
	Attribution of patient to provider				
	Attribution of provider to clinic	O/P			
	Attribution of clinic to plan	P	Uknown		One of the goals of the All Payer Claims Database is to attribute a clinic/provider to plan.
	Other:				
Patient Matching	State Government*	O/P			DSHS has identified a system for matching patients, across social and health services.
	State government and non-state government				

Health IT Item	Detail	For Detail indicate: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
Health-IT Infrastructure in State					
Statewide Clinical Notification System	ADT Notification to _____ from hospital	P			There is a local standard notification system in place through state HIE which notifies Managed Care Plans when their enrollee is admitted to hospital. Will expand to national standard within Link4Health initiatives.
	ADT Notification to _____ from hospital	O	98 Emergency Departments (as of 2014)	2012	Washington State has a Emergency Department Information Exchange (EDIE). Most hospitals across Washington State are using the EDIE system. The system notifies physicians with information about frequency of ED visits and a summary of discharges for the past 12 months. Users have the ability to share patient guidelines with each other and load and view patient treatment plan.
	ADT Notification to _____ from hospital	Operational		2011	The Comprehensive Hospital Abstract Reporting System (CHARS) is a Department of Health system used to: Identify and analyze hospitalization trends Establish statewide diagnosis related group (DRG) weights, a way of comparing hospital stays across all hospitals

Health IT Item	Detail	For Detail indicate: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
Health-IT Infrastructure in State					
					Identify and quantify health care access, quality, and cost containment issues. CHARS contains coded hospital inpatient discharge information derived from hospital billing systems. CHARS collects age, sex, zip code and billed charges of patients, as well as the codes for their diagnoses and procedures. CHARS data are available for 1987 to 2014. Coded hospital-based observation stay data is available from 2008 forward.
	ADT Notification to _____ from hospital				
Plan Level Clinical Notification System	ADT Notification to _____ from hospital				There is a local standard notification system in place through state HIE which notifies Managed Care Plans when their enrollee is admitted to hospital. Will expand to national standard within Link4Health initiatives.
	ADT Notification to _____ from hospital				
Shared-Care Plans	Statewide Shared Care Plans:				

Health IT Item	Detail	For Detail indicate: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
Health-IT Infrastructure in State					
	Community Level Shared Care Plans: *(Define 1)community (2) shared care plan*)				
	ACO/MCO Level Shared Care Plans: *(Define 1)community (2) shared care plan*)				Link4Health CDR provides shared care plan for apple health enrollees assigned to Managed Care and will expand to all Medicaid in 2016. Shared care plan in this instance is an integrated health record that includes health goals and planned interventions.
Care Summary Exchange	Medicaid is adopting the CCDA national standard for the exchange of care summaries through the state HIE	P	1	11/12/2015	We are working to advance the standard CCDA through the HIE and into the Link4Health CDR.
Access to clinical information by non-MU providers	Provider Type: MH/SU/LTPAC/LTSS/ Other (specify) (*Indicate which provider types)*	P	1	11/12/2015	All authorized health care providers serving Medicaid will be able to access the Link4Health CDR using certified EHR system or through a web based portal if they do not have an EHR. The Link4Health CDR will contain, Medical, behavioral health, claims and encounter data for all Medicaid services.

Health IT Item	Detail	For Detail indicate: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
Health-IT Infrastructure in State					
Data Aggregation and Analytics	Statewide Capacity to Collect: needed data sources identified Clinical data from provider EHR systems	P	1	11/12/2015	Link4Health CDR will collect clinical data housed in Medicaid provider EHR system through required exports of CCDA care summary documents through state HIE. Required of providers subcontracted with managed care organizations with certified EHR systems beginning no later than 2/1/2017. Other payers can purchase this service.
	Statewide Capacity to Collect: interfaces with needed data sources OneHealthPort HIE	O	1	11/12/2015	Specific interface capability (web/VPN/HIE) by data sources, vendor, additional clarifications: DOH, HCA and LNI subscribe to HIE currently for health information exchange. State HIE is available to

Health IT Item	Detail	For Detail indicate: Operational (O) Planned (P)	Total Number or Unknown	As of Date	Clarifying Comments/Further Explanation
Health-IT Infrastructure in State					
					any health organization or state agency.
	State Gov. *Capacity to Retain: Data Warehouse/Data Repository Link4Health CDR Dimensions – (community data warehouse) for Medicaid at this time integrates administrative and clinical data.	P		11/12/2015	Specific data (claims/clinical/other) by vendor, additional clarifications such as how often refreshed, "source of truth", elements included, etc.: Link4Health refreshed eligibility weekly; claim and encounter monthly; and clinical daily. Source of truth for clinical data is provider EHR system.
	State Gov.* Capacity to Analyze: Analytic tools (name tool: _____) Link4Health CDR Dimensions (community data warehouse) includes community mainstream management reports and dashboards for state measures for Medicaid	P		11/12/2015	Specific interface capability (web/VPN/HIE) by data sources, vendor, additional clarifications: Link4Health CDR Dimensions is a service from OneHealhPort using HIE for Medicaid. Other payers can subscribe to this service.

Health IT Item	Detail	For Detail indicate: Operational (O) Planned (P)		Total Number or Unknown		As of Date	Clarifying Comments/Further Explanation
Health-IT Infrastructure in State							
	population.						
	State Gov.* Capacity to Share with Providers Link4Health CDR Dimensions (community data warehouse) includes community mainstream management reports and dashboards for state measures for Medicaid population.	P				11/12/2015	Specific interface capability (web/VPN/HIE) by data sources, vendor, additional clarifications: Available to authorized providers, clinics, hospitals and managed care organizations for the Medicaid population they serve.
Clinical Registries: non-Public Health							
Public Health Reporting through HIE (Each is separate interface so respond by "detail item")	PH System	Connects to same HIE(s) as all the other PH Systems	Connects to HIE(s) but not same as other PH Systems	Operational (OY/ON) Planned (PY/PN) by Detail Level			

Health IT Item	Detail	For Detail indicate: Operational (O) Planned (P)		Total Number or Unknown		As of Date	Clarifying Comments/Further Explanation
Health-IT Infrastructure in State							
	Immunization: Adult and Children	X		P	Unknown		
	Immunization: Children Only	N/A	N/A	N/A	N/A		
	Syndromic Surveillance			Not planned	N/A		
	Cancer Registry			Not planned	N/A		
	Other Registry: Prescription Monitoring	X		P	Uknown		
	Other:						

Table 13: Relationship of SIM related Health IT to MITA/Medicaid/HITECH and State Enterprise IT Systems (Workbook Tab 13)

Medicaid System	**Relationship to SIM** *(if relationships explain – if none indicate none)*	**I-APD Status** *(submitted to CMS, approved by CMS, not submitted to CMS, not required,)*	**Related Contract** *(submitted to CMS, approved by CMS, not submitted to CMS, not required)*	**MITA /7 Standards and Conditions** *(meets the requirements (Y); to be determined (TBD); not required (N/A)*	**State HIT Plan** *(included in approved SMHP (A); in process (P); needs to be added (TBD); not required (N/A)*
MMIS - claims	SIM AIM program will interface claims data into the data lake (logical data warehouse)				N/A
MMIS-program integrity	FADS – Fraud and Abuse (component of MMIS) – part of O-APD – plan is to phase this out and replace with prospective fraud and abuse	Approved with O-APD			N/A
Medicaid-eligibility (member management)	SIM AIM program will interface data into the data lake (logical data warehouse)				N/A
Medicaid-MU Program	Medicaid MU program has been effective in incentivizing EHRs to provide a firmer foundation for State HIE. Participation in Link4Health CDR may help providers meet modified Stage 2 MU criteria for HIE and Medication Reconciliation.	APD for MU program approved by CMS for 2016/2017	Approved by CMS	eMiPP system meets current MU requirements / new requirements effective Dec 2015	Included in State SMHP MU plan
Medicaid – managed care	SIM Model 1 project will interface with the MMIS and draw data from the MMIS-claims system. Making changes now to MMIS to accommodate	APD Approved for system changes	Amendments have been approved and executed.	Yes	N/A
Medicaid-other:(Link4Health	Medicaid eligibility claims, encounter and clinical data will be loaded into the	MMIS OAPD approved for Link4Health CDR	Part of MMIS (module) to do the DDI work sustainably. Approved and	Yes	Section 2B of SHMP

Medicaid System	Relationship to SIM *(if relationships explain – if none indicate none)*	I-APD Status *(submitted to CMS, approved by CMS, not submitted to CMS, not required,)*	Related Contract *(submitted to CMS, approved by CMS, not submitted to CMS, not required)*	MITA /7 Standards and Conditions *(meets the requirements (Y); to be determined (TBD); not required (N/A)*	State HIT Plan *(included in approved SMHP (A); in process (P); needs to be added (TBD); not required (N/A)*
CDR)	Link4Health CDR.	data loads	executed related contracts.		
Medicaid-other (name):					N/A

LEVERAGING AND EXPANDING EXISTING PUBLIC/PRIVATE HEALTH INFORMATION EXCHANGES

Table 14: Role and Expansion of Public/Private HIEs (Workbook Tab 13)

(narrative addressing role of current public/private HIEs and any plans for expansion of HIEs through the SIM initiative)

Significant progress has been made in expanding Health Information Technology (HIT) capabilities. Electronic health records (EHRs) have become the norm for sophisticated delivery systems, some forms of health information (e.g., claims, meds, and labs) are routinely exchanged across enterprises electronically and the federal government has spearheaded important progress on the standards front. However, one area of HIT has lagged – clinical information exchange.

For purposes of this discussion, "clinical information" refers to the data content of the Consolidated Clinical Document Architecture (CCDA). The CCDA standard includes the high value clinical documents that all certified EHRs are required to import and export. These clinical documents can enable better care coordination by delivering data to diverse care team members at the point of service. For HCA and others at risk to control cost and improve population health, adding clinical information to claims data will greatly enhance measurement and analytic capabilities.

To help realize these important benefits, HCA will lead a broad partnership effort within the state to accelerate clinical information exchange by implementing an enterprise clinical data repository (Link4Health CDR). HCA hopes the Link4Health CDR will be ready for a soft opening with a controlled group of delivery systems in first quarter 2016. One year later, beginning in February of 2017, managed care organizations will require their participating providers to populate the CDR with clinical summary documents each time they see an Apple Health enrollee assigned to managed care. As the repository becomes populated, HCA will expect providers to check the CDR for clinical summary data when they see a Medicaid beneficiary who has also received care in other systems. These two transactions will help enable providers involved in the meaningful use program to address two key requirements of the newly published modified stage 2 requirements.

HCA has contracted with OneHealthPort, the statewide HIE for the initial Link4Health CDR services. HCA has elected this path in order to make Link4Health CDR services available to other parties that have similar needs. By partnering through the HIE, HCA and other organizations interested in improving performance can lower costs, recognize operating efficiencies and accelerate adoption by utilizing a shared Link4Health CDR platform.

OneHealthPort is in the early stages of testing the Link4Health CDR service. They are working with a short list of large and small health care delivery systems and their EHR vendors to test the CCDA and will begin testing the query and response capabilities in early 2016. Additional services will be considered to support community alerts for patients falling outside targeted performance measures, tools to support the care coordination workflow and tools to enable large data extracts for advanced analytics. We know from past experience (e.g., claims) that moving the industry from "0 to 60" on clinical information exchange will be a challenging process. Even with national standards, there is hard work ahead for all parties. HCA is convinced that now is the time to begin this work and that tackling it together through the HIE is the best path forward for all parties. HCA is leveraging existing authorities through contracts with MCO's asnd through incentives in the meaningful use program to advance the services available through the HIE and the use of standards. HCA is pleased to see the capabilities that can be brought to market and the pricing advantages available from an aggregate purchase. HCA is committed to operationalizing and expanding the Link4Health CDR service and to working in partnership with managed care organizations and delivery systems to implement the service in the most efficient and effective way possible. Our managed care partners have joined HCA in a shared funding model so that the Link4Health CDR is sustainable. Given the ability of this service to be used by multi-payers, we hope that the service will expand to cover lives other than those sponsored by Medicaid eventually including state, school district and higher-education public employees.

B. Policy

POLICY LEVERS

Table 15: Health IT Policy Levers for the Key Care Delivery Transformation and Payment Reform SIM Commitments (Workbook Tab 8)
(Focus Statutory or Regulatory Authority)

Health IT Policy Lever	Detail	Policy Lever Operational by Detail Level *Yes/No (OY/ON)* Planned *Yes/No (PY/PN)*	If Operational or Planned As of Date	Clarifying Comments/Further Explanation *(If language, copy and paste language in this column)*
Statutory or Regulatory Authority				

Health IT Policy Lever	Detail		Policy Lever Operational by Detail Level *Yes/No (OY/ON)* Planned *Yes/No (PY/PN)*	If Operational or Planned As of Date	Clarifying Comments/Further Explanation *(If language, copy and paste language in this column)*
Statutory or Regulatory Authority					
Statutory or regulatory authority related to privacy and security	Related to mental health providers:	1a. Medicaid Chapter 70.02 RCW (Washington Uniform Health Care Information Act); 45 CFR Part 160 and Part 164 (Federal Health Insurance Portability and Accountability Act);			Specifics on language: Operational efforts include a work group developing a unified interpretation of privacy and confidentiality laws that recognizes authority for sharing health information to support clinical care. Workgroup deliverable includes a broad awareness education campaign that will include Medicaid, State Funded non-Medicaid, and commercial / private providers.
		1.b State Funded non-Medicaid (Same as 1a)			Specifics on language: Same as 1a
		1.c. Commercial /Private (Same as 1a)			Specifics on language: Same as 1a
	Related to substance use disorder providers (42 CFR Part 2)	2a. Medicaid Same as 1a Additionally, 42 CFR Part 2 and Chapter 70.96A RCW			Specifics on language: Same as 1a. .
		2.b State Funded non-Medicaid Same as 2a			Specifics on language: Same as 1a

Health IT Policy Lever	Detail		Policy Lever Operational by Detail Level *Yes/No (OY/ON)* Planned *Yes/No (PY/PN)*	If Operational or Planned As of Date	Clarifying Comments/Further Explanation *(If language, copy and paste language in this column)*
Statutory or Regulatory Authority					
		2.c. Commercial /Private Same as 2a			Specifics on language: Same as 2a
	Related to HIEs:	3a. Medicaid Chapter 70.02 RCW (Washington Uniform Health Care Information Act); 45 CFR Part 160 and Part 164 (Federal Health Insurance Portability and Accountability Act); Chapter 43.19 RCW (creating Washington Office of Chief Information Officer with over statewide IT security standards for state-run HIE); Governor's Executive Order 00-03 regarding public records and privacy protections			Specifics on language: Same as 1a
		3.b State Funded non-Medicaid Same as 3a			Specifics on language: Same as 1a

Health IT Policy Lever	Detail		Policy Lever Operational by Detail Level *Yes/No (OY/ON)* Planned *Yes/No (PY/PN)*	If Operational or Planned As of Date	Clarifying Comments/Further Explanation *(If language, copy and paste language in this column)*
Statutory or Regulatory Authority					
		3.c. Commercial /Private Chapter 70.02 RCW (Washington Uniform Health Care Information Act); 45 CFR Part 160 and Part 164 (Federal Health Insurance Portability and Accountability Act);			Specifics on language: Same as 1a
	Related to Health IT, excluding HIEs:	4a. Medicaid Same as 3a, above, for any state Health IT initiatives			Specifics on language: Same as 1a
		4.b State Funded non-Medicaid Same as 3a, above, for any state Health IT initiatives			Specifics on language: Same as 1a
		4.c. Commercial /Private Same as 3c			Specifics on language: Same as 1a
	Related to other: explain	5a. Medicaid			Specifics on language:
		5.b State Funded non-Medicaid			Specifics on language:
		5.c. Commercial /Private			Specifics on language:

Health IT Policy Lever	Detail		Policy Lever Operational by Detail Level *Yes/No (OY/ON)* Planned *Yes/No (PY/PN)*	If Operational or Planned As of Date	Clarifying Comments/Further Explanation *(If language, copy and paste language in this column)*
Statutory or Regulatory Authority					
Statutory or Regulatory authority related to governance	Statutory or Regulatory authority related to HIEs	1a. Medicaid Chapter 70.02 RCW (Washington Uniform Health Care Information Act); 45 CFR Part 160 and Part 164 (Federal Health Insurance Portability and Accountability Act); Chapter 43.19 RCW (creating Washington Office of Chief Information Officer with over statewide IT security standards for state-run HIE); Governor's Executive Order 00-03 regarding public records and privacy protection			Specifics on language: There is no specific regulatory requirement for a specific governance structure. However, governance structures developed through agency policy and procedure must apply the applicable laws and policies in decisions made regarding how health information is collected, shared, and used.
		1.b State Funded non-Medicaid Same as 1a			Specifics on language: Same as 1a
		1.c. Commercial /Private Chapter 70.02 RCW (Washington Uniform Health Care Information Act); 45 CFR Part 160 and Part 164 (Federal Health Insurance Portability and Accountability Act);			Specifics on language: The state does not have authority over how commercial / private entities establish governance structures. However, those governance policies and procedures must apply the applicable laws and policies in decisions made regarding how health information is collected, shared, and used.

Health IT Policy Lever	Detail		Policy Lever Operational by Detail Level *Yes/No (OY/ON)* Planned *Yes/No (PY/PN)*	If Operational or Planned As of Date	Clarifying Comments/Further Explanation *(If language, copy and paste language in this column)*
Statutory or Regulatory Authority					
	Related to Health IT beyond HIEs	2a. Medicaid Same as 1a			Specifics on language: Same as 1a
		2.b State Funded non-Medicaid Same as 1a			Specifics on language: Same as 1a
		2.c. Commercial /Private Same as 1c			Specifics on language: Same as 1c
Regulatory/ Statutory Authority related to Data Governance	Topic of statutory/ regulatory language	a. Medicaid Chapter 70.02 RCW (Washington Uniform Health Care Information Act); 45 CFR Part 160 and Part 164 (Federal Health Insurance Portability and Accountability Act); Chapter 43.19 RCW (creating Washington Office of Chief Information Officer with over statewide IT security standards for state-run HIE); Governor's Executive Order 00-03 regarding public records and privacy protection			Specifics on language: The states cited in column 3 set the legal and policy framework to guide decisions governance of how protected health information is collected, used and shared.

Health IT Policy Lever	Detail		Policy Lever Operational by Detail Level *Yes/No (OY/ON)* Planned *Yes/No (PY/PN)*	If Operational or Planned As of Date	Clarifying Comments/Further Explanation *(If language, copy and paste language in this column)*
Statutory or Regulatory Authority					
		b State Funded non-Medicaid Same as a			Specifics on language: Same as a
		c. Commercial /Private Chapter 70.02 RCW (Washington Uniform Health Care Information Act); 45 CFR Part 160 and Part 164 (Federal Health Insurance Portability and Accountability Act);			Specifics on language: Same as c
Regulatory/ Statutory Authority related to the Exchange of Information	Statutory/ regulatory *(topic):*	a. Medicaid RCW 43.05.039			Specifics on language: HCA is required in law to implement the HITECH ACT through designation of the lead agency for Washington's HIE (OneHealthPort)
		b State Funded non-Medicaid Same as a			Specifics on language: Same as a
		c. Commercial /Private			Specifics on language:

Table 16-continued: Health IT Policy Levers for the Key Care Delivery Transformation and Payment Reform SIM Commitments (Workbook Tab 8)

(Focus Contractual/Participation)

Health IT Policy Lever	Detail		Policy Lever Operational by Detail Level Yes/No (OY/ON) Planned Yes/No (PY/PN)	If Operational or Planned As of Date	Clarifying Comments/Further Explanation (If language, copy and paste language in this column)
Contractual/ Participation Requirements					
Contractual Requirements related to Data Governance	Contract language in MCO/ACO (topic) : Link4Health Clinical Data Repository (CDR)	a. Medicaid	OY	December 2014	Specifics on language: Medicaid Managed Care Contracts include requirement for participation in the Integrated Patient Record / Clinical Data Repository performance improvement project. Participation includes the MCO appoint a representative to provide input into the Link4Health CDR project plan and evaluation of the project improvement plan.
		b State Funded non-Medicaid	PY		Specifics on language: Accountable Care Program contracts include: requirement for having a certified EHR contribution of clinical data from its EHR to the state HIE hosted by OneHealthPort once the Link4Health CDR service is offered; requirement that any ACP Program Providers with a certified HER system must agree to contribute data to the Link4Health CDR once available.
		c. Commercial /Private			Specifics on language:
Data Governance Participation Requirements	Conditions of participation (provider/	a. Medicaid	PY		Specifics on language: Medicaid Managed Care Contracts include requirement that subcontracted providers with certified EHR systems

Health IT Policy Lever	Detail		Policy Lever Operational by Detail Level Yes/No (OY/ON) Planned Yes/No (PY/PN)	If Operational or Planned As of Date	Clarifying Comments/Further Explanation (If language, copy and paste language in this column)
Contractual/ Participation Requirements					
	entity type): Managed Care Organization				export a care summary from their EHR using a standard CCDA each time an Apple Health enrollee assigned to them is seen beginning no later than 2/1/2017.
		b State Funded non-Medicaid	PY		Specifics on language: Accountable Care Program contracts include: requirement for having a certified EHR contribution of clinical data from its EHR to the state HIE hosted by OneHealthPort once the Link4Health CDR service is offered; requirement that any ACP Program Providers with a certified EHR system must agree to contribute data to the Link4Health CDR once available.
		c. Commercial /Private			Specifics on language:
Contractual Requirements for Exchange of Information	Contract language in MCO/ACO (topic/scope)	a. Medicaid	PY		Specifics on language: MCO subcontracted providers with certified EHR systems are required to export a care summary from their EHR using a standard CCDA each time an Apple Health enrollee assigned to them is seen beginning no later than 2/1/2017.

Health IT Policy Lever	Detail		Policy Lever Operational by Detail Level Yes/No (OY/ON) Planned Yes/No (PY/PN)	If Operational or Planned As of Date	Clarifying Comments/Further Explanation (If language, copy and paste language in this column)
Contractual/ Participation Requirements					
		b State Funded non-Medicaid			Specifics on language:
		c. Commercial /Private			Specifics on language:
Participation Requirements for Exchange of Information	Conditions of participation language (provider /entity type)	a. Medicaid	PY		Specifics on language: MCO subcontracted providers with certified EHR systems are required to export a care summary from their EHR using a standard CCDA each time an Apple Health enrollee assigned to them is seen beginning no later than 2/1/2017.
		b State Funded non-Medicaid			Specifics on language:

Table 16-continued: Health IT Policy Levers for the Key Care Delivery Transformation and Payment Reform SIM Commitments (Workbook Tab 8)

(Focus Payment and Service Delivery Levers)

Health IT Policy Lever	Detail	Policy Lever Operational by Detail Level	If Operational or	Clarifying Comments/Further Explanation *(If language, copy and paste*

			Yes/No (OY/ON) Planned Yes/No (PY/PN)	Planned As of Date	language in this column)
Payment and Service Delivery					
Payment Incentives for HIT	To whom and for what *(provider/patient - how much incentive and for doing what)*	a. Medicaid	PY		Specifics: HCA is clarifying with CMS that providers contributing care summaries to the Link4Health CDR and querying the Link4Health CDR for integrated health records can meet two key objectives for Meaningful use incentives for health information exchange and medication reconciliation.

1115 Medicaid Waivers

Table 17: Waiver Process/Approval for Medicaid Health IT Component (If applicable) (Workbook Tab 9)

Key Medicaid Waiver Components with Health IT that are Relevant to the Success of the SIM Initiative(s) *(both direct Health IT or requires Health IT for support)*	Submitted to CMS (Y/N)	Approved by CMS *(Y/N and (date if yes)*	Key Technical Architecture Component(s)	Amount of Funding for Key Technical Architecture Component *(if applicable)*	Additional Clarifications and Comments
Washington's 1115 Waiver application is pending approval. However, the work and goals of the Waiver would rely heavily on the AIM infrastructure established by SIM. Outcomes measurement to make strides on clinical quality and program sustainability are all a function of AIM (in either a short-term or longer-term incarnation)	Y	Pending	Addition of two new LTSS benefit packages for Medicaid beneficiaries. Program evaluation Updates to eligibility systems Updates to data systems to include supported housing and supported employment service codes	Our Waiver has not cited anything yet in the application re: key technical architecture; we will be standing on the shoulders of the Healthier Washington SIM which we will leverage for the Waiver work	We have been careful in our planning to ensure that no component of SIM is dependent on the 1115 Waiver (pending). There are, of course, elements of the Waiver that are dependent on SIM – such as the AIM initiative and Accountable Communities of Health.

SIM Health IT Alignment with Other State, Federal and External Health IT Efforts

Table 18: SIM Health IT Alignment with other State, Federal and External Health IT Efforts (Workbook Tab 9)

Existing State Health IT Initiatives	Existing State Health IT Initiatives Detail	Funding Source (Medicaid MU, ONC, Foundation, State)	Efforts to Coordinate and Build Upon Health IT Effort	Explain How State will avoid Duplication of Activities and/or Funding
MPI – two tools used for Link4Health CDR and RDA/IPCD	Public-Private statewide initiative to share clinical data in state's HIE – MPI is a key component	Federal funding: MMIS funding and HiTech and State Match	MPI/CDR are key foundational components of SIM All Medicaid consumers will have a longitudinal clinical record with both claims and clinical elements. Aim is to collect enough clinical data to add to quality measures that we can't get from administrative data alone.	Federal funding for MPI/Link4Health CDR will be tracked explicitly and separately. State has contracted out to a Lead Organization (OneHealthPort) to build and maintain the MPI/Link4Health CDR We are not seeking funding for point to point connections > we are paying for setup of the Link4Health CDR and professional fees. Cost per life is covered by managed care to leverage Link4Health CDR for HEDIS measures.
Washington Statewide Common Measures Set (Performance Measures)	52 common measures were approved by Performance Measures Coordinating Committee in 2014.	State	Use of 52 statewide common measures is a fundamental starting place for our SIM plan, our evaluation, and our IT e-measurement capabilities with AIM and external partners (WHA)	The state has already started the process of adding several behavioral health measures to the common set. Funding for the further development of the Statwide Common Measures is separate from SIM.
HIE: Providers sub-contracted with MCOs to submit CCDAs / Adoption of standardized Health Information Exchange (HIE) transactions	Link4Health Clinical Data Repository CDR is one of about 30 services in the OneHealthPort/state HIE	HIE is subscription based, and does not employ state funds	Use HIE to transport clinical and claims data for quality and patient safety HCA is advancing Washington's Medicaid enterprise capabilities to collect, share and use integrated physical and behavioral health information from delivery system	We will be adopting the single-sign-on service for HIE which is already paid for / unlimited transactions. Link4Health CDR will be no cost to HIE users.

Existing State Health IT Initiatives	Existing State Health IT Initiatives Detail	Funding Source (Medicaid MU, ONC, Foundation, State)	Efforts to Coordinate and Build Upon Health IT Effort	Explain How State will avoid Duplication of Activities and/or Funding
			EHR's The Medicaid Information Technology Architecture (MITA) provides a structured view of into relevant current and emerging business processes to support pay for MITA performance.	
State-run hospitals adopting EHR systems (eastern/western state)	Future initiative to move state behavioral facilities to EHR.	Unknown / Dept of Corrections going for funding / may be some state/federal funding	Many patients are Apple Health enrollees Adds to the longitudinal patient record	Link4Health CDR is not an EHR We have not purchased any kind of an EHR for state facilities.
Administration of Medicaid incentive program > incentivize adoption of certified EHRs	By submitting data to the Link4Health CDR, they will be meeting their MU requirement for exchange of data across vendors	HITECH	Link4Health CDR	
Longitudinal data sets in the Link4Health CDR	Assumes a multi-payer sponsorship model with the clinical data repository service; this will sustain the model beyond Medicaid disenrollment			
Multi-payer partnerships > Link4Health CDR service was established to serve any interested payer or provider organization	Assumes a multi-payer sponsorship model with the clinical data repository service; this will sustain the model beyond Medicaid disenrollment			
Department of Health / HCA partnership to advance submission of required public health data through the HIE	Reduce the point to point connections between providers and DOH and all associated on-boarding. Quick hook-up to the Link4Health			

Existing State Health IT Initiatives	Existing State Health IT Initiatives Detail	Funding Source (Medicaid MU, ONC, Foundation, State)	Efforts to Coordinate and Build Upon Health IT Effort	Explain How State will avoid Duplication of Activities and/or Funding
	CDR vs. many multiple hook-ups to the DOH.			

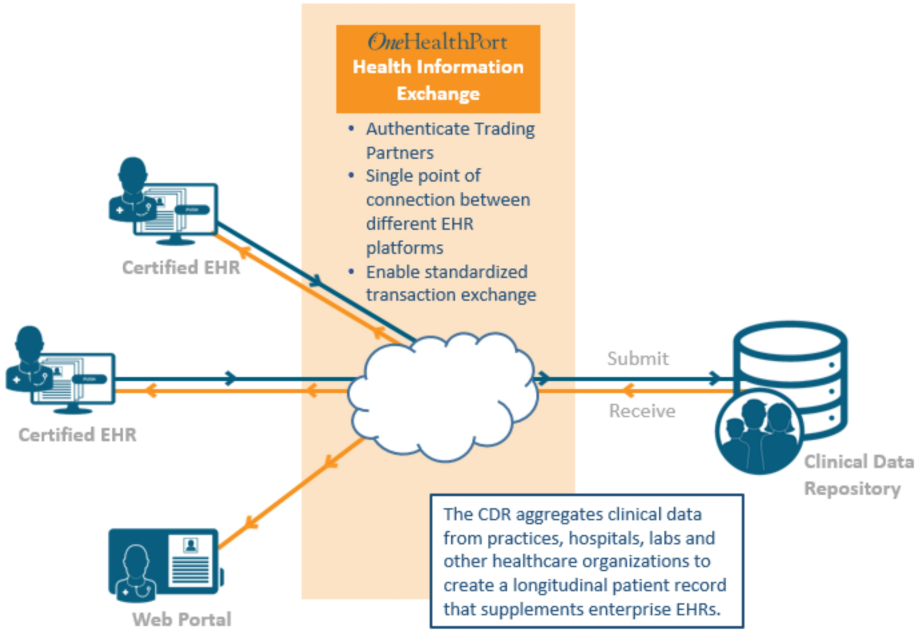

Table 19: State Methods to Improve Transparency (Workbook Tab 15)

Focus Area	Method/Process	Expected Outcome/Goal (including time period for results)
Aim #1: Build healthy communities and people through prevention and early mitigation of disease throughout the life course	Provider, regional support network and consumer view into the methodology, data and cost information regarding population health measures and planned interventions – via a website or other initiative information. Provider access to the clinical data repository and HIE. AIM initiative creation of interactive dashboards, e-measures, etc. On the Link4Health CDR side, we provide access to a full range of services, care and needs that a Medicaid consumer has (it is a shared care plan)	Metrics for healthy communities available to communities, providers, and ACH entities. We can now monitor real-time patients who are falling outside their care plan or the set measures; identify gaps in care to become more preventive Legislature has proposed legislation around publishing open data sets; OCIO has hired an Open Data Lead. (No ETA) Related work groups around de-identification are being formed in preparation.
Aim #2: Integrate care and social supports for individuals with physical and behavioral comorbidities	Via Link4Health CDR, We can now see the results of diagnostic tests which will decrease duplication of tests In the future, will include behavioral / social services in Link4Health CDR	Lower costs of care – by 2016 YE.
Aim #3: Pay for value, instead of volume, with the state leading by example as "first mover"	The statewide APCD will: Support public reporting of health care quality information and improve health care price transparency. Assist patients, providers, and hospitals to make informed choices about care Enable providers, hospitals, and communities to improve by benchmarking their performance against that of others by focusing on best practice Enable purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time Promote competition on cost and quality The Office of Financial Management is overseeing implementation of the APCD. At the end of October 2015 OFM released a procurement for a	In the recently released procurement the Lead Organization will oversee a website to share findings from APCD. Publically available data on the website is slated for the beginning of 2017.

Focus Area	Method/Process	Expected Outcome/Goal (including time period for results)
	Lead Organization to coordinate and manage the database.	

Table 20: State Methods to Encourage Innovative Uses of Data (Workbook Tab 15)

State Health IT Area	Methods Planned or Operational
Collecting, securing, and providing the necessary Medicaid data, private payer data and/or Medicare data (e.g. identifiers)	*Operational* ProviderOne collects, stores and provides claims and encounter data for Medicaid beneficiaries. ACES – contains eligibility information on Medicaid beneficiaries MCSource/Pay 1 – contain eligibility, enrollment, claims/encounter and payment data for PEBB beneficiaries *Planned* Analytics, Interoperability and Measurement (AIM) initiative under SIM intended to support Healthier Washington goals and aims – as well as serve the agency (HCA) with innovative analytics tools with which to administer benefits across the state. This includes innovative new reports, publicly available data, and Tableau dashboards. AIM will include data from many data sources, including: Medicare data – Healthier Washington will be applying for Part A, B and D data for inclusion in the AIM logical data warehouse. DOH population health data sets including Clinical Care data, Notifiable Conditions/Case-based datasets, Population-based datasets, Surveys, and Environmental Health Data. DSHS services and client outcomes data; chemical dependency and mental health data Washington All Payer Claims Database (APCD) will bring together all payer data into a single repository for use by payers, state and providers. Link4Health Clinical Data Repository (CDR) will securely collect, store and provide qualified users access to physical and behavioral health of Medicaid and PEBB beneficiaries.
Providing data for all patients covered by the SIM program (public, and commercial), including baseline and historical data for three years prior to the Project Period	Planned As mentioned in Section C: Evaluation, we are committed to providing data required to perform evaluation and patient survey activities. We have collected baseline and historical data where possible to identify all patients covered by SIM.

State Health IT Area	Methods Planned or Operational
Providing CMS and its contractor(s) with identifying and contact information for beneficiaries who receive services under the model.	Operational ProviderOne contains contact information for Medicaid beneficiaries MC Source contains contact information for PEB beneficiaries Planned Link4Health Clinical Data Repository (CDR)

PROMOTION OF PATIENT ENGAGEMENT AND SHARED-DECISION MAKING

Table 21: Patient Engagement and Shared-Decision Making (Workbook Tab 15)

Information Shared	Health IT Tool	Focus *(Individual/Caregiver (I) or Population Group (P))*	Implementation Level *(Provider, managed care entity, state, other-name)*	Patient Cost Implication *(Charge, reduction of co-pay if used, other-name)*
Individual clinical data	Clinical Data Repository (Link4Health)/CDR	Individual/Caregiver (I)	State > Providers	Free to patients / provider systems pay fees
Individual claims data	OneHealthPort (OHP) / Washington Health Alliance (WHA)	Caregiver (I) and Population Group (P)	Providers / Payers	Free to patients / providers/payers pay fees
Disease/Condition specific information	Use of web site and/or social media for promotion of SDM and education of patients and providers	Caregiver (I) and Population Group (P)	Providers/patients	No cost implications to patients

PROPOSE MULTI-PAYER STRATEGIES TO ENABLE AND EXPAND THE USE OF HEALTH IT

Table 22: Multi-payer Strategies to Enable and Expand Use of Health IT (Workbook Tab 15)

Multi-payer Health IT Strategy	Payers	By Payer Status: *(Planned, Engaged or Currently Participating)*	Implementation Date *(Indicate if expected date or actual date)*
Washington APCD / All Payer Claims Database In Washington State, is led by Office of Financial Management	Washington APCD – Private and Public payers	Engaged	Goal: Q3 2016
ACO / Accountable Care Organizations In Washington State, is led by HCA in SIM pilot with two options for public employees: Puget Sound High Value Network and University of Washington Medical	Public Employees (PEB)	Engaged (ready for Open Enrollment)	1/1/2016
Model 4 / Multi-payer data aggregation solution (TBD) Intent is to aggregate data across multiple payers to better enable clinical care across the continuum	Private Employer / Payers	Planned	1/1/2017

C. Infrastructure

Analytical Tools, Data-Driven, Evidence-Based Approaches, Tele-health and Remote Patient Monitoring

Table 23: State Implementation of Health-IT Tools to Coordinate Care (Workbook Tab 15)

Health IT Tools	Purpose of Analytical Tools *(Identification and assessment-indicate type, coordination of care, decision support, other-name)*	Status *(Planned, designed, implemented, operational and indicate as of date)*
Link4Health CDR	Longitudinal record, shared care plan + Workflow tool (Care Assist), identifying gaps in care	Planned for Q12016
PRISM	Integrated state agency client database powering a predictive modeling tool that provides the following uses: Triaging high-risk populations to more efficiently allocate scarce care management resources Intuitive and easily accessible source of patient health and social service data for clinicians and case manager Informing care planning and care coordination for clinically and socially complex persons Identification of child health risk indicators for high-risk children Identification of behavioral health needs Identification of other potential barriers to care Access to treating and prescribing provider contact information for care coordination A source of regularly updated contact information from the medical eligibility determination process	Operational
Community Health Assessment Tool (CHAT)	The Community Health Assessment Tool (CHAT) provides secure, web-based access to a repository containing a variety of data collections gathered and maintained by the Washington State Department of Health (DOH) in separate, uncoordinated databases. The CHAT tool will permit the continuation of established periodic assessments by Local Health Jurisdictions and other healthcare professionals in DOH while enlarging the opportunities for accessing and under-standing these data.	Operational

Health IT Tools	Purpose of Analytical Tools *(Identification and assessment-indicate type, coordination of care, decision support, other-name)*	Status *(Planned, designed, implemented, operational and indicate as of date)*
Washington Tracking Network (WTN)	The Washington Tracking Network (WTN) gathers and analyzes data about environmental health hazards, exposure to hazards, and health outcomes based on exposure. Data can be accessed through a public portal and a secure web-based system. Having these data available in one place makes it easierto find out more about how the environment may be affecting your health and the community where you live.	Operational
Immunization Information System (IIS)	The Immunization Information System (IIS) is a secure, web-based tool for healthcare providers and schools. Providers can run reports from the system to determine their immunization coverage rates. No mapping functionality currently exists.	Operational

Table 24: Telehealth and Remote Patient Monitoring (Workbook Tab 15)

Category	*Use Case (Population, geographic location, other-specify)*	Status *(Planned, designed, implemented, operational - indicate as of date)*	Barriers Identified *(Legal/Regulatory, funding, interest, other-specify)*
Telehealth	Once we have a value-based models in rural settings, Washington State is exploring innovative ways to increase use of telehealth. One of the anticipated outcomes of developing value-based payment models (especially in rural areas) would be the ability to use resources to support telehealth services for rural residents. Policy work under way to develop workforce and establish payment structure for telehealth in rural and urban areas. Part of State Health Innovation Plan to increase tele-health to promote prompt clinical care in rural areas and after hours. There is a telemedicine/telehealth workgroup across HCA/DSHS/DOH and its purpose is to encourage the licensing commissions (Board of Physician Specialty) to increase utilization of telehealth – with particular focus on rural areas. DOH is currently surveying licensed professionals on use of telemedicine > this endeavor will let people know the state is interested and carries some weight. There is some language with the ACP contract (Model 3) about telehealth and use thereof. Legislation passed in 2015 to increase payments	*Planned and Operational*	*Regulatory payment barriers, technical barriers*
Remote Patient Monitoring	Policy work under way, part of State Health Innovation Plan to increase remote patient monitoring in effort to increase quality of care and patient outcomes. Rural health innovation?	*N/A*	*Financial and technical barriers*

Table 25: e-Measurement Capacity (Workbook Tab 2)

e-Measurement Focus Area	Detail	Y/N	Funded through SIM $ (Y/N)	Part of Federal Initiative (SIM, CPCI, MU)	Clarifying Comments/Further Explanation	As of Date
e-Measurement Reporting Capacity	State: Medicaid	Y	N	N	State Medicaid business is administered on the Washington Provider One system. E-measurement is limited to administrative measures – PMPM, provider and utilization reports. All using Claims data.	
	Commercial Payer	Y	N	N	WHA provides comprehensive e-measurement reports to HCA and the state on the 52 common measures.	
	Provider	Y	N	Federal / HITECH / MMIS	Link4Health CDR is solution in use for providing e-measurement reports to providers. Go-live scheduled for Q12016. Link4Health CDR will provide dashboard reports. Also, providers supporting Medicaid and PEB receive select e-measurement reports based on claims data. MCOs are relying on the Link4Health CDR to automate HEDIS reporting. Reduces burden on providers and on costs to MCOs.	
	Medicare	Y	N	N	Medicare data e-measures are available to state of Washington	
	State: non-Medicaid	Y	N	N	Non-Medicaid business is also administered on ProviderOne system. E-measurement is limited to administrative measures – PMPM, provider and utilization reports. All using Claims data.	
e-Measurement Results Reported By State	State: Medicaid	Y	N	N	State Medicaid business is administered on the Washington Provider One system. WHA provides e-measurement results to State. State publishes on public website.	

e-Measurement Focus Area	Detail	Y/N	Funded through SIM $ (Y/N)	Part of Federal Initiative (SIM, CPCI, MU)	Clarifying Comments/Further Explanation	As of Date
					HIE will provide results measures to CMS.	
	Commercial Payer	Y	N	N	WHA provides comprehensive e-measurement reports to HCA and the state on the 52 common measures. Results are reported on WHA website.	
	Provider	Y	N	N	Link4Health CDR is solution in use for providing e-measurement reports to providers. Go-live scheduled for Q12016. Also, providers supporting Medicaid and PEB receive select e-measurement reports based on claims data.	
	Medicare	Y	N	N	Medicare data e-measures are available to state of Washington. Data is reported by State via the WHA common measures dashboard.	
	State: non-Medicaid	Y	N	N	Non-Medicaid business is also administered on ProviderOne system. E-measurements are available. Data is reported by State via the WHA common measures dashboard.	
State Reported Dashboard	Statewide Information (identify if information is segmented by county or less than state level)	Y	Y	N	WHA provides a dashboard of key measures by county.	
	Plan Level	Y	Y	N	WHA provides a dashboard of key measures at the plan level for beneficiaries in Washington	
	Provider Level	Y	Y	N	Part of Link4Health CDR – to be delivered in 2016.	

Table 26: Public Health IT Systems Integration (Workbook Tab 2)

Public Health IT System	**State PH Interface with County/Local Public Health**	**State PH Interface with Providers**	**Data flowing bi-directional through an HIE from/to State PH – Yes/No** ***(if Y-name the HIE)***
Examples: immunization registry, cancer registry, etc.	***Examples: interfacing-portal, VPN, HIE, etc.***	***Examples: interfacing-portal, VPN, HIE, etc.)***	
Clinical Care Data Immunization Information System (IIS) Newborn screening data Prescription Monitoring Program(PMP) data Hearing data (EDDHI)	Pertinent information included in DOH web-based tools, including: CHAT WTN DOH website – Automated routine analysis driving fact sheets and reports	Limited information shared with OneHealthPort (state HIE and Clinical data repository) via Rhapsody interface.	Yes – OneHealthPort (v
Notifiable Conditions / Case-based Datasets Washington Disease Reporting System (WDRS) (CD, TB, STD, HIV, birth defects, lead, pesticides) Cancer Registry Hospital Acquired Infection data National Violent Death Reporting System (NVDRS) WIC data	Pertinent information included in DOH web-based tools, including: CHAT WTN DOH website – Automated routine analysis driving fact sheets and reports	DOH Website	No
Surveys Healthy Youth Survey PRAMS Behavioral Risk Factor Surveillance System	Pertinent information included in DOH web-based tools, including: CHAT WTN DOH website – Automated routine analysis driving fact sheets and reports	DOH Website	No

Public Health IT System	State PH Interface with County/Local Public Health	State PH Interface with Providers	Data flowing bi-directional through an HIE from/to State PH – Yes/No *(if Y-name the HIE)*
Population-based Datasets Birth / fetal data Electronic Death Registry System (EDRS) CHARS hospitalizations Syndromic Surveillance / ER data Trauma registry	Pertinent information included in DOH web-based tools, including: CHAT WTN DOH website – Automated routine analysis driving fact sheets and reports	DOH Website	No
Environmental Health Data	Pertinent information included in DOH web-based tools, including: CHAT WTN DOH website – Automated routine analysis driving fact sheets and reports	DOH Website	No
Highly confidential, Specialty Data Child Death Review Death with Dignity data Abortion data	Pertinent information included in DOH web-based tools, including: CHAT WTN DOH website – Automated routine analysis driving fact sheets and reports	DOH Website	No

Table 27: Percentage of Provider Organizations Enabled for HIE (Workbook Tab 2)

Measure Element	Define and Identify Data Source
Target Goal by Project Period	Specify Goal: Approximately 494 organizations have certified EHR that could share data through the HIE. 182 clinics with over 30% Medicaid patient volume 88 hospitals with over 10% Medicaid patient volume = 270 org goal for initial project period All contributing care summary data no later than Feb 2017
Baseline	Define baseline: = 270 org goal for initial project period All contributing data by Feb 2017
Number of provider organizations enabled for health information exchange.	Define Provider Organizations: Hospitals with certified EHRs Define "enabled": Has certified EHR and subscribe to state HIE and completed onboarding support Data Source: HIE / OHP
Total number of provider organizations in the state that are targeted for health information exchange.	Define Provider Organizations: 494 Define "targeted": Has certified EHR and subscribe to state HIE and completed onboarding support Data Source: State + Medicaid and Medicare EHR data source

HEALTH IT TO SUPPORT FRAUD AND ABUSE PREVENTION, DETECTION AND CORRECTION

Table 28: Health IT to Support Fraud and Abuse Prevention, Detection and Correction (Workbook Tab 2)

In Washington, we contract with a fraud and abuse detection vendor (in the Klas top tier) to conduct retrospective claims audits to detect fraud and abuse in paid claims. Most of our Fraud and Abuse detection work is retrospective using algorithms, rules-based, overpayment detection, neural net risk based modeling – all retrospective. Our current fraud/abuse contract will expire end of September 2016. We intend to do something different. It can't ALL be prospective but there are new methods available. We will be looking at tools to set on top of our logical data warehouse (AIM). We may use our existing human resources for a different approach; we are pursuing the notion of social networks to identify creative methods to keep pace with fraud. Fraud and Abuse (FADs) in claims is handled via our Medicaid processing system, ProviderOne.

Technical Assistance

TA TO PROVIDERS

Table 29: State Health IT TA to Providers (Workbook Tab 5)

Targeted Provider Type	Health IT TA Provided	How Health IT TA Delivered *(examples: web-based, on site, initial or ongoing, other-explain)*	SIM Funded (Yes/No)	TA Status *(Planned, Implemented, Operational)*
Physical Health Provider	Via the practice transformation support Hub, practice coaches, webinars and electronic media available to help providers bridge the gap between fee-for-service and value-based payment models. Providers will receive onboarding support to Link4Health CDR via OHP.	Practice Transformation Support Hub is the vehicle of delivery	Y	Planned
Behavioral Health Provider	Via the practice transformation support Hub, practice coaches, webinars and electronic media available to help BH providers bridge the gap between fee-for-service and value-based payment models – as well as fully integrated managed care. Briefings on HIPAA and 42 CFR Part 2 Training to adopt an EMR where possible.	The Practice Transformation Support Hub is the vehicle of delivery. The pending Link4Health Clinical Data Repository (CDR) will make data available to BH providers that has never been available before. In the future, BH providers will embrace EMRs to further enable their practice and data collection.	Y	Planned
Will the ACHs be delivering any TA to providers?	No TA will be provided direct to providers via the ACH.			

Table 30: Non-eligible MU Providers (Workbook Tab 5)

(narrative explanation of planned efforts to extend resources to ineligible MU incentive payment providers, such as LTPAC/LTSS providers and BH providers) *Ineligible MU providers have been waiting for some time for an assist to transition to EHRs. Current planned efforts include a behavioral health EHR (partially funded by SIM), the Link4Health Clinical Data Repository (CDR) with both clinical and behavioral data included (not funded by SIM). Fully integrated managed care, inclusive of behavioral health and substance use disorder practitioners, is a major goal of the Washington State SIM. Ineligible MU providers will have access to an integrated Medicaid health record either through their certified EHR or through a clinical portal without an EHR.*

Program Monitoring and Reporting

The measures outlined in Appendix A, Portfolio of Reporting Metrics, identify and detail the specific quality performance metrics intended to capture data on quality, cost, utilization, and population health. The cross-system measures were selected for their ability to demonstrate performance across all SIM investment areas. While CMMI provided a set of recommended metrics, as permissible HCA chose alternative metrics that better reflect the demographics, needs, and priorities of Washington State. The following information will be collected and reported annually for each performance metric:

- Metric area
- Metric title
- Metric definition/description
- Numerator definition
- Denominator definition
- NQF number, if applicable
- Alignment to other CMS programs
- Baseline value
- Accountability target

These metrics will allow us to better identify, track and understand the impacts Healthier Washington activities have on quality, cost, utilization, and population health over the performance period.

Data Collection, Sharing and Evaluation

Washington State is highly committed to working with CMMI on the state and federal evaluation process. We understand the need to collaborate closely with our federal evaluation team to ensure our local evaluators are not duplicating efforts unnecessarily. In many cases, required components to complete any evaluation may require formal and legal approvals and may not be entirely within our control.

We have partnered with the University of Washington as the primary agent to complete our statewide evaluation. They have been working closely with DSHS, Medicaid, and HCA public employee data owners to obtain all necessary data to conduct the evaluation. We are working on a Medicare data request for parts A, B, and D. As a purchaser, the state has historically been provided with this data and it has been very valuable.

While it waits for the AIM and Link4Health CDR solutions, the DSHS Research and Data Analysis (RDA) organization stores significant amounts of Medicaid data with which we can examine the integration of physical and behavioral health. This detailed data set will be used for the project evaluation and the federal evaluation. Other partners, such as the Washington Health Alliance, have been storing data from many private payers in the voluntary all payers claims database (APCD) for many years; we estimate that the Alliance currently has data from 20 different payers and 30 unique suppliers. Additionally, by the end of the SIM grant we will have a mandatory APCD. Rules are now being written to define the required data specifications for

the Washington APCD; the RFP to select a lead organization and data vendor was published in October 2015.

Of course, CMMI may already possess some required Washington beneficiary data: TMSIS data (Medicaid) has been provided to CMS per our agreement and we also submit BRFSS data to CMS. CMS would already have access to the Medicare contingent and could leverage that for Medicare surveys.

One of the foundational Healthier Washington data components is the state's Link4Health Clinical Data Repository (or CDR). The Link4Health CDR is in the process of gathering data from "first movers" in the state who have a stake in building a clinical data repository and having it available in the state's HIE (by Q12016) . Eventually Link4Health CDR data will become aggregated into the AIM strategy.

Data security is of paramount importance to the Healthier Washington AIM initiative. Part of the strategy driving the AIM endeavor is to further secure and control access to our mission critical data and protect our clients. Across the Washington State agencies involved in health and health care, we have modernized our Identity and Access Management systems, locked down our desktop and laptop and mobile computing devices, and maintained strict data access approval requirements for all state data.

Under the direction of our Healthier Washington privacy and security manager, we will ensure we have the requisite data sharing agreements in place. We also have launched a Link4Health Privacy and Security work group that will play a role in AIM data governance. We are aware we need agreements with all sub-contractors (and sub-sub-contractors) as well as primary contractors.

The following table is provided for CMMI utility in gauging the different data sets that we will use and how that information will be leveraged for each SIM component area:

Data Set	Which SIM investment area will use it?	File Specs	Time Range of data > 3 years prior	Where stored?	How secured? Accessed?	How removed/ archived?
Medicaid	Practice Transformation Hub ACH Model 1 Model 2 Model 3 Model 4 AIM	Member data, claims and encounter data	10 years	HCA/ ProviderOne	Data secured per Washington State Office of the CIO security standards and requirements (https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets) Data accessed via extract from ProviderOne	Archival after seven years.
Medicare	Model 2 AIM	Member data Claims data	10 years	CMS	Data secured per Washington State Office of the CIO security standards and requirements (https://ocio.wa.gov/policies/141-	Per the terms of each data set

Data Set	Which SIM investment area will use it?	File Specs	Time Range of data > 3 years prior	Where stored?	How secured? Accessed?	How removed/ archived?
					securing-information-technology-assets/14110-securing-information-technology-assets) Data accessed via request to CMS Research Data Assistance Center (ResDAC)	agreement
Payer	Model 3 AIM	Member data Claims data	10 years	Washington Health Alliance	Data access request to WHA	Archival after 7 years
Population Health	ACH Practice Transformation Hub AIM	Member data Claims data Health status uploads	10 years	Department of Health	Data secured per Washington State Office of the CIO security standards and requirements (https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets)	Archived per policy; available through 7 years and on tape beyond
Private Payers	Model 4 AIM	Member data Claims data	May vary / WHA goes back to 2005	WHA	Data secured per HIPAA requirements. Data access request to WHA	Archival after 7 years
PEB	ACH Model 3 AIM	Member data Claims data	10 years	Regence BlueShield	Data secured per Washington State Office of the CIO security standards and requirements (https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets) Data access request to Regence	Archival after 7 years

Both RDA and HCA have methods of identifying patients (for Medicaid services) to compile a picture of services delivered across the continuum. In its Medicaid business, HCA uses a client ID within ProviderOne, and RDA has created a patient identifier in their Integrated Client Database. Medicare beneficiaries are identified with a CMS-generated ID. We also track "duals" with a unique ID. Both Milliman and the Alliance have models for patient identification and a common identifier – across payers. We are able to identify dual-eligibles and track them across the continuum.

Our draft state Evaluation Plan calls for comparing select SIM populations against non-SIM comparable populations. It will be necessary to pinpoint individuals impacted by each model test – and to find other like non-SIM populations against which to measure the SIM effect. While the

data will be de-identified, individuals will be assigned an identifier which will allow our Evaluation team to pull data related to the evaluation of each test model. Comparison states (Hawaii, California, etc.) have been identified to provide a synthetic control group and a comparison model. Long-term, AIM will provide a unifying identification mechanism to map individuals across payers to planned interventions. At that point, given the strength of the Link4Health CDR and the Washington APCD strategies, we will have claims and clinical encounter data in our AIM data warehouse that will cover every individual in Washington.

Should CMMI decide to proceed with beneficiary surveys and/or focus groups as part of the Federal evaluation, we can indeed target specific populations (with a plus/minus error ratio) and we have confirmed we have demographic data on file. While we believe CMS already has our beneficiary information (and therefore our identifiers), we could provide those as needed. Related to the Federal evaluation, we can: release data for Medicaid patients and PEB beneficiaries (subject to the appropriate data sharing agreements), and assist CMS in working through the Alliance process (a vendor request) for getting client contact information from private payers.

Related to the Federal evaluation, we can't: guarantee payer compliance with data requests, give precise lists of populations impacted by SIM (we can get close), or guarantee participation by all providers of which CMMI may make requests.

Healthier Washington is committed to measuring client experience. We recently partnered on a survey with DSHS to survey clients on their experience. Also, HCA conducts a small, routine survey monthly to confirm clients received services billed; we do about 500 of those a month to ensure bills are for services received. While we have not previously conducted a focus group on patient experience, we have quality improvement targets built into our contracts for administering the PEB program (which is CAHPS reporting with de-identified data). We also measure client experience in some SIM areas:

The Alliance has been conducting "Your Voice Matters" surveys for the last 3 years to measure patient experience related to CG CAHPS provider groups.

Under Model 3 (ACP), 5 CAHPS measures are in the quality improvement model which impacts payment – either gainsharing or payment penalties.

We have also asked the two ACPs to use the Alliance CAHPS questions in their surveys. There are two measures in common measure set of 52 related to patient experience (they are CAHPS questions and build upon the WHA survey) – and Model 3 has already built these into their contracts.

As outlined in the ACH Evaluation Plan, the Center for Community Health and Evaluation (CCHE) will use several data sets to evaluate the regional ACHs and the initiative as a whole. Related to client experience, data used to inform the evaluation will include ACH multi-sector member feedback based on regional surveys.

Finally, there are future plans to survey the Practice Transformation Support Hub stakeholders related to client experience, and the Link4Health CDR team will be sampling to measure client experience in the provider environment.

We do plan, as part of our state-based evaluation, to conduct broader surveys, focus groups, and key informant interviews as a key component of our formative and process-oriented evaluation. We would be happy to share those data and results with CMMI. We share our SIM quarterly updates with CMMI. We also plan to share our Hub Listening Session results with CMMI. We will ensure that CMS knows when we are doing this type of data collection.

We recently collaborated with CMS on an evaluation of our "duals" population. It required significant clean-up in order to ensure a strong survey response. Our goal is always to deliver clean data and to collaborate with CMS on effective surveys and evaluations. Providing clean data requires time and resources and, often, translation work. We look forward to working with CMS to ensure any data meets the specifications of Washington State and our clients – and ensuring that we have taken any extra steps to isolate the precise population needed.

Our state evaluator, University of Washington, has a long history of running evaluations concurrently with other federal or private entities. There is an art to not getting in each other's way; we firmly believe in collaborating with the state and federal entities and allowing for concurrent efforts and non-duplication of efforts where possible.

It is our intent to cooperate with CMS regarding any and all needs and requirements for the evaluation. We agree not to receive additional reimbursement for providing data or other information to CMS, noting that mutual negotiations may be necessary to deliver on any requests not currently funded or resourced.

Fraud and Abuse Prevention, Detection and Correction

The HCA is nationally recognized as a leader in program and payment integrity. With ongoing emphases on data analytics, algorithms, audits, and close coordination between program integrity, policy, and technical systems, HCA maintains optimal oversight of both provider payments and quality of care.

With the goal of identifying and preventing fraud, waste, and abuse, program integrity has largely been the domain of the Office of Program Integrity (OPI), a team of more than 40 auditors, analysts, clinicians and coders dedicated to identifying and recovering improper payments and otherwise saving Medicaid dollars through prevention. In the last three biennia, OPI has saved and recovered more than $140 million in Medicaid dollars. OPI's efforts are augmented by additional, similar activities throughout the agency, including program and contract monitoring, recovering on third-party liability, and managed care oversight.

Currently, the HCA is realigning its operations to more appropriately and comprehensively oversee the performance of the managed care model, through which more than 80 percent of the state's Medicaid population is served. Far from posing barriers to innovation, realignment is elevating and expanding program integrity operations. Multiple divisions and offices will provide enhanced oversight in the new organization, which will increase opportunities to detect, correct, and prevent fraud, waste and abuse.

Appendices

A. Portfolio of Reporting Metrics
    - Model Participation Metrics
    - Payer Participation
    - Model Performance Metrics
    - State Health Care Landscape
B. ACH Measuring Chain of Impact
C. ACH Theory of Change
D. Healthier Washington Staff Directory
E. ACH Designation Criteria

Appendix A

Portfolio of Reporting Metrics

Model Participation Metrics

	Model Participation Metrics: Metrics intended to capture data on the participation of providers in SIM as well as the number of beneficiaries impacted. The metric set includes a minimum set of required metrics each Awardee must report to the CMMI SIM Program on a quarterly and/or annual basis. Awardees may develop or select additional model								
	Metric Area	**Metric Title**	**Metric Definition/Description**	**Numerator Definition**	**Denominator Definition**	**Notes**	**Payment Taxonomy Category (2-4)**	**Baseline Value**	**Accountability Targets***
Payment Model One	**Beneficiaries**	Population Impacted by SIM (by model)	The total number of beneficiaries (individuals) receiving care through **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of beneficiaries (individuals) receiving care through **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of beneficiaries **targeted** for inclusion in **each value-based purchasing and/or alternative payment model** supported by SIM.	Report data for each value-based purchasing and/or alternative payment model supported under SIM separately. The denominator reflects the target goal of that Test Year. Please refer to the Model Test Operational Plan Excel workbook.	Category 4	0	850,000
	Providers	Providers Participating in SIM (by model)	The total number of providers participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of providers participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of providers **targeted** for inclusion in **each value-based purchasing and/or alternative payment model** supported by SIM.	Report data for each value-based purchasing and/or alternative payment model supported under SIM separately. The denominator reflects the target goal of that Test Year. Please refer to the Model Test Operational Plan Excel workbook. Individual providers may be defined by a unique NPI. Please review SIM definitions tab.	Category 4	0	21,000
	Provider Organizations	Provider Organizations Participating in SIM (by model)	The total number of provider organizations participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of provider organizations participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of provider organizations **targeted** for inclusion in **each value-based purchasing and/or alternative payment model** supported by SIM.	Report data for each value-based purchasing and/or alternative payment model supported under SIM separately. The denominator reflects the target goal of that Test Year. Please refer to the Model Test Operational Plan Excel workbook.	Category 4	0	6
Payment Model Two	**Beneficiaries**	Population Impacted by SIM (by model)	The total number of beneficiaries (individuals) receiving care through **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of beneficiaries (individuals) receiving care through **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of beneficiaries **targeted** for inclusion in **each value-based purchasing and/or alternative payment model** supported by SIM.	Report data for each value-based purchasing and/or alternative payment model supported under SIM separately. The denominator reflects the target goal of that Test Year. Please refer to the Model Test Operational Plan Excel workbook.	Category 3	0	562,000
	Providers	Providers Participating in SIM (by model)	The total number of providers participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of providers participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of providers **targeted** for inclusion in **each value-based purchasing and/or alternative payment model** supported by SIM.	Report data for each value-based purchasing and/or alternative payment model supported under SIM separately. The denominator reflects the target goal of that Test Year. Please refer to the Model Test Operational Plan Excel workbook. Individual providers may be defined by a unique NPI. Please review SIM definitions tab.	Category 3	0	2,600
	Provider Organizations	Provider Organizations Participating in SIM (by model)	The total number of provider organizations participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of provider organizations participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of provider organizations **targeted** for inclusion in **each value-based purchasing and/or alternative payment model** supported by SIM.	Report data for each value-based purchasing and/or alternative payment model supported under SIM separately. The denominator reflects the target goal of that Test Year. Please refer to the Model Test Operational Plan Excel workbook.	Category 3	0	6
Payment Model Three	**Beneficiaries**	Population Impacted by SIM (by model)	The total number of beneficiaries (individuals) receiving care through **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of beneficiaries (individuals) receiving care through **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of beneficiaries **targeted** for inclusion in **each value-based purchasing and/or alternative payment model** supported by SIM.	Report data for each value-based purchasing and/or alternative payment model supported under SIM separately. The denominator reflects the target goal of that Test Year. Please refer to the Model Test Operational Plan Excel workbook.	Category 4	0	200,000
	Providers	Providers Participating in SIM (by model)	The total number of providers participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of providers participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of providers **targeted** for inclusion in **each value-based purchasing and/or alternative payment model** supported by SIM.	Report data for each value-based purchasing and/or alternative payment model supported under SIM separately. The denominator reflects the target goal of that Test Year. Please refer to the Model Test Operational Plan Excel workbook. Individual providers may be defined by a unique NPI. Please review SIM definitions tab.	Category 4	0	3,340
	Provider Organizations	Provider Organizations Participating in SIM (by model)	The total number of provider organizations participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of provider organizations participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of provider organizations **targeted** for inclusion in **each value-based purchasing and/or alternative payment model** supported by SIM.	Report data for each value-based purchasing and/or alternative payment model supported under SIM separately. The denominator reflects the target goal of that Test Year. Please refer to the Model Test Operational Plan Excel workbook.	Category 4	0	10
	Beneficiaries	Population Impacted by SIM (by model)	The total number of beneficiaries (individuals) receiving care through **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of beneficiaries (individuals) receiving care through **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of beneficiaries **targeted** for inclusion in **each value-based purchasing and/or alternative payment model** supported by SIM.	Report data for each value-based purchasing and/or alternative payment model supported under SIM separately. The denominator reflects the target goal of that Test Year. Please refer to the Model Test Operational Plan Excel workbook.	Category 2-4	0	200,000

Payment Model Four	**Providers**	Providers Participating in SIM (by model)	The total number of providers participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of providers participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of providers **targeted** for inclusion in **each value-based purchasing and/or alternative payment model** supported by SIM.	Report data for each value-based purchasing and/or alternative payment model supported under SIM separately. The denominator reflects the target goal of that Test Year. Please refer to the Model Test Operational Plan Excel workbook. Individual providers may be defined by a unique NPI. Please review SIM definitions tab.	Category 2-4	0	6,100
	Provider Organizations	Provider Organizations Participating in SIM (by model)	The total number of provider organizations participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of provider organizations participating in **each value-based purchasing and/or alternative payment model** supported by SIM.	Total number of provider organizations **targeted** for inclusion in **each value-based purchasing and/or alternative payment model** supported by SIM.	Report data for each value-based purchasing and/or alternative payment model supported under SIM separately. The denominator reflects the target goal of that Test Year. Please refer to the Model Test Operational Plan Excel workbook.	Category 2-4	0	5
Totals for all Payment Models	**Beneficiaries**	Population Impacted by SIM	The total number of beneficiaries (individuals) receiving care through **any value-based purchasing and alternative payment model** supported by SIM.	Total number of beneficiaries (individuals) receiving care through **any value-based purchasing and alternative payment model** supported by SIM.	Total State population.	Report a unique count of beneficiaries impacted across all value-based purchasing and alternative payment models supported by SIM.	See individual model taxonomy above.	0	1,812,000
	Providers	Providers Participating in SIM	The total number of providers participating in **any value-based purchasing and alternative payment model** supported by SIM.	Total number of providers participating in **any value-based purchasing and alternative payment model** supported by SIM.	Total number of providers in the State.	Report a unique count of providers participating across all value-based purchasing and alternative payment models supported by SIM. Individual providers may be defined by a unique NPI. Please review SIM definitions tab.	See individual model taxonomy above.	0	33,040
	Provider Organizations	Provider Organizations Participating in SIM	The total number of provider organizations participating in **any value-based purchasing and alternative payment model** supported by SIM.	Total number of provider organizations participating in **any value-based purchasing and alternative payment model** supported by SIM.	Total number of provider organizations in the State.	Report a unique count of provider organizations participating across all value-based purchasing and alternative payment models supported by SIM. Provider organizations may be defined by a unique TIN. Please review SIM definitions tab.	See individual model taxonomy above.	0	11

Appendix A

Portfolio of Reporting Metrics

Payer Participation

Payer Participation: The focus of this tab is specific to payer participation in value-based purchasing and/or alternative payment models supported by SIM. Awardees must report information on payer participation and should align their reporting to the Payment Taxonomy Framework Categories to the best extent possible. Awardees should consider using this framework to establish principles for data-sharing and goal-setting among payers in the state.

Payer Participation in Value-based and Alternative Payment Model

	Category 1 Payments: Fee-for-service with no link of payment to quality			Category 2 Payments: Payment Linked to Quality			Category 3 Payment: Alternative Payment Models			Category 4 Payment: Population-based Payment		
Payer Name	**A. Total Number of Beneficiaries**	**B. Total % of Payments to Providers**	**C. Payment Model Name(s) and other Notes**	**A. Total Number of Beneficiaries**	**B. Total % of Payments to Providers**	**C. Payment Model Name(s) and other Notes**	**A. Total Number of Beneficiaries**	**B. Total % of Payments to Providers**	**C. Payment Model Name(s) and other Notes**	**A. Total Number of Beneficiaries**	**B. Total % of Payments to Providers**	**C. Payment Model Name(s) and other Notes**
Medicaid	*1,649,042**	*0%*	*No payment model address FFS with no link of payment to quality.*	*0*	*0%*	*No payment model address FFS with no link of payment to quality.*	*0*	*0%*	*Payment Test Model 2 (FQHC/RHC APM) Targeted for piloting January 2017.* *Payment Test Model 2 (CAH APM) Targeted for piloting Q2-Q3 2017*	*0*	*0%*	*Payment Test Model 1 Targeted for implementation April 1, 2016.*
Public Employee Benefits Board (PEBB)	*357,798 (or 192,333 subscribers) (October 2015)***	*0%*	*No payment model address FFS with no link of payment to quality.*	*0*	*0%*	*No payment model address FFS with no link of payment to quality.*	*0*	*0%*	*No payment model address FFS with no link of payment to quality.*	*0*	*0%*	*Payment Test Model 3 Targeted for implementation January 2017.*
Commercial	Will be based upon payer participation.	0%	*No payment model address FFS with no link of payment to quality.*	*0*	*0%*	*No payment model soley addresses link of payment to quality. Payment Test Model 4 will fall into category 2-4, the specific cateogry is yet to determined.*	*0*	*0%*	No payment model soley addresses link of payment to quality. Payment Test Model 4 will fall into category 2-4, the specific cateogry is yet to determined.	0	0%	No payment model soley addresses link of payment to quality. Payment Test Model 4 will fall into category 2-4, the specific cateogry is yet to determined.

* Title XIX only: (1210) CN TANF, (1220) ACA EXPANSION, (1230) CN Aged, (1250) CN Blind/Disabled (1253) T19 CN DISAB PRES SSI, (1260) CN Other Children (1270) CN Pregnant Women, (1280) Other Disabled - Breast & Cervical Cancer, (1290) Medicaid Buy-In - HWD, (1330) MN Aged,(1350) MN Blind/Disabled (1495) MSP QMB Only-Partial Dual

**Includes all Medicare and Non-Medicare populations.

	Category 1: Fee for Service – No Link to Quality	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models on Fee-for Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	• Some payment is linked to the effective management of a population or an episode of care • Payments still triggered by delivery of services, but, opportunities for shared savings or 2-sided risk	• Payment is not directly triggered by service delivery so volume is not linked to payment • Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (eg, >1 yr)
Examples				
Medicare	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value- based purchasing • Physician Value- Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable Care Organizations • Medical Homes • Bundled Payments	• Eligible Pioneer accountable care organizations in years 3 – 5 • Some Medicare Advantage plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and organizations
Medicaid	Varies by state	• Primary Care Case Management • Some managed care models	• Integrated care models under fee for service • Managed fee-for-service models for Medicare-Medicaid beneficiaries • Medicaid Health Homes Medicaid shared savings	• Some Medicaid managed care plan payments to clinicians and organizations • Some Medicare-Medicaid (duals) plan payments to clinicians and

Appendix A

Portfolio of Reporting Metrics

Model Performance Metrics

Model Performance Metrics: This tab includes metrics intended to capture data on quality, cost, utilization and population health. Awardees are required to report metrics that track quality, cost, utilization and population health to the CMMI SIM Program on a quarterly and/or annual basis. The CMMI SIM program has provided a set of recommended metrics listed under the model performance metrics tab. Awardees are free to select alternative metrics that better reflect the goals of their SIM proposal as long as the alternative metrics address the four areas of cost, utilization, quality and population health. Alternative metrics must be discussed with and approved by an awardee's Project Officer. Furthermore, Awardees may develop or select additional performance metrics to track activities specific to their SIM initiative which are not captured in the recommended model performance metrics suggested by the CMMI SIM Program. Awardees are expected to provide baseline values and target goals in their Operational Plan. The Awardee should plan to discuss these areas further with Project Officers and engage Technical Assistance as needed.								Baseline Value				Accountability Target
Metric Area	**Metric Title**	**Metric Definition/Description**	**Numerator Definition**	**Denominator Definition**	**NQF#**	**Reporting Frequency**	**Alignment to Other CMS Programs**	**Suggested By**	**Commercially-Insured Population**	**Medicaid-Insured Population**	**All**	**Notes**	**Accountability Target**
Population Health	Behavioral Health: % of Adults Reporting 14 or more days of Poor Mental Health	Percentage of adults ages 18 and older who answer "14 or more days" in response to the question, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	Adults ages 18 and older who answer "14 or more days" in reponse to the question, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	Adults ages 18 and older who responded to the question, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	BRFSS	Annual		Selected/Developed by Awardee in Consultation with PO	NA	NA	12%	Source of Data: BRFSS; may not be stratified by payer type.	TBD Targets not established
Utilization	Plan All-Cause Readmission Rate	For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays* (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission *An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).	At least one acute unplanned readmission for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay, that is on or between the second day of the measurement year and the end of the measurement year.	Patients age 18 and older with a discharge from an acute inpatient stay (Index Hospital Stay) on or between January 1 and December 1 of the measurement year.	1768	Annual	Health Home Measure Set, 2015 Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid	Selected/Developed by Awardee in Consultation with PO	9%	NA	NA	This is an NCQA-HEDIS measure. It is not approved for use in the Medicaid population. Note rate is observed rate, not ratio of observed to expected (observed rate is unadjusted).	0.6223
Utilization	30 Day Psychiatric Inpatient Readmission	For members 18 years of age and older, the number of acute inpatient psychiatric stays during the measurement year that were followed by an acute readmission for a psychiatric diagnosis within 30 days.	Count of Index Hospital Stays (IHS)	Count of 30-Day Readmissions	Washington State (Homegrown)	Annual	Adult Quality Medicaid Meaures Grant (AQM)	Selected/Developed by Awardee in Consultation with PO	NA	13%	NA	Results for this measure have been calculated by DSHS and are only available for the Medicaid population.	TBD Targets not established, as this measure will not be implemented until April 2016 following Behavioral Health Organizations(BHO) timelines.
Utilization	Potentially Avoidable ED Visits	Avoidable emergency visits using the Medi-Cal Diagnosis list to identify potentially avoidable ED visits; considered very conservative measure.	The Alliance leveraged the list of diagnoses defined by the Medi-Cal Statewide QIP to identify potentially avoidable ER visits. While the original list included 165 diagnosis codes, the Alliance eliminated three codes on this list that were deemed potentially serious after review by the Alliance Quality Improvement Committee. The diagnoses that were eliminated from the numerator list are: • Disseminated Candidiasis (112.5) • Candidal Endocarditis (112.81) • Candidal Meningitis (112.83) All other numerator-qualifying diagnoses identified by the Medi-Cal QIP were used in the Alliance-based numerator criteria.	Emergency room visits are defined using HEDIS criteria with modifications as outlined below: -Emergency room visits are defined by criteria outlined in the HEDIS Table AMB-B. -Exclude mental health and chemical dependency services. -Exclude members who are younger than 12 months (based upon age at the date of service).	Medi-Cal	Annual		Selected/Developed by Awardee in Consultation with PO	10%	13%	12%	This is known to be a very conservative measure of potentially avoidable ER visits.	TBD Medi-cal is no longer supporting this measure and the evaluation workgroup is recommending to the PMCC that we change this measure.
Population Health	Adult Access to Preventative/Ambulatory Health Services	The percentage of members 20 to 44 years, 45 to 64 years, and 65 years and older who had an ambulatory or preventive care visit.	One or more ambulatory or preventative care visits during the measurement year.	The eligible population.	NCQA	Annual	Health Home Measure Set, 2015 Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid	Selected/Developed by Awardee in Consultation with PO	Adult Access to Primary Care Practitioners - Ages 20 - 44 years 90% Adult Access to Primary Care Practitioners - Ages 45-64 years 95% Adult Access to Primary Care Practitioners - Ages 65+ years 97%	Adult Access to Primary Care Practitioners - Ages 20 - 44 years 83% Adult Access to Primary Care Practitioners - Ages 45-64 years 85% Adult Access to Primary Care Practitioners - Ages 65+ years 83%	Adult Access to Primary Care Practitioners - Ages 20 - 44 years 89% Adult Access to Primary Care Practitioners - Ages 45-64 years 95% Adult Access to Primary Care Practitioners - Ages 65+ years 92%		95.6 97.19 98.73
Quality	Child and Adolescents' Access to Primary Care Practitioners	Percentage of children and adolescents ages 12months to 19 years that had a visit with a PCP, including four separate percentages: -Children ages 12 to 24 months and 25 months to 6 years who had a visit with a PCP during the measurement year -Children ages 7 to 11 years and adolescents ages 12 to 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year	For12-24 months and 25 months-6 ears: one for more visits with a PCP (ambulatory vists value set) during the measurement year. For 7-11 years, 12-19 years: One or more visits with a PCP (ambulatory visits value set) during the measurement year. Count all members who had an ambulatory or preventative care visit to any PCP/ Exclude specialist visits.	The eligible population.	NCQA	Annual	Health Home Measure Set, 2015 Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid	Selected/Developed by Awardee in Consultation with PO	Child and Adolescent Access to Primary Care Practitioners - Ages 12-24 months 94% Child and Adolescent Access to Primary Care Practitioners - Ages 2 - 6 years 81% Child and Adolescent Access to Primary Care Practitioners - Ages 7 - 11 years 85% Child and Adolescent Access to Primary Care Practitioners - Ages 12-19 years 84%	Child and Adolescent Access to Primary Care Practitioners - Ages 12-24 months 94% Child and Adolescent Access to Primary Care Practitioners - Ages 2 - 6 years 81% Child and Adolescent Access to Primary Care Practitioners - Ages 7 -11 years 84% Child and Adolescent Access to Primary Care Practitioners - Ages 12-19 years 84%	Child and Adolescent Access to Primary Care Practitioners - Ages 12-24 months 94% Child and Adolescent Access to Primary Care Practitioners - Ages 2 - 6 years 81% Child and Adolescent Access to Primary Care Practitioners - Ages 7 -11 years 85% Child and Adolescent Access to Primary Care Practitioners - Ages 12-19 years 84%		99.86 95.03 96.81 93.91

Population Health	Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Percentage of members 18 to 75 years of age with diabetes (type 1 and type 2) who had HbA1c > 9.0% during the measurement year. Requires clinical data; results only available at health plan level for starter set	Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year. The outcome is an out of range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	0059	Annual	HEDIS- Health Care Effectiveness and Data and Informaton Set (HEDIS) Reporting	Selected/Developed by Awardee in Consultation with PO	37%	44%	NA	Source of Information: NCQA Quality Compass so you may not publish their benchmark data; for commercial, the national average is 31%; for Medicaid the national average is 44%; lower is better.	18.49
Population Health	Childhood Immunization Status	Percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday	Children who received the recommended vaccines by their second birthday.	Children who turn 2 years of age during the measurement year.	0038	Annual	HEDIS- Health Care Effectiveness and Data and Informaton Set (HEDIS) Reporting	Selected/Developed by Awardee in Consultation with PO	NA	NA	33%	Source of Data: Department of Health; may not be stratified by payer type.	64.88
Quality	Patient Experience Provider Communication (CG-CAHPS)	52-items survey instrument (CG-CAHPS) with 3 domain-level composites. Reporting on one composite measure in particular (Provider Communication, composite of 6 survey questions)) as it correlates with improved outcomes; Top Box scores to be reported	CG-CAHPS Survey items and composites will be calculated using a top-box scoring method. The top box score refers to the percentage of patients whose responses indicated that they "always" received the desired care or service for a given measure. The top box numerator for the Overall Rating of Provider is the number of respondents who answered 9 or 10 for the item, with 10 indicating "Best provider possible".	The measure's denominator is the number of survey respondents. The target populations for the surveys are patients who have had at least one visit to the selected provider in the target 12-month time frame. This time frame is also known as the look back period. The sampling frame is a person-level list and not a visit-level list.	0005	Annual	HEDIS- Health Care Effectiveness and Data and Informaton Set (HEDIS) Reporting	Selected/Developed by Awardee in Consultation with PO	NA	NA	79%		97.33
Quality	Patient Experience: Communication about Medications and Discharge Instructions (HCAHPS)	27-items survey instrument with 7 domain-level composites. Reporting on two areas (Communication about Medicines and Discharge Information) as they relate specifically to improving care transitions and reducing hospital readmissions.	HCAHPS is administered to a random sample of adult inpatients between 48 hours and six weeks after discharge. Patients admitted in the medical, surgical and maternity care service lines are eligible for the survey; HCAHPS is not restricted to Medicare beneficiaries. Hospitals may use an approved survey vendor or collect their own HCAHPS data if approved by CMS to do so. HCAHPS can be implemented in four survey modes: mail, telephone, mail with telephone follow-up, or active interactive voice recognition (IVR), each of which requires multiple attempts to contact patients. Hospitals must survey patients throughout each month of the year. IPPS hospitals must achieve at least 300 completed surveys over four calendar quarters.	Eligibility for the HCAHPS Survey The HCAHPS Survey is broadly intended for patients of all payer types who meet the following criteria: Eighteen (18) years or older at the time of admission Admission includes at least one overnight stay in the hospital • An overnight stay is defined as an inpatient admission in which the patient´s admission date is different from the patient´s discharge date. The admission need not be 24 hours in length. For example, a patient had an overnight stay if he or she was admitted at 11:00 PM on Day 1, and discharged at 10:00 AM on Day 2. Patients who did not have an overnight stay should not be included in the sample frame (e.g., patients who were admitted for a short period of time solely for observation; patients admitted for same day diagnostic tests as part of outpatient care). Non-psychiatric MS-DRG/principal diagnosis at discharge Note: Patients whose principal diagnosis falls within the Maternity Care, Medical, or Surgical service lines and who also have a secondary psychiatric diagnosis are still eligible for the survey. Alive at the time of discharge Note: Pediatric patients (under 18 years old at admission) and patients with a primary psychiatric diagnosis are ineligible because the current HCAHPS instrument is not designed to address the unique situation of pediatric patients and their families, or the behavioral health issues pertinent to psychiatric patients.	0166	Annual		Selected/Developed by Awardee in Consultation with PO	Patient Experience - Primary Care Provider Communication Patient Experience - Inpatient, Medicines Explained Patient Experience - Inpatient, Discharge Information	NA NA NA	NA NA NA	79% 64% 87%	No National Benchmark TBD
Population Health	Well-Child Visits	The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	Children who received at least one well-child visit with a PCP during the measurement year.	Children 3-6 years of age during the measurement year.	1516	Annual		Selected/Developed by Awardee in Consultation with PO	63%	57%	59%		84.89
Cost	Annual Per-Capita Health Care Spending Growth Relative to State GDP	This measure contains information on annual state-purchased health care expenditures per Capita, including total Medicaid spending per enrollee and total Public Employee spending per enrollee, including growth relative to the Washington State GDP.	Numerator=[(Annual Total Medicaid Spending+ Annual Total PEBB Spending)/(Average Monthly Medicaid eligibles in the year + Average Monthly PEBB enrollees in the year)]	Denominator=State's Annual GDP/State population	Washington State (Homegrown)	Annual		Selected/Developed by Awardee in Consultation with PO	NA	NA	5.8% (2014)		TBD
Cost	Medicaid Spending Per Enrollee	This measure contains information on Medicaid spending per enrollee and includes both state and federal Medicaid payments. This measure represents the average (mean) level of payments across all Medicaid enrollees, including those receiving full Medicaid benefits, during a calendar year, based on date of payment.	Medicaid expenditures, including both state and federal Medicaid payments, for Medicaid enrollees receiving full Medicaid benefits.	Medicaid member months.	Washington State (Homegrown)	Annual		Selected/Developed by Awardee in Consultation with PO	NA	$4,847	NA		TBD
Population Health	First Trimester Care	Birth Certificates that indicate date of 1st prenatal visit	Birth Certificates that indicate date of 1st prenatal visit	Birth Certificates	ResultsWA	Annual		Selected/Developed by Awardee in Consultation with PO			74.00%		76%
Population Health	Tobacco: % of Adults who smoke Cigarettes	Numerator: # of adults ages 18 and older who answer "every day" or "some days" in response to the question, "Do you now smoke cigarettes every day, some days, or not at all?" Denominator: # of adults age 18 and older who answer this question.	# of adults ages 18 and older who answer "every day" or "some days" in response to the question, "Do you now smoke cigarettes every day, some days, or not at all?"	# of adults age 18 and older who answer this question.	BRFSS	Annual		Selected/Developed by Awardee in Consultation with PO	NA	NA	17%	Source of Data: BRFSS; may not be stratified by payer type.	TBD Targets not established
Population Health	Personal Care Provider	WA residents who report they have a personal doctor or health care provider	WA residents who report they have a personal doctor or health care provider	WA adult residents	ResultsHCA	Annual		Selected/Developed by Awardee in Consultation with PO			68% (2013)		82%
Population Health	Chronic Care Engagement	Adults with a Diabetes diagnosis who have had a visit with a primary care provider in the past 12 months	Adults with a Diabetes diagnosis who have had a visit with a primary care provider in the past 12 months	Adults with Diabetes	Results HCA	Annual		Selected/Developed by Awardee in Consultation with PO			68% (2013)		Not yet established.

Appendix A

Portfolio of Reporting Metrics

State Health Care Landscape

State Health Care Landscape & Delivery System Reform: In January 2015, HHS announced clear goals for moving from volume to value in Medicare payments by tying 30 percent of Medicare fee-for-service payments to alternative payment models by 2016 and 50 percent by 2018. Overall, HHS seeks to have 85 percent of all Medicare fee-for-service payments in value-based purchasing by 2016 and 90 percent by 2018. In this context, States are encouraged to develop similar goals, as well as identify and track metrics intended to capture data on providers and beneficiaries impacted by APMs in the State regardless of SIM funding. This tab includes a set of metrics each Awardee may report to the CMMI SIM Program on an annual basis. For more information on the goals of HHS regarding value-based purchasing and alternative payment models, please see "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume Fact Sheet."

Metric Area	Metric Title	Metric Definition/Description	Numerator Definition	Denominator Definition	Notes	Reporting	Defined by
State Health Care Landscape_Beneficiaries	Population impacted by value-based purchasing and alternative payment models	The total number of beneficiaries (individuals) receiving care through **any value-based purchasing and alternative payment models.**	Total number of beneficiaries (individuals) receiving care through **any value-based purchasing and alternative payment model.**	Total state population	Report a unique count of beneficiaries impacted across all value-based purchasing and alternative payment models.	Annual	CMMI SIM Program
State Health Care Landscape_Providers	Providers participating in value-based purchasing and alternative payment models	The total number of providers participating in **any value-based purchasing and alternative payment models.**	Total number of providers participating in **any value-based purchasing and alternative payment model.**	Total number of providers in the state	Report a unique count of providers participating in value-based purchasing and alternative payment models. Individual providers may be defined by a unique NPI. Please review SIM definitions tab.	Annual	CMMI SIM Program

Appendix B

Measuring Chain of Impact

DRAFT

Measuring the Chain of Impact

Balancing local variation with a coordinated statewide measurement strategy

Short-term Operational & Collaboration Measures

Measure ACH function, strength and collaboration as a coalition:

- Collective Action
- Collaboration
- Governance/ Leadership
- Representation
- Sustainability
- Data Capacity
- Community Engagement

Evaluate progress with operational & collaboration measures

Intermediate Activity Measures

Measure ACH project-specific progress

Community-driven projects based on local health needs and in consideration of existing initiatives

Evaluate progress with tailored evaluation metrics

Measure ACH participation in Healthier WA more broadly:

- Coordinated statewide activities
- Practice Transformation, Behavioral Health Integration, Payment Reform, etc.

Evaluate with metrics tailored to the nature/type of each ACHs participation - TBD

Long-term Regional Health Outcome Measures

Regional variation: Each ACH selects measures from a subset of the Common Measure Set (TBD) to match project goals.

Measures categories:

- Child/Adolescent health
- Adult primary/preventive care, including Adult Diabetes control, testing and screening
- Adult Behavioral Health
- Adult ED visits & readmissions
- Health care costs

Statewide alignment: Healthier WA team identifies the subset of measures that span the various Healthier WA activities. This set is then used to measure impact across all initiatives in all regions, including the participation of ACHs.

Appendix C

Theory of Change

10.28.15

Healthier Washington: Accountable Communities of Health

***DRAFT** Theory of Change Model*

Inputs

Healthier Washington Funding | **Local Resources** | **Existing Regional Initiatives**

Key Condition

ACH Designation: Readiness to Implement Strategies

Strategies

Build Operational Elements

- Governance
- Structure
- Staffing
- Convening
- Data capacity
- Financial plan
- Sustainability
- Relationships

Develop & Strengthen Regional Partnerships (clinical and broader community partners)

Community Health Planning

- Develop Regional Health Needs Inventory, including health inequities
- Development of Regional Health Improvement Plan, including social determinants of health priorities

(To Be Clarified)

State-level Partnerships

- Advise & consult with Healthier WA
- Bring regional perspective to state policy and practice decisions
- Follow HCA guidelines for ACH role

Outcomes

Increased Organizational Capacity

- Management, stability, transparency regarding decision making, etc. meet criteria for optimal operations
- Local partners have committed resources

ACHs are Sustainable

Cycle of collaboration and improvement

Strengthened Regional Collaboration

- Greater range of actors engaged / sharing understanding / aligned on a set of key health improvement priorities that are informed by regional data
- Partners pursuing complementary activities, with alignment facilitated by the ACH
- Partners pursuing collective ACH projects funded by local & other partner investment

Increased Implementation of Regional Complementary and Collective Health Improvement Activities

Project-related Change in Policy, Practice and Systems

To be determined by Healthier WA

Key questions about ACH role & partnership, including level of resources for ACH health improvement work

Reach a level of project magnitude, spread and sustainability needed to achieve regional change

Regional Changes in Policy, Practice, and Systems

Impact

- **Regional population-level changes in health and well-being (regional and State) and improvements in health equity**
- **Regional changes to the Triple Aim: Improve access and quality, decrease cost**

Center for Community Health and Evaluation www.cche.org

Appendix D

Healthier Washington
Staff Directory

SIM Component/Project Area Key Staff Directory					
SIM Component/Project Area	Component/Project Lead			Contact Information	
	Position/Title	First Name	Last Name	Phone Number	Email Address
AIM	Chief Information Officer	Adam	Aaseby	360-725-1241	adam.aaseby@hca.wa.gov
Communications	Healthier Washington Communication Consultant - HCA	Victor	Andino	360-725-9563	victor.andino@hca.wa.gov
Budget	Financial Claims Data Analyst	Lori	Anthonsen	360-725-1854	lori.anthonsen@hca.wa.gov
Accountable Communities of Health (ACH)	ACH Project Specialist	Glenn	Baldwin	360-725-3820	glenn.baldwin@dshs.wa.gov
Consulted Leadership Team	HCA Communications Director	Amy	Blondin	360-725-1915	amy.blondin@hca.wa.gov
Communications	Communications Consultant - DOH	Tiffany	Brown	360-236-4003	tiffany.brown@doh.wa.gov
Telehealth and Education	Special Initiatives Manager	Rebecca	Burch	360-725-0864	rebecca.burch@hca.wa.gov
Operations	Healthier Washington Operations Manager	Alyson	Chase	360-725-9834	alyson.chase@hca.wa.gov
Community Healthcare Improvement and Linkages	Manager	Kathleen	Clark	360-236-3686	kathleen.clark@doh.wa.gov
Evaluation	University of Washington Professor of Health Services	Doug	Conrad	206-616-2923	dconrad@uw.edu
Budget	Healthier Washington Grants and Budget Specialist	Janet	Cornell	360-725-0859	janet.cornell@hca.wa.gov
DOH Connector	Director, Office of Infectious Diseases	Maria	Courogen	360-236-4017	maria.courogen@doh.wa.gov
Analytics, Interoperability & Measurement (AIM)	Epidemiologist 3	Beverly	Court	360-902-0726	beverly.court@dshs.wa.gov
Executive Governance	Special Assistant to the Governor for Health Reform	Bob	Crittenden	360-902-0557	robert.crittenden@gov.wa.gov
Plan for Improving Population Health	Healthy Communities Consultant	Marilyn	Dold	360-236-3403	marilyn.dold@doh.wa.gov
Accountable Communities of Health	Community Transformation Specialist	Kayla	Down	360-725-0496	kayla.down@hca.wa.gov
Accounting	Healthier Washington Accounting Specialist	Mellisa	Ferris-Dapron	360-725-9818	mellisa.ferris-dapron@hca.wa.gov
Payment Redesign	Payment Redesign Model Analyst (model tests 3 and 4)	J.D.	Fischer	360-725-1061	jd.fischer@hca.wa.gov
DSHS Connector	Behavioral Health and Service Integration Project Director	Karen	Fitzharris	360-725-2254	karen.digre-fitzharris@dshs.wa.gov
Consulted Leadership Team	HCA Deputy Chief Medical Officer	Charissa	Fotinos	360-725-9822	charissa.fotinos@hca.wa.gov
AIM	DSHS Research and Data Analysis	Roger	Gantz	360-902-0268	roger.gantz@dshs.wa.gov
Practice Transformation	Director, Practice Transformation Hub	Cezanne	Garcia	360-236-4029	cezanne.garcia@doh.wa.gov
AIM	Senior Research Manager	Andy	Glenn	360-902-7790	andy.glenn@dshs.wa.gov
Contracts	Contracts Specialist 2	Greg	Grahn	360-725-0917	gregory.grahn@hca.wa.gov
Policy	Senior Health Policy Analyst	Jenny	Hamilton	360-725-1101	jenny.hamilton@hca.wa.gov
Contracts	Contracts Specialist 3	Andria	Howerton	360-725-9995	andria.howerton@hca.wa.gov
Consulted Leadership Team	HCA Chief Financial Officer	Thuy	Hua-Ly	360-725-1855	thuy.hua-ly@hca.wa.gov
Practice Transformation	Practice Transformation Specialist	Jim	Jackson	360-725-2283	jim.jackson@dshs.wa.gov
AIM	Data Privacy and Security Manager	Karen	Jensen	360-725-1887	karen.jensen@hca.wa.gov
Healthier Washington	HCA Chief Policy Officer/Healthier Washington Coordinator	Nathan	Johnson	360-725-1880	nathan.johnson@hca.wa.gov
Payment Redesign	Payment Redesign Model Analyst (model tests 1)	Isabel	Jones	360-725-0862	isabel.jones@hca.wa.gov
Policy, Planning and Performance	Policy, Planning and Performance Deputy Director	Kari	Karch	360-725-0858	kari.karch@hca.wa.gov
Consulted Leadership Team	HCA Chief Medical Officer	Dan	Lessler	360-725-1612	daniel.lessler@hca.wa.gov
Consulted Leadership Team	HCA Medicaid Director	MaryAnne	Lindeblad	360-725-1863	maryanne.lindeblad@hca.wa.gov
Consulted Leadership Team	DOH State Health Officer/Chief Science Officer	Kathy	Lofy	206-418-5510	kathy.lofy@doh.wa.gov
Consulted Leadership Team	HCA Chief Operations Officer	Susan	Lucas	360-725-1703	susan.lucas@hca.wa.gov
AIM	Management Analyst 5	Amanda	Lysne	360-725-1693	amanda.lysne@hca.wa.gov
Evaluation	DSHS Research and Data Analysis Director	David	Mancuso	360-902-7557	david.mancuso@dshs.wa.gov
Consulted Leadership Team	HCA Public Employees Benefits Division Director	Lou	McDermott	360-725-0891	lou.mcdermott@hca.wa.gov
Policy	Senior Health Policy Analyst	Kali	Morris	360-725-1240	kali.morris@hca.wa.gov

Consulted Leadership Team	DSHS Assistant Secretary for Aging and Long-Term Support	Bill	Moss	360-725-2311	bill.moss@hca.wa.gov
ACH	Community Transformation Specialist	Lena	Nachand	360-725-1643	lena.nachand@hca.wa.gov
ACH	Community Transformation Manager	Chase	Napier	360-725-0868	chase.napier@hca.wa.gov
Healthier Washington	Healthier Washington Administrative Coordinator	Megan	Oczkewicz	360-725-1980	megan.oczkewicz@hca.wa.gov
Consulted Leadership Team	OFM Senior Budget Assistant	Rich	Pannkuk	360-902-0539	richard.pannkuk@ofm.wa.gov
Payment Redesign	Healthier Washington Payment Redesign Analyst	Savannah	Parker	360-725-1321	savannah.parker@hca.wa.gov
Performance Measures and Shared Decision Making	Practice Transformation Specialist	Laura	Pennington	360-725-1231	laura.pennington@hca.wa.gov
Payment Redesign	Medicaid Transformation Manager	Marc	Provence	360-725-1876	marc.provence@hca.wa.gov
Executive Governance	DSHS Secretary	Kevin	Quigley	360-902-7800	kevin.quigley@dshs.wa.gov
Payment Redesign	Special Assistant for Policy and Programs	Rachel	Quinn	360-725-0477	rachel.quinn@hca.wa.gov
Policy, Planning and Performance	Executive Assistant to Nathan Johnson and Kari Karch	Jessica	Reese	360-725-0857	jessica.reese@hca.wa.gov
Consulted Leadership Team	DSHS Acting Assistant Secretary	Carla	Reyes	360-725-2260	carla.reyes@dshs.wa.gov
Healthier Washington	Administrative Assistant 5	Marquita	Schlender	360-236-4150	marquita.schlender@doh.wa.gov
Executive Governance	OFM Senior Policy Advisor	Andi	Smith	360-902-0655	andi.smith@gov.wa.gov
Payment Redesign	Payment Redesign Model Analyst (model tests 2)	Gary	Swan	360-725-1250	gary.swan@hca.wa.gov
Executive Governance	HCA Director	Dorothy	Teeter	360-725-1523	dorothy.teeter@hca.wa.gov
Executive Governance	DOH Secretary	John	Wiesman	360-236-4030	john.wiesman@doh.wa.gov
Consulted Leadership Team	DOH Deputy Secretary for Public Health	Dennis	Worsham	360-236-4019	dennis.worsham@doh.wa.gov
Healthier Washington	Healthier Washington Deputy Coordinator	Laura	Zaichkin	360-725-1635	laura.zaichkin@hca.wa.gov
Non-SIM funded partners/staff					
HCA = Health Care Authority					
DOH = Department of Health					
DSHS = Department of Social and Health Services					
OFM = Office of Financial Management					

Appendix E

ACH Designation Criteria

Healthier WASHINGTON

Framework for the Accountable Community of Health Readiness Proposal (6.15.2015)

A. Purpose

The intent of the ACH Readiness Proposal is to assess (through minimum requirements and outputs) whether the emerging structure is developing into a functional ACH with a strong foundation for collaboration on regional health improvement efforts in partnership with the State. This portfolio should reflect ACH readiness for the next phase of development and activity within the region.

B. Submission

Demonstration of readiness should take the form of a portfolio, containing documentation and supporting narrative. The categories for designation align with the ACH Pilot/Design contract and are as follows:

1. Demonstration of operational governance structure, interim or otherwise, includes a plan for testing/adjustment.

2. Governing body membership reflects balanced, multi-sector engagement. At a minimum, balanced engagement refers to the participation of key community partners that represent systems that influence health; public health, the health care system, and systems that influence the Social Determinants of Health (SDOH), with the recognition that this includes different spheres of influence. The governance model should also include a process for adjusting as the environment changes.

3. Community engagement activities are underway and additional community engagement activities are planned in addition to engagement that occurs through the governance structure (e.g., ACH governing body and committee meetings).

4. Established backbone functions to perform financial and administrative functions. These functions can be performed by one or more organizations, interim or otherwise, and must demonstrate accountability to the ACH. There must be a process for ongoing evaluation and confirmation of the backbone organization(s).

5. Initial priority areas (service gaps and/or health priorities) and strengths identified as part of ongoing regional needs inventory and assessment development. Initial regional health improvement project(s) or plan identified with a plan in place to continue this development in alignment with forthcoming ACH technical assistance opportunities (i.e., framework for regional initiatives inventory and priority identification).

6. Initial operating budget established. Initial sustainability planning strategy documented and includes, but is not limited to, initial considerations for enhancing revenue base. This strategy could include a summary that outlines early efforts to consider Federal, State, local and private philanthropic resources to sustain the ACH.

C. Instructions

Between August 1 and November 30, 2015, please send the required documentation as outlined below to the HCA Community Transformation email: communitytransformation@hca.wa.gov. Applications will be accepted on a rolling basis between August 1 and November 30, 2015 in recognition of the Design contract reporting date and statewide ACH designation goal. If a region anticipated a challenge with readiness by November 30, the ACH lead should contact the State and appropriate partners. Phase One funding will follow a successful application for designation pending CMMI approval timing.

In the email, please attach one PDF document that contains the following:

- An introductory cover letter that explicates the intent of the proposal and appropriate contact information should follow-up questions or discussions be necessary;
- Table of contents for all required documents that are to be included, broken down by Categories 1-6;
- Narrative for each Category (1-6) that introduces the required document. Each introductory narrative must clearly convey how the included document supports the corresponding category requirements;
- For the inclusion of documents that show additional ACH activities (see "Additional Activities" on next page), please include a cover letter that explains key context and values (to both the HCA and ACH), followed by the applicable documents.

Overall, this portfolio should demonstrate development and progress in alignment with ACH activities and deliverables. The cover letters and documents should clearly justify the application for designation in a format that is concise yet reflective of the applicable ACH activities to date.

D. Evaluation

The submitted designation portfolio will be reviewed and evaluated by a multi-agency state team based on:

- Comprehensive cover letter that outlines the region's intent to pursue ACH designation
- Table of contents with each document listed by Category
- Narrative to introduce each category (1-6) and the required supporting documentation to reflect the criteria and outputs

- If applicable, narrative to introduce additional activities with supporting documentation
- Summative narrative with reflection of process, with specific mention to Section 4b of ACH Design Contract objectives.

E. Feedback & Approval

Contingent upon the timeline of CMMI approval, Design regions will know designation status up to 30 days post Readiness Proposal submission. Design regions should anticipate funding approval and processing on a similar timeframe and should be prepared to coordinate with HCA regarding the submission of a budget for the next phase of work.

F. Category Outputs

Outputs for each category should include, but are not limited to the following:

<u>Categories 1 through 3</u>

- Bylaws, charter(s) or other documentation that addresses:
  - Governance (i.e. chosen organizational structure, composition of boards and advisors, policies and procedures for distributing resources);
  - Engagement strategies (i.e. cascading engagement, how traditional and non-traditional partners have had an opportunity to learn about the ACH initiative and provide input and how unengaged partners and populations might be included in the future);
  - Membership/participation (i.e. who is currently involved and who is not and at what levels), roles and responsibilities (i.e. a description of each member's tasks and who those tasks relate to)

- A decision making process developed, documented and approved by the governing board, including:
  - Description of how disagreements will be handled; and
  - Conflict of interest (COI) process or decision documented addressing the ACH's policy on COI

- Process established and documented to allow for adjustments to the ACH structure as issues/gaps emerge over time (i.e. the iterative nature and process is acknowledged and reflected in the governance and engagement strategies)

<u>Category 4</u>

- Backbone functions/roles identified and documented, whether fulfilled by one or multiple organizations. This documentation should also include a process for the governing board to select and/or reaffirm the backbone organization(s), allowing for adjustments as necessary.

Category 5

- Draft or final inventory developed and highlights initial priority areas (i.e. explanation of what services/resource gaps and assets exist across the region, such as transportation, housing, education, insurance, health care access, etc.)
- Work plan in place to reflect the iterative development of the inventory and future or ongoing development for the RHIP (including potential support from ACH TA team) with goals, deliverables, a timeline, and roles and responsibilities

Category 6

- Pathway for sustainability planning developed, including considerations around financial and social capital (i.e. considerations regarding potential savings characterization, additional grant sources, community matching funds, social impact bonds, membership dues, etc.)

Additional Activities

The emerging ACH has likely completed other activities that the above outline does not reflect (i.e. public commentary provided to HCA, participation in regional and national health improvement initiatives, investment in regional health improvement projects, regionally developed measurement systems, etc.). It is appropriate, although not required, for this portfolio to reflect the various activities and investments by the emerging ACH.

G. Summative Narrative

Each ACH will turn in two items as part of Design contract: 1) an objective portfolio documenting the work to date, and 2) more subjective reflection paper on the process to date. It is the intent of this descriptive piece to include reflection and more subjective expansion on the context described in the ACH Readiness Proposal cover letters that introduce each deliverable category.

In formatting this summative narrative, a helpful way to think about each category of work is in the "What? So What? Now What?" structure. This follows three questions: What happened?

Why do we care? And what did we learn from what happened that will inform what we do now? This is an opportunity to highlight successes and lessons learned as the specific ACH has developed a strong foundation for regional health improvement efforts in partnership with the State. Additional instructions provided below.

Required Content**:**

The summative narrative should leverage the cover letter narrative provided within the Readiness portfolio. It should be considered an opportunity, to take time to perform an honest reflection on how the initiative is going to date. As such ACHs may choose to submit a separate document as there could be more sensitive information contained within this summative piece than within the ACH Readiness Proposal. If that is the case, the ACH will need to notify the State that this will be a separate document, but must be turned in on the same date as the rest of the Readiness Proposal.

Additional objectives not identified as independent categories within the Readiness Proposal, although potentially included and highlighted there in, should be included within this narrative.