Washington State Health Care Authority

REPORT TO THE LEGISLATURE

# State Health Care Innovation Plan

## Final Status Report

Engrossed Second Substitute House Bill 2572, Chapter 223, Laws of 2014

July 31, 2019

# State Health Care Innovation Plan

## Final Status Report

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# Executive Summary

The five-year State Health Care Innovation Plan created a framework for health system transformation that is far-reaching in its core strategies for achieving better health, better care, and lower costs for at least 80 percent of Washingtonians.

The Innovation Plan, now called Healthier Washington, gained strong support in the 2014 legislative session with passage of E2SHB 2572 (2014) and related funding to further develop Healthier Washington elements. This was followed by the $65 million federal award of a four-year Round Two Model Test grant, which concluded January 2019.

E2SHB 2572 (2014) directed the Health Care Authority (HCA) to report annually on the progress of the innovation plan. While that section of the bill was vetoed, the Governor directed the HCA to comply with the reporting requirements. This report represents the final status report which summarizes accomplishments and lessons learned from the entire four-year State Innovation Model (SIM) grant period, from February 1, 2015, through January 31, 2019. It also discusses sustainability strategies for SIM initiatives and programs, as required in the Center for Medicare and Medicaid Innovation (CMMI) reporting requirements. The report format follows the CMMI required reporting format, slightly condensed.

At a high level, the programmatic components of SIM are:

- Accountable Communities of Health (ACHs)
- Payment reform test models
- Population health strategies and provider supports
- Community engagement, collaborative governance, and health equity

## Accountable Communities of Health

The nine regional ACHs are key drivers of health system transformation. They bring together public and private community partners to advance shared regional health goals and harness the collective impact of clinical delivery, community services, community members, social services, and public health.

## Payment Reform Test Models

Washington tested four payment redesign models as part of our vision for achieving better health and higher value through innovative strategies for payment, benefits, and financing. Preparing and launching these models required intensive community and market partnering, along with a willingness to move beyond traditional arrangements. These payment models are:

- Model 1: integrated managed care
- Model 2: encounter to value and rural health transformation

- Model 3: Accountable Care Program for public employees and retirees
- Model 4: multipayer data aggregation pilot

## Population Health Strategies and Provider Supports

To make changes to the health system and move to new models of care delivery, many supportive functions are necessary. These supports allow for new models of payment and care delivery to achieve greater success. Within the SIM initiative, these functions included:

- **Practice transformation and workforce capacity building**
  In partnership with HCA, the Washington State Department of Health (DOH) supported a Practice Transformation Support Hub for providers moving to value-based arrangements and integrated care. The Hub included an online portal to house vital resources providers could use in transforming their practices. Workforce capacity development activities included assessing the current landscape of health professionals, and building data collection and reporting tools to provide real-time workforce demand data and recommendations on the types of professionals needed and where.
- **Patient and family engagement**
  Engaging people and their families in care decisions is a vital, two-way conversation. We created a process for expert reviewers to certify patient decision aids.[1] Cultural humility in care coordination is also important, and we supported the Lummi Nation's development of a culturally-relevant care coordination tool.
- **Data, analytics, performance measurement, health information technology, and health information exchange**
  The Analytics, Research, and Measurement (ARM) team (formerly Analytics, Interoperability, and Measurement [AIM]), helped build capacity to translate, analyze, and visualize data, including data from Medicaid, Public Employee Benefits, and other sources. A dedicated interagency health information technology (HIT) team focused on HIT/health information exchange (HIE) by exploring appropriate exchange of substance use disorder information and developing a state-led clinical data repository. HCA worked with the Washington Health Alliance to create and maintain a state common measure set, and we also partnered with OFM to develop an all payer claims database.

## Community Engagement, Collaborative Governance, and Health Equity

Healthier Washington is a collaborative effort involving multi-sector state, regional, and community partners. The Healthier Washington initiative includes a strong governance structure that facilitates collaborative engagement and transparent communication across state agencies and geographic

[1] Patient decision aids are a means of helping people make informed choices about health care that take into account their personal values and preferences. Decision aids are a part of a shared decision making process, encouraging active participation by patients in health care decisions.

areas. We made strategic investments in health equity, engagement with tribal nations, and convening different groups of health system stakeholders throughout the SIM period.

# Summary: Initiatives and Strategies at a Glance

The table below describes each SIM program and pilot and plans for the future.

| Component/driver | Future plans |
|---|---|
| Accountable Communities of Health (ACHs) | ACHs will continue, supported by funding from the Medicaid Transformation (1115 Waiver), with incentive payments continuing through mid-2023. We are exploring strategies for sustainability of ACHs as organizations, with a focus on the functions they provide within the health system. Individual ACHs are also seeking additional funding and creating use-cases for their own sustainability. |
| Plan for Improving Population Health (P4IPH) | The Population Health Planning Guide is complete and available on our website. Our P4IPH initiative is embedded into the functions of the ACHs, and efforts to engage local health departments in chief health strategist work will continue. |
| Practice Transformation Support Hub: Connector function | DOH will continue to oversee connector services. |
| Practice Transformation Support Hub: Practice coaching, facilitation, and training | Coaching, facilitation, and training for practices will become a community asset after the SIM period. |
| Practice Transformation Support Hub: Hub Resource Portal (WA Portal), now called Healthier Washington Collaboration Portal (WA Portal) | DOH will continue to support and manage the Healthier Washington Collaboration Portal. |
| Shared decision making (SDM) | HCA will continue to certify PDAs as an agency process. Spread and scale efforts will continue, led by the Bree Collaborative. |
| Workforce/community health workers (CHWs) | Workforce development will remain a function of the state, in partnership with the Washington State Workforce Board. ACHs also have a required commitment to workforce development. |

| Component/driver | Future plans |
|---|---|
| Model 1: Fully integrated managed care | Legislation and funding is in place to continue integrated managed care, with full implementation on track for January 2020 in all regions, and as a key achievement milestone required for federal funding in the 1115 waiver. Efforts will continue with support and development of clinical integration for the coming years. |
| Model 2: encounter to value: alternative payment methodology (APM4) | Model refinement is underway with review and evaluation of financing and quality metrics, and discussions with FQHCs. |
| Model 2: encounter to value: Rural Multi-Payer model | This model is currently in development, pending further development from CMMI. HCA continues to engage with partners across the state and with federal partners with an eye toward engaging federal participation and implementation in the coming years. |
| Model 3: Accountable Care Program (ACP) | The UMP Plus plan will continue to be offered to public employees, and will be offered for the first time to school employees in 2020. |
| Model 4: Greater Washington Multi-payer | Components are being considered for agency contracts and new models, and continuation of this pilot is awaiting resources. |
| Performance measurement | The PMCC will continue to convene, supported by HCA. Washington's state common measure set will continue to exist and evolve, with public reporting on the measures provided by the Washington Health Alliance and APCD. |
| Health information technology/health information exchange (HIT/HIE) | Our interagency HIT/HIE investments will continue through support from state agency funds, HITECH funds, and Medicaid waiver support. |
| Data and analytics | HCA ARM team and RDA will continue to create data products to support ACHs, as well as continuing evaluation efforts for SIM and Medicaid Transformation. |

# SIM Evaluation Findings

As required by CMMI, we conducted an evaluation to determine the impacts of the SIM program. A federal evaluation, conducted by CMMI, is also forthcoming and will include a discussion of all states involved in the SIM Round Two investment. Washington partnered with the University of Washington (UW) Department of Health Services at the School of Public Health to conduct the state-led evaluation. The state also partnered with the Center for Community Health and Evaluation to evaluate ACHs, and the Research and Data Analysis (RDA) division at DSHS to evaluate the early adopter region of integrated managed care in Southwest Washington.

SIM was a large-scale endeavor with many different investments. Although state evaluation partners delivered final reports, results are preliminary. Despite this, there are clear successes in Washington, most notably building critical capacity and infrastructure for lasting systems change. Highlights from the SIM evaluation are below, pulled from the UW final report. While these are findings from UW, the Healthier Washington team agrees with their analysis and findings.

## Highlights: University of Washington Evaluation

**Leadership:** SIM worked best when leadership, vision, and governance were clear and consistent at the outset and during transformation to ensure buy-in and sustainability. Throughout the four years of SIM planning and implementation, SIM performed well when leadership was aligned with the triple aim.

**Vision:** The SIM initiative would have benefited from having more specific vision, goals, roles, and definitions of success clearly articulated for each program component at the outset, including a concept for how each component fit into the overall SIM initiative and related to other SIM components.

**Launch:** SIM successfully launched all the components laid out in its State Health Care Innovation Plan: nine Accountable Communities of Health, four payment redesign models, the Practice Transformation Support Hub, and the Analytics Research and Measurement Team (formerly known as Analytics, Interoperability, and Measurement).

**Siloed implementation:** Implementation of SIM components was structured generally in parallel programs that often operated in silos. To achieve statewide system change, implementation would have benefited from greater integration and partnership between components.

**Communications:** Clear, on-going communication is needed across interventions and among all participants. SIM had a general vision and much detailed work going on in the field, but SIM was missing those specific blueprints proposing options for implementation paths, as well as a model that described how the components worked together as a system to achieve the triple aim (better health, better care, and lower cost).

**Data ambitions and reality:** Data interoperability is critical for health systems transformation. Health data systems are still in the early developmental stages. For certain SIM components, it was

often difficult to secure accurate and complete data in a timely manner. Data issues were a major barrier to realizing the full potential of SIM.

**Promising early results:** SIM has built the infrastructure and foundation to launch future system transformation. Stakeholders support SIM goals and remain optimistic that SIM will eventually achieve the goals. SIM experience indicates that some improvements in the quality of health care have been achieved within the 2016–2019 time frame. Provider engagement has been important in early successes. SIM met its goal that, by January 2019, at least 50 percent of commercial payments are in value-based arrangements.

**Statewide transformation takes time:** Statewide system transformation is hard work and takes time to implement. SIM's experience suggests that achieving improved population health, better integration of care, and reduced health care cost growth statewide in three years is unlikely. Significant improvements in population health are difficult to achieve because they require patient engagement and community partnerships (e.g., to address social determinants of health). Effective cost control will likely take even longer.

**Critical preparation for system transformation:** SIM increased Washington's readiness for health system change in the next decade. It deepened understanding of how to do value-based payment and how to position the Accountable Communities of Health under the Medicaid Transformation Project.

**Going beyond the state as first mover:** The state has been an effective "first mover" for value-based payment, but the time is ripe to broaden and accelerate the scope and scale of value-based payment efforts in the state. The public sector should consider using its "bully pulpit" to leverage value-based payment and population health management among commercial payers and self-insured purchasers, and to bring in the Medicare population.

**Funding after 2022:** The state, in collaboration with its multi-sector stakeholders, needs to develop options to sustain work on the triple aim, especially after Medicaid Transformation Project funding ends. At a minimum, the state should continue to convene stakeholders, refine its internal operations and contracts, and monitor and apply for funding from new opportunities, including funding support from the State Legislature. It would be fruitful to explore philanthropic, association, and private funding sources, and to research other models to support desired system change.

## Highlights: Research and Data Analysis Evaluation

The RDA evaluation examined the impact the transition to integrated managed care had on the health and social outcomes of Apple Health clients in Clark and Skamania counties. Of the health and social outcomes examined, two-thirds showed no significant relative change in Southwest Washington from the previous year. However, the outcome measures that had significant differences were mostly positive for this region. For example, mental health treatment penetration, inpatient utilization, and diabetes screening rates for those with serious diagnoses such as schizophrenia or bipolar disorder showed statistically significant improvements.

# Background

## Legislation Overview

E2SHB 2572 (2014) directed the HCA to report annually on the progress of the innovation plan. While that section of the bill was vetoed, the Governor directed the HCA to comply with the reporting requirements. This report represents the final status report which summarizes accomplishments and lessons learned from the entire four-year State Innovation Model (SIM) grant period, from February 1, 2015 through January 31, 2019. It also discusses sustainability strategies for SIM initiatives and programs, as required in the CMMI reporting requirements. The report format follows the CMMI required reporting format, slightly condensed.

The Legislature supported the Innovation Plan when it passed E2SHB 2572 (2014) and 2SSB 6312 (2014) and when it funded further develop of Innovation Plan elements (in anticipation of a second SIM funding opportunity). The bills provided further support for Healthier Washington elements around quality and price transparency; community mobilization; clinical practice transformation; and integrated purchasing of physical health, mental health, and substance abuse services on a regional basis.

E2SHB 2572 (2014) outlined mechanisms for the state to improve how it purchases health care.

Provisions included:

- Designating and supporting Accountable Communities of Health (ACHs), regional organizations responsible for aligning community actions and initiatives to achieve healthy communities, improve health care quality, and decrease costs. This included awarding state-funded grants to support two pilot communities (followed by federal grant funding to expand to 9 regions).
- Using purchasing mechanisms to reduce extraneous medical costs across programs. HCA and the Department of Social and Health Services (DSHS) were directed to restructure Medicaid procurement on a phased basis to support integrated physical health, mental health, and substance use disorder treatment services. This restructuring was also consistent with 2SSB 6312 (2014) and Behavioral Health Task Force recommendations. Additionally, HCA was directed to use purchasing and payment incentives for Medicaid and Public Employees Benefits Board (PEBB) Program benefits that promote quality, efficiency, cost savings, and health improvement.
- Establishing a statewide all-payer claims database (APCD) to support transparent health care information reporting. Data suppliers submit claims data, including public purchasers, carriers, and voluntary reporting for self-funded employers.
- Developing standard statewide health performance measures through a Governor-appointed performance measures committee tasked with identifying and recommending statewide performance measures through a transparent process.

# What is Healthier Washington?

The Healthier Washington story began with a $1 million SIM grant in 2012 which funded a planning process for health system transformation in Washington. This grant, led by the Health Care Authority (HCA) in collaboration with many health and wellness system partners, culminated in the Washington State Health Care Innovation Plan (SHCIP).

In 2014, Washington was awarded a $64.9 million SIM Round Two grant, a large investment that put the SHCIP in motion across the state. This SIM Round Two grant, the first major investment under Healthier Washington, is largely responsible for much of the state-led health system capacity building between 2015 and 2019. It is also the focus of this report.

Within the original SHCIP, we developed three strategies to carry Washington through this journey. Although the wording and framing of these strategies evolved over the years, the overall intent remained the same. They included:

1. Driving value-based purchasing across the community, starting with the state as a "first mover."
2. Improving health overall by building healthy communities and people through prevention and early mitigation of disease throughout the life course.
3. Improving chronic illness care through better integration of care and social supports, particularly for individuals with physical and behavioral comorbidities.

## State Innovation Model Test Grant

The SIM Round Two grant application detailed the state's intent to implement the strategies developed in the SHCIP. The proposal included:

- Forming regional Accountable Communities of Health.
- Developing and implementing four payment redesign models, including integrating physical and behavioral health into managed care.
- Creating a Practice Transformation Support Hub.
- Creating a state common measure set.
- Developing a plan for improving population health.
- Pursuing projects related to health literacy, person and family engagement, and data and HIT investments.

The Center for Medicare and Medicaid Innovation (CMMI) awarded funding in late 2014 for a four-year grant period consisting of four "award year" periods. The grant began February 1, 2015 and concluded January 31, 2019. We began using the name Healthier Washington to frame this system-wide effort that evolved to encompass more than just SIM grant activities.

Washington's health system transformation landscape is vast and complex, with many individuals and organizations leading change all over the state. SIM has been an exercise in effective partnership as much as state-led innovation, seeking where possible to augment and catalyze

change. There are also other large-scale transformation efforts outside of SIM, including Washington's Medicaid Transformation work. This 1115 waiver, finalized in early 2017, leverages much of the infrastructure SIM had put in place, including Accountable Communities of Health.

## Medicaid Transformation Project

Healthier Washington is a system-wide initiative with a multitude of implemented projects, each intended to address care delivery, costs, and outcomes. In January 2017, after two years of detailed negotiations, HCA — in partnership with DSHS — and the federal Centers for Medicare & Medicaid Services (CMS) reached agreement on a five-year Medicaid 1115 demonstration waiver to continue and accelerate Healthier Washington initiatives. The waiver, called the Medicaid Transformation project, provides up to $1.1 billion of incentives for delivery system reform, with $375 million dedicated to fund long-term supports and foundational community services for Washington Apple Health (Medicaid) clients. The Medicaid Transformation goals reinforce the overarching goals of Healthier Washington initiative. The goals of the five-year demonstration are:

- Reduce avoidable use of intensive services and settings such as acute care hospitals, psychiatric hospitals, nursing facilities, traditional long-term services and supports, and jails with behavioral health integration;
- Improve population health, with a focus on prevention and management of diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders, and oral health;
- Accelerate the transition to value-based payment using payment methods that take the quality of services and other measures of value into account; and
- Ensure that Medicaid per-capita cost growth is below national trend through projects and services that improve health outcomes and reduce the rate of growth in the overall cost of care for Medicaid clients.

These goals will be achieved via three initiatives:

1. **Transformation through Accountable Communities of Health**. This initiative provides communities with financial resources to improve the health system for Medicaid clients at the local level. Each region, through its ACH, will pursue projects aimed at transforming the Medicaid delivery system to serve the whole person and use resources more wisely. These projects are aimed at:
    - Health systems capacity building: Support for development of new value-based care models; workforce development, including non-conventional service sites; and improvements in data collection and analytic capacity.
    - Care delivery redesign: Bidirectional integration of physical and behavioral health care; improved care coordination, including clinical-community linkages; and better transitions between services and settings.
    - Prevention and health promotion: Focused on chronic disease prevention and management, and maternal and child health, for Medicaid clients.

The Medicaid Transformation is not a grant. ACHs and their partners receive funds only after they meet project goals. In the early years, payments will be made for meeting process milestones. Later, payments will be based on performance on specific outcome measures.

2. **Broaden the array of service options that enable individuals to stay at home and delay or avoid the need for more intensive care**. The state is creating a "next generation" system of care that supports families in caring for loved ones, delaying or avoiding more intensive long term services and supports when possible. We're working toward these outcomes by creating better linkages within the health care system and building a robust system to support the broad range of paid and unpaid medical and personal care assistance that people may need — for several weeks, months, or years — when they experience difficulty completing self-care tasks as a result of aging, chronic illness, or disability. Two new limited benefit packages — Medicaid Alternative Care and Targeted Supports for Older Adults — provide these services.

3. **Provide targeted foundational community supports.** Targeted supportive housing and supported employment Medicaid benefits will be available to clients most likely to benefit.[2] We built this initiative around the growing body of evidence linking homelessness and unemployment with poor physical and mental health. While Medicaid funds will not be used to provide housing or jobs, supportive services can promote stability and positive health outcomes while preventing homelessness and dependence on costly medical and behavioral health care, including long-term institutional care.

In July 2018, CMS approved an amendment to the state's Medicaid Transformation waiver. The waiver allows federal Medicaid funding to be used for services provided to Apple Health clients to treat opioid addiction and other substance use disorders (when those services are offered in in-patient settings or facilities larger than 16 beds) and are primarily treating mental health or substance use.

Medicaid Transformation will continue through December 2021, with Medicaid incentive payments scheduled through 2023.

While SIM and Medicaid Transformation funding have always been separate, the work involved in each is integral to health care system evolution in our state.

[2] Supportive housing services are designed for people who experience chronic homelessness, frequent or lengthy institutional contacts or stays in residential care, frequent turnover of in-home caregivers, and a PRISM (Predictive Risk Information SysteM) Risk score of 1.5 or above. Supported employment services target people enrolled in the Aged, Blind or Disabled program or the Housing and Essential Needs program, people diagnosed with severe and persistent mental illness, substance use disorder, or co-occurring mental illness and SUD, vulnerable youth and young adults with behavioral health needs, and people who receive long-term services and supports.

However, this report focuses on the State Innovation Models work and the final status report for the SIM funded activities, following the federal reporting format.[3] We are proud of our efforts in Washington, and our evaluation partners confirm these investments have led to improvements across the system, including creating critical infrastructure for continued systems change.

**Figure 1: Healthier Washington and How It Connects to Communities**

Note: Visit the Healthier Washington website for a downloadable version of this poster.

[3] Refer to Medicaid Transformation-focused reports for more details on that implementation effort: https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources

# Progress Toward Achieving Innovation Plan Aims

## Accountable Communities of Health

ACHs are a structural backbone to health system transformation in Washington State. These regional entities form the infrastructure needed for our collaborative and regional approach.

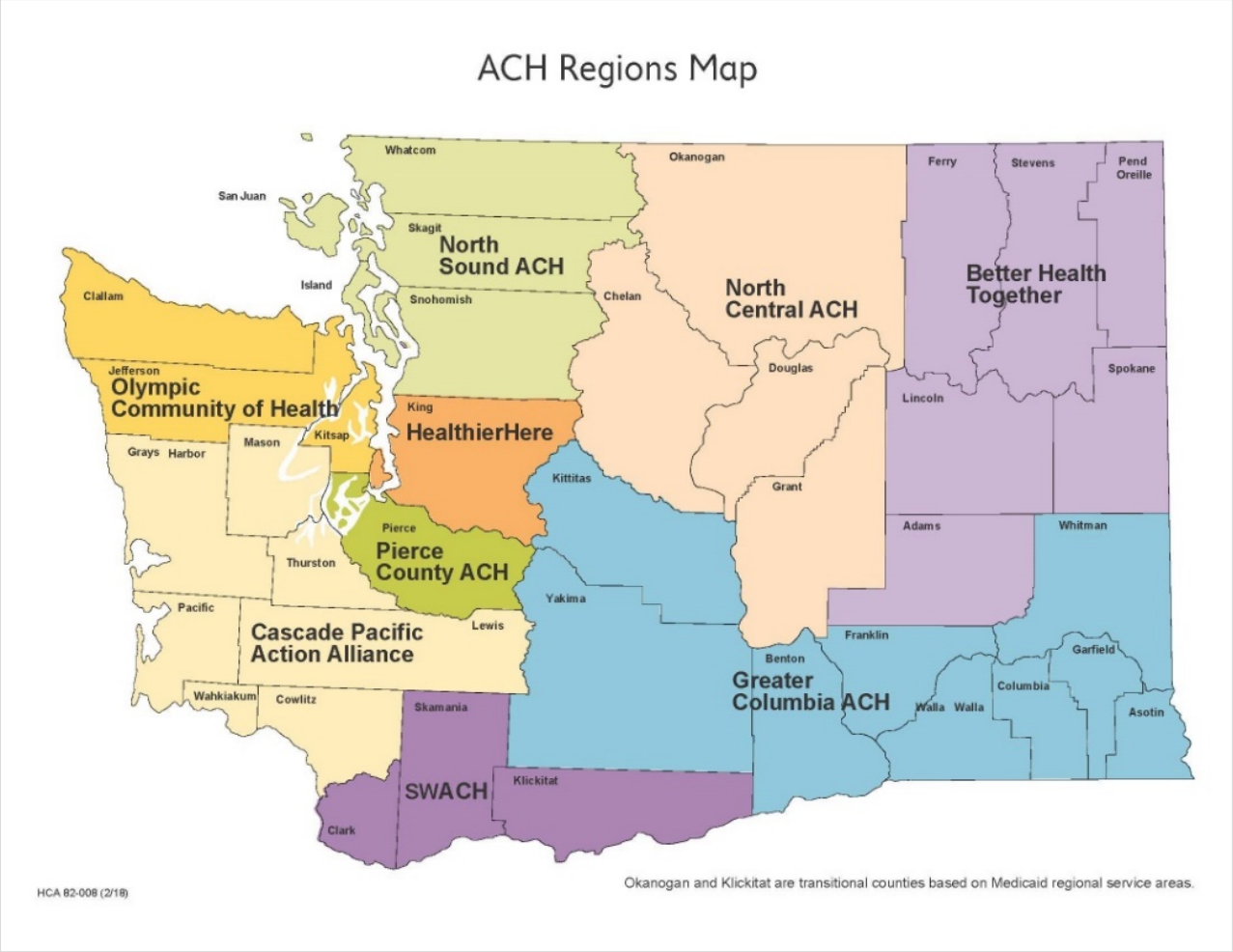
State legislation authorized ACH development in 2014, signaling support from policy leaders for community engagement. SIM investments and state support enabled Washington to implement the 2014 legislation and formalize regional collaboration through ACHs to reinforce and build upon existing partnerships. ACHs were developed during the SIM period.

During the SIM period, ACHs formed and became legal entities, built relationships with traditional and non-traditional health and wellness system partners, and collaborated with the state to develop projects and plans for addressing the health concerns and opportunities in their regions.

ACHs became heavily involved in Medicaid Transformation (the state's Section 1115 waiver), as the waiver relies on ACHs to serve as lead entities for implementing regional projects, delivering incentive dollars to providers, and partnering with the state to develop statewide structures and processes.

This intentional work makes strategic use of these collaborative, community-based entities. However, ACHs are not revenue-producing entities and are not projected to become service providers. The Medicaid Transformation project will support ACHs through the waiver period, scheduled to end in 2021, with performance incentive payments scheduled into 2023.

**Figure 2: Accountable Communities of Health by Region**




## Year 1 Accountable Communities of Health Activities

Award year 1 began with continued design of what an ACH might be and how it might be operationalized. This ACH design continued through regional engagement in "design regions." Two design pilots were officially designated as ACHs in the second quarter: North Sound and Cascade Pacific Action Alliance. Design and implementation activities continued through the rest of the year, including regional health needs assessments, multi-sector coalition meetings, and project design and implementation in pilot regions. All nine ACHs were officially designated by January 31, 2016, a scheduled milestone for the first award year.

The Center for Community Health and Evaluation (CCHE) was selected to evaluate ACH performance across the SIM period. Because ACHs were evolving entities of an entirely new type, CCHE's evaluation structure was participatory and relied heavily on bidirectional conversations and feedback to create a flexible evaluation approach that could build in new knowledge. Throughout the SIM period, CCHE provided feedback, facilitation, and in-person support as ACHs

shaped themselves, performed regional health needs assessments, and developed strategic plans for how to improve health outcomes in their regions.

## Year 1 Accountable Communities of Health Activities

In the second year of SIM, ACHs began to develop as organizations. The state provided cross-collaboration support in the form of weekly calls and quarterly meetings. The Analytics, Research, and Measurement (ARM) team also provided significant data support through Healthier Washington data dashboards, which launched in award year 2. This year, ACHs were each required to design a regional project to implement. Project themes included chronic disease self-management (supported by community health workers), long acting reversible contraceptive use, opioid crisis response strategies, and care coordination.

Five of the nine projects centered around or utilized community health workers in some way, though the target populations and focus conditions varied. Two of the nine projects required Medicaid client administrative data, which sparked a novel data-sharing strategy by the ARM team to support these needs. All proposed projects demonstrated some degree of linkage between population health strategies and the care delivery system.

In the latter half of award year 2, ACHs moved to implement these projects, with help and guidance from the state. In January 2017, we reached an agreement in principle on the Medicaid Transformation 1115 waiver, an acceleration of health system transformation in Washington that featured the ACHs as critical infrastructure for Medicaid Transformation project implementation and funds flow to providers. At this time, ACHs began to reassess project spread and scale opportunities to align with future Medicaid Transformation projects.

## Years 3 and 4 Accountable Communities of Health Activities

ACHs continued to mature as they focused on the process of becoming legal entities. This involved no longer relying on a "backbone organization," and developing the capacity to enter into contracts with outside organizations and providers. ACHs also continued to invest in population health strategies, working within their regions to engage the community and focus on regional issues of social determinants of health and health equity.

Data and analytic support was critical to developing these strategies, and the ARM team proactively pursued relationships with ACH data teams to support evolving data needs. In award year 3, CCHE did an analysis and created a work plan for population health 'hard-wiring' within ACH regions. This work plan supported continued focus on whole-population health strategies. Medicaid Transformation Year 1 and SIM Year 4 coincided, and ACHs focused within SIM on specific whole-population health strategies, most notably around community engagement and health equity.

ACHs provided representation on the Health Innovation Leadership Network's Communities and Equity Accelerator Committee. North Sound ACH invested in specific health equity training and

development in their region, while also partnering with other ACHs to share knowledge and lessons learned. All ACHs have some forum for community engagement, and about half also set up Community Voice Councils to ensure the public had a voice in strategic planning and implementation. In award year 4, ACHs began discussing organizational sustainability as required under the federal grant.

## Next Steps

ACHs began implementing their Medicaid Transformation projects January 2019. They will continue to focus on that work for the next few years. Concurrently, ACHs will continue to deepen partnerships with community-based organizations and partners across the health and wellness sector, invest in prevention and social determinants of health programs to help save dollars in the delivery system later, and test strategies for cost-savings and reinvestment opportunities.

While ACH funding will continue through the Medicaid Transformation, with incentive payments scheduled through 2023, conversations continue around the ACHs' community-defined roles and potential policy-defined roles. These conversations focus on defining the unique role ACHs play in ongoing health transformation and population health strategies, while recognizing existing regional health system capacity and infrastructure — apart from the ACH.

The state continues to explore policy and other related methods to support ACH sustainability. Ongoing assessment and evaluation activities related to Medicaid Transformation will inform these conversations.

## Lessons Learned

- Strong clinical and payer engagement is foundational to long-term delivery system reform transformation. This means that shifting resources for investments in prevention programs will take time. Thoughtful attention should be given to align overall payment reform and regional health care system transformation.
- There are many challenges surrounding data access and exchange, especially around social determinants of health data. For readily available Medicaid claims data, the ARM team successfully employed creative data sharing solutions that met the majority of ACH data needs, which could be met from available data and sharing "small numbers" granular data. However, some ACHs are interested in protected health information and social determinants data. These requests pose a challenge, in part because the ACHs are not Health Insurance Portability and Accountability Act (HIPAA)-covered entities, a designation required to manage protected health information. We are still exploring these challenges, and we expect answers will emerge as ACH roles mature and there is better understanding of ACH-level population health management goals.
- There is a tension — even though desired outcomes are the same — between community-driven transformation and the state's role in supporting, leading, and providing guidance and standards. If organizations' efforts are too independent, there may be duplication and

fragmentation. The alternative requires a larger state role and a more assertive and prescriptive approach.

## Working With Washington's Tribal Governments

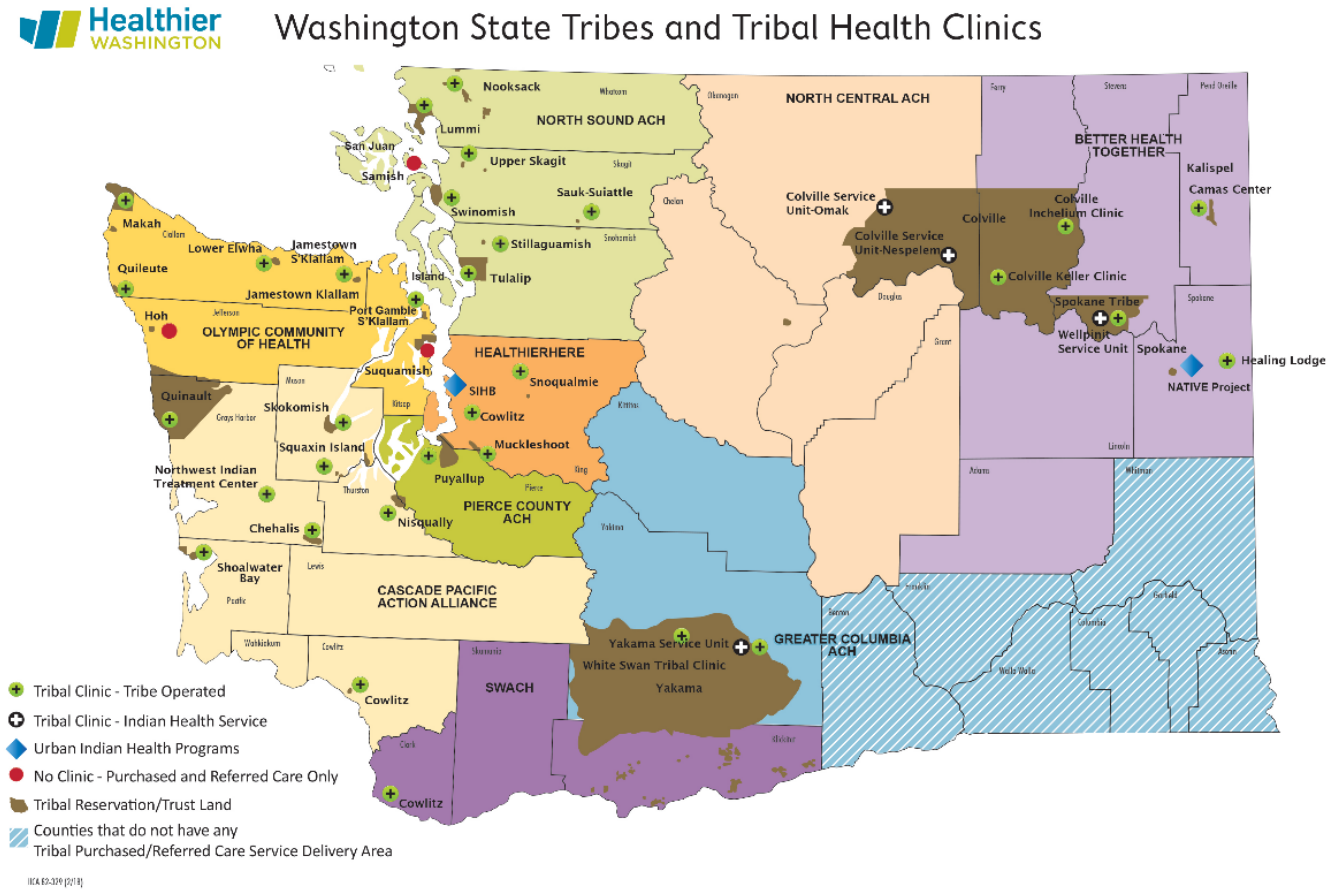
SIM included a strategy for engaging with Washington's tribal governments in achieving better health outcomes. This included funding for the American Indian Health Commission (AIHC) to meet with and provide guidance to Washington's 29 tribes and two urban Indian health programs. The conversations focused on potential implications of Washington's ACH design and implementation on tribal and urban Indian communities.

AIHC also provided technical assistance to HCA, ACHs, and tribes on ACH design and implementation and meeting the needs of the tribal communities they serve. Partnering with the AIHC was vital to the ongoing evolution of tribal health system transformation, a government-to-government process with differing systems, payment mechanisms, and priorities.

As the ACHs evolved, we learned that engaging with ACHs was difficult for tribes because of ACH regional placement. Tribal land boundaries overlapped with multiple ACHs, and tribes did not have the capacity to engage with multiple ACHs, often with different priorities or operating procedures.

We addressed these challenges in the Medicaid Transformation Project 1115 waiver by allocating funds specifically for tribal health system transformation projects. Funds were not distributed to tribes or tribal providers through ACHs. We also provided funding to the Lummi Nation to support a pilot project for the tribe to create a culturally appropriate care coordination tool.

**Figure 3: Washington State Tribes and Tribal Health Clinics**




# Value-Based Payment Models

## Payment Model 1: Integrated Managed Care

Part of HCA's goal to create a system that provides better care and leads to better health outcomes is a commitment to taking care of the whole person. Part of this whole-person care strategy is to integrate physical and behavioral health purchasing and payment into Medicaid managed care. Before 2016, all of Washington's Medicaid clients, except fee-for service clients, [4] received physical health services through a managed care organization (MCO), mental health services through regional service networks, and substance use disorder treatment services through a county-based system. This division created separate health care delivery systems that were difficult for clients to navigate — especially for clients with co-occurring physical and behavioral health conditions.

After listening to different stakeholders in the community, we included a strategy in the SHCIP for integrating behavioral health services into managed care. The original strategy aimed to match

[4] Fee-for-service clients represent around 10 percent of the state Medicaid population.

Medicaid purchasing regions with ACH boundaries, and allow MCOs to be the accountable entity for the whole health of the population they serve in that region. After we developed the plan, state legislation provided additional support and direction.

E2SHB 2572 (2014) and 2SSB 6312 (2014) included language supporting integrated managed care and mandating that all regions transition to this arrangement by January 1, 2020; the integrated managed care phase-in began in 2016, and the final regions will be phased in on January 1, 2020. This legislation also directed the state to integrate mental health and substance use disorder treatment services through local behavioral health organizations (BHOs) as an interim step to full integration.

The Legislature passed legislation in 2018 to move the Division of Behavioral Health and Recovery (DBHR) from the Department of Social and Health Services (DSHS) into the HCA by July 2018. This change made one state agency responsible for administering whole-person care to Medicaid clients.

## Year 1 Integrated Managed Care Activities

This first year of SIM was a planning and development year for integrated managed care. While foundational legislation passed in 2014, there was still a large amount of work to do to ready partners. We developed an incentive structure to help divide state regions into three transition groups:

- Early adopters would go first and have access to additional time and incentive funding.
- Mid-adopter regions would go next, also with access to additional time and incentive dollars.
- On-time adopters would move forward by the 2020 legislative deadline and not have access to additional incentive funds.

This transition process also involved work to phase out the previous behavioral health purchasing structure through regional service networks and counties (and later the BHOs), whose functions would now be MCO responsibility.

## Year 2 Integrated Managed Care Activities

A major milestone early in award year 2 was the adoption of integrated managed care in the first state region on April 1, 2016. This region, comprised of Clark and Skamania counties in the Southwest Washington ACH, worked closely with HCA and DSHS to make the transition. Behavioral health providers partnered closely with the state and the county to prepare for new billing and reporting practices, and MCOs worked to ensure a smooth transition for clients and providers in the region.

## Year 3 Integrated Managed Care Activities

In award year 3, we focused on transitioning our first mid-adopter region, North Central Washington (Douglas, Chelan, and Grant counties), and continuing to help with implementation and monitoring of the recently-transitioned Southwest Washington region. Identification of and readiness activities for additional mid-adopter regions began, and a plan for additional financial

incentives through the Medicaid Transformation project took shape. At the end of award year 3, the North Central region was the second region in the state to transition to integrated managed care. This occurred on January 1, 2018.

## Year 4 Integrated Managed Care Activities

Readiness activities continued in earnest for several regions preparing to transition: King, Pierce, Greater Columbia, North Sound, Spokane, Klickitat County (to join the Southwest Washington region), and Okanogan County (to join the North Central region).

- King, Pierce, Greater Columbia, and Spokane regions, and Klickitat and Okanogan counties transitioned January 1, 2019, the last month of the SIM period.
- The North Sound region transitioned July 1, 2019.

Readiness activities also began for on-time adopter regions planning to transition in 2020, and we continued to support the early-adopter and mid-adopter regions.

## Next Steps

We will continue supporting regions and providers that already transitioned and regions that are planning to transition. After a delay, the North Sound region transitioned in July 2019. Cascade Pacific Action Alliance and Olympic Community of Health regions are scheduled to transition on January 1, 2020.

Once all of Washington's regions move to integrated managed care, we will continue supporting providers, clients, MCOs, county governments, and other partners in their work to support the whole-person health of individuals and families and ensure full clinical integration of care.

The Medicaid Transformation project has contracted with an independent external evaluator, Oregon Health Sciences University. The evaluation plan contains research questions about integrated managed care to allow us to continue to measure the impact of our efforts in the coming years.

Once financial and administrative integration are complete, partners can implement new strategies for clinical integration across the state. Washington is in the beginning stages of creating a vision for clinical integration, and we will continue partnering with key stakeholders to develop goals and guidelines.

## Lessons Learned

Through this process of integrating our Medicaid purchasing regions, we learned many lessons. Most notably, we learned that system changes take time and patience. While regions have similarities, each requires unique attention to navigate regional differences. In terms of provider support moving from one payer to multiple MCOs was very challenging for many behavioral health providers; they had to make many billing workflow and organizational process changes. These changes included updated system configurations, differences in contracting, changes in submitting

# Payment Model 2: Encounter to Value and Rural Health Transformation

Payment model 2, Washington's rural health payment strategy, included two payment models in one approach.

One track focuses on rural health clinics (RHCs) and federally qualified health centers (FQHCs). These critically important providers support rural and underserved populations primarily covered by Medicaid.

The state engaged these providers to move away from encounter-based requirements in favor of an alternative payment methodology (APM) that supports value-based care. This flexible payment strategy encourages innovation through financial incentives and improved outcomes based on quality, and allows for positive changes in care delivery. Called APM4, this APM is the fourth iteration of alternative payment for these facility types.

The second payment model track, the Rural Multi-Payer model, is a strategy to target critical access hospitals through value-based payment reform, access to data, and care transformation. Washington's critical access hospitals are also at the heart of rural health delivery.

Thirty of Washington's 39 counties are rural and have less than 100 people per square mile. A network of RHCs, FQHCs, and small rural hospitals serves these residents. The people living in these rural communities experience unique barriers to optimal health, including lower access to quality care, increased disparities in health outcomes, and decreased connections to social determinants of health.

Rural health delivery systems face issues related to thin margins, underutilization, and difficulty recruiting and retaining health professionals. For these reasons, a distinctive strategy to transform health and wellness in rural areas has been a foundational interest of the Healthier Washington initiative.

## Alternative Payment Methodology 4

### Years 1 and 2 Alternative Payment Methodology 4 Activities

Award years 1 and 2 focused on developing overall strategies for Alternative Payment Methodology 4 (APM4). These strategies led with policy development and stakeholder engagement with FQHCs and RHCs, provider associations, and managed care organizations. Our strategy was to address historical issues unique to FQHCs and RHCs while transforming to value-based care. Our principle goal was to advance value-based purchasing; introduce downside risk; and, as the system transformed, slowly increase accountability.

APM4 participants receive a guaranteed minimum payment (based on federal requirements) and as care delivery shifts toward population health and value-based care and away from fee-for-service, participants are rewarded based on the quality of care. This supports expanded care teams, new

operating procedures, increased access, and becoming a provider of choice. To design and implement the model, we:

- Supported subject matter experts and conducted modeling for new payment arrangements in 2016 and 2017.
- Facilitated working sessions with MCOs, FQHCs, and RHCs, representative associations, and state leadership during 2016 and the first quarter of 2017.
- Established a principled agreement on a proposed model and key design elements in April 2017.

## Years 3 and 4 Alternative Payment Methodology 4 Activities

After a focused period of working with FQHCs and RHCs to finalize and execute agreements, APM4 launched July 1, 2017 with a self-selected group of 16 FQHCs. These 16 were out of 26 FQHCs total in Washington.

While early adoption was promising with one RHC, they dropped out based on technical capacity challenges to adopt the model. With participating clinics, we ultimately chose to implement the model as a rate change, using current processes and existing systems. The flow of dollars and process for reconciliation did not change from the previous way of doing things, though new requirements for metric reporting and incentive payments were included.

## Next Steps

Based on initial assessment of the 2017 experience we are currently discussing model refinements with FQHCs.

## Lessons Learned

- Persistence is key to success. Health system transformation is not easy and takes time. We had an extensive engagement process and shifted how we interact with providers. It is also important that partnerships do not end with signed agreements — a commitment to long-term implementation is required.
- Flexibility is important to success and builds trust. We had to be flexible as we developed the quality and reconciliation process. These models are complex and require both parties to collaborate and recognize limitations.
- This kind of health system change requires leadership support, vision, and culture change. We were ultimately successful in reaching pilot implementation because there were leadership champions who advocated for the work and removed barriers.
- Ongoing, close monitoring and refinement will be important over time. Accountability must be bidirectional, and appropriate monitoring and attention to risks and issues as they arise is critical.

## Rural Health Transformation

### Years 1 and 2 Rural Health Transformation Activities

In developing the strategy for our hospital-focused rural health transformation work, we started our engagement process at the end of 2015. HCA had conversations with the Washington Rural Health Access Preservation (WRHAP) group in 2016 and early 2017. WRHAP hospitals are small, financially stressed hospitals. After extensive conversations, the state was not able to advance their proposal as a CMMI project because it was not in alignment with the value-based purchasing goals and the more inclusive multi-payer requirements from CMMI. Ultimately, the WHRAP group was able to get legislative support for their proposal, and we have continued working on the modest WHRAP payment transition activities, while continuing to engage with a wider set of stakeholders and partners to develop a broader rural health multi-payer strategy.

Key stakeholders and partners included rural hospital CEOs and board members, the Washington State Hospital Association, and federal partners from CMMI. After preliminary conversations with this wider set of stakeholders, we relaunched our efforts to develop a model with a wider scope.

### Years 3 and 4 Rural Health Transformation Activities

After recognizing the need for fundamental change across all rural providers, we took a new approach to meet model goals and continue the work. At the end of 2017 and through 2018, we relaunched the research and development of this portion of payment model 2 to be more inclusive of other rural hospitals, MCOs, and commercial payers.

Years 3 and 4 focused on partnering with payers and providers to develop a new model, working closely with federal partners, and contracting with experts to assist with model development and financial analysis. The relaunch garnered broad interest, and providers and payers continued to be cautiously interested in transformation.

- This new iteration of our Rural Multi-Payer approach proposes a hospital global budget methodology, with attributes unique to rural Washington. We held working sessions with payers during the last quarter of the SIM grant, once a preliminary model was in development. We discussed the model and sought early interest. In February 2018, we received letters of interest representing 49 organizations showing interest in partnering with the state on pursuing a new rural model, and we worked closely with experts at CMMI to talk through model development. At the end of award year 4, we submitted a concept paper, proposed model, and financial analyses to CMMI for review and feedback.

### Next Steps

The sustainability and future development of the Rural Multi-Payer model is contingent upon CMMI input and recommendations. While there is market readiness to pursue a state-led model, much of our rural hospital revenue is dependent on Medicare, federal partnership, and participation. Washington is committed to rural health system transformation, and we will adjust our approach based on CMMI input and future partnership opportunities. As we work to develop that partnership, we will continue engaging health system stakeholders.

### Lessons Learned

- The pathway for development of rural transformation strategies is an iterative process to:
  - Seek principled agreements on shared goals, and use those to develop a model.
  - Reach agreement with authorizing environments to inform implementation and operational model needs.
  - Reach agreement with providers and payers, and develop detailed roles and responsibilities.
  - Coordinate readiness activities and then implement models.
- Internal support and alignment are important to ensure expectations are clear and people know how to engage.
- We need to establish clear goals and outcomes for the model early — and refer to them often — because changes can create confusion.
- It is challenging to move forward without further direction from CMMI. We hope to have clear direction from federal entities to maintain stakeholder engagement.

## Payment Model 3: Accountable Care Program

As a purchaser, HCA is positioned to test new models of accountable care for public employees enrolled in the state's Public Employees Benefits Board (PEBB) Program. As outlined in the SHCIP, an early strategy for health transformation was to create an accountable care organization-like model, soliciting formal networks of providers and health systems that would agree to assume financial and clinical accountability for a defined PEBB member population.

In turn, these networks would provide "best-in-class" patient service and experience — including access to high quality and timely service at lower costs — and deliver integrated physical health, mental health, and substance use treatment services. The Accountable Care Program (ACP) has been successful in exploring accountable networks of care for PEBB members. The program has reached milestones on member enrollment, performance measure outcomes, and programmatic sustainability.

### Year 1 Accountable Care Program Activities

HCA released a request for applications to choose provider networks for the ACP in the final quarter of 2014, before the SIM program formally launched. Award year 1 consisted of focused conversations with health system respondents, as well as payers already providing services to PEBB members. We also held monthly calls with the Boeing Company, a local purchaser that had already launched an ACP for their employees. These calls allowed us to learn and benefit from their implementation for our own program.

In the second quarter of award year 1, we selected two provider networks to participate in the ACP: UMP Plus—Puget Sound High Value Network and UMP Plus—UW Medicine Accountable Care Network. These two networks agreed to start providing accountable care benefit options to public employees living in the five-county Puget Sound region starting January 2016.

After we selected the networks, work focused on operations and implementation. This included planning for 2016 open enrollment, partnering with Regence as third-party administrator (to handle claims processing and prior-authorization services), and communicating to public employees about the new program. The UMP Plus program launched January 2016, serving 10,569 public employees who enrolled during the preceding open enrollment period.

## Year 2 Accountable Care Program Activities

Year 2 activities focused on continued outreach to public employees prior to 2016 open enrollment and working with the ACP networks on expansion into additional counties. We added four additional counties for 2017: Grays Harbor, Skagit, Spokane, and Yakima. HCA provided technical support to each network.

Year 2 open enrollment successfully increased membership in each network by 25 percent. Membership increased 50 percent for the program as a whole from 2016 to 2017. Both networks performed to the state's satisfaction on clinical and financial performance measures.

## Years 3 and 4 Accountable Care Program Activities

In award years 3 and 4, enrollment continued to grow. In 2017, UMP Plus covered more than 25,000 enrollees, and that number grew to more than 30,000 in 2018. Clinical and financial quality remained satisfactory. In award year 3, the program transitioned fully to state agency operations, no longer needing SIM investments to function. Although we made additional attempts to expand, no additional counties were added during this time. We also worked to create a more attractive premium differential between UMP Plus and our traditional participating provider organization plan (UMP Classic), and succeeded in lowering the ACP plan premium relative to UMP Classic.

In addition to ACP-centered work, Healthier Washington's payment model 3 also focused on spreading and scaling value-based purchasing to organizations across the state. This strategy included many group and individual meetings with local purchasers to share strategies and understand the barriers employers encounter when attempting to move to ACO-like arrangements. We also shared redacted contracts and emphasized using quality measures from the state common measure set in contracting.

Using our own contract leverage, HCA required the ACP third party administrator to offer a similar benefit plan to its commercial market portfolio. Payment model 3 efforts also included internal work on the creation of bundled payment strategies, performance-based withholds in Medicaid, and a Centers of Excellence program for public employees.

When the Legislature directed HCA to purchase care for Washington State school employees starting in 2020, we committed to exploring a statewide ACP-like offering to this new population. In early 2018, the state decided to extend the ACP contracts, rather than re-procure, and include the school employee population. ACP negotiations for public employees and school employees for 2020 to 2024 began in early 2019.

## Next Steps

HCA determined that the best way to deliver high quality and high value care to public employees is through the ACP. At the time of this writing, HCA is negotiating contract extensions for 2020 and beyond with each network.

Next steps also include developing a similar offering for school employees through the new School Employees Benefits Board (SEBB) Program. SEBB is currently in development; open enrollment for school employees will begin in October 2019 for coverage in January 2020. UMP Plus will be an option for the SEBB population in the first year of the program.

## Lessons Learned

- Overall, member experience was very positive with a high retention rate for UMP Plus enrollees.
- While we were successful in launching and growing UMP Plus, we hoped to encourage other employers to adopt direct provider contracting models. We found instead that most employers did not believe they were ready or did not believe they had the capacity and expertise to purchase care for their employees in this way.
- We encountered difficulty expanding UMP Plus into additional counties. Our original goal was for the networks to be statewide. However, the networks faced myriad challenges engaging new providers in additional counties. These challenges largely reflected market infrastructure readiness, capacity, and willingness to consider risk.

# Payment Model 4: Greater Washington Multi-Payer

The intent of payment model 4 was to test whether multipayer participation in an innovative claims and clinical data aggregation platform could advance value-based purchasing by empowering providers to take on risk, improve care coordination, and more effectively manage population health.

Our strategy for the SIM period was to procure a contractor to build the data aggregator and partner with provider networks to test whether this better information access could produce process and outcome improvements. In essence, model 4 explored the kinds of systems that could give providers the most complete health information to manage the health of their attributed population in real time.

HCA released an ambitious request for proposals, requiring a lead organization to take on a certain degree of risk over an expansive model and we received no bids. We then developed a modified version of the model that focused on providing claims data from Medicaid and public employees to two provider networks, with the help of data vendors. This more targeted approach led to two pilot demonstrations, one with a rural provider network and one with an urban provider network.

While more data aggregation strategy than payment model, this effort taught us many lessons about creating and managing multipayer data feeds and presenting them to providers in an

accessible way. This effort was also an interesting exploration of current market forces around the desire and ability to share and aggregate data on a larger scale. It also uncovered the difficulty and cost associated with a state agency managing data from multiple sources.

## Years 1 and 2 Greater Washington Multi-Payer Activities

In September 2015, HCA released a Request for Applications (RFA) for payment model 4. The RFA detailed ambitious targets for the creation of a statewide, multipayer network by the prospective contractor. HCA received two letters of intent to apply, but received no applications from vendors.

In the following months, HCA re-evaluated the model 4 direction and scope. After extensive discussions with payer and provider stakeholders, HCA recognized it needed to scale back contractor requirements and pursue a pilot-style approach in a more targeted environment. In the first quarter of award year 2, we developed a new vision to pilot this approach with a provider network.

By the end of the year, we finalized contracts to work with one rural provider network, Summit Pacific, and one urban provider network, Northwest Physicians Network (NPN). As part of their contracts, each network completed a baseline report on quality measures.

## Years 3 and 4 Greater Washington Multi-Payer Activities

With contracts in place, the work of providing data feeds and aggregating data began. HCA performed data transmission, and each contractor worked with their data vendors to receive transmissions. Additionally, a data vendor ensured that provider networks could receive the data in a usable format, without needing to have in-house analytic expertise. Data sharing agreements, security design reviews, test transmissions, and other required processes took extensive work to complete.

We encountered additional challenges in award year 4. One of the networks terminated their agreement with the data vendor due to the network being acquired by another company. This delayed progress because we had to repeat data transmission requirements.

HCA also encountered issues with including pharmacy data because of substance use disorder privacy concerns. Once we addressed these challenges by excluding particular data elements, we were able to send data to the networks and they were able to access patient panel information and test how it could support them in delivering better care. The fundamental data-sharing model that was ultimately developed was successful, leading to many lessons learned around sharing claims data with providers to drive population health management.

### Next Steps

Although NPN and Summit Pacific provided post-SIM sustainability plans, additional funding is required to continue the same activities. In the absence of funding, there is no current commitment to continuing the work. In spite of this, HCA values both the fundamental data-sharing model and its worth for providers.

We added a requirement in the MCO contracts that each plan submit its entire assignment roster to HCA each month. This requirement supports our future capacity to engage providers in a similar data sharing strategy by allowing us to see which clients are assigned to which primary care providers. This information could then be used to improve care coordination and population health management. We also ensured that HCA's Enterprise Data Management and Analytics (EDMA) Division, which handles this type of data transmission work, is prepared to support future needs.

### Lessons Learned

- The original model 4 RFA effort was ambitious. Unfortunately, no payer, provider, or vendor organization had the necessary infrastructure, capacity, and readiness to respond to the RFA.
- Getting NPN, Summit Pacific, and their data aggregation vendor through the Washington State Office of the Chief Information Officer's security design review process was a significant challenge that took considerable time and effort to complete.
- Security and privacy concerns caused delays implementing the data-sharing process, even after NPN and Summit Pacific completed the security design review.
- Both NPN and Summit Pacific faced "small numbers" challenges in compiling data for some of the quality measures.[5]
- Familiarizing the MCOs with the encryption process to transmit their assignment files was challenging and took longer than expected. Issues with consistent transmission continued through the duration of the model.

# Population Health Strategies and Provider Supports

## Practice Transformation

Practice transformation provides investments in knowledge, training, and tools to effectively coordinate care, promote clinical-community linkages, and transition to value-based care. We operationalized practice transformation by creating a Practice Transformation Support Hub (Hub), an online provider resource portal. The Hub was developed as a transitional resource to be used during the SIM years. Now, the role of practice transformation support has transitioned to the

[5] Small numbers challenges refer to situations where the number of patients in a subset of data is so small, they are potentially identifiable.

ACHs. The Hub remains a valuable resource of curated online tools for practices in all stages of transformation.

## Practice Transformation Support Hub

### Years 1 and 2 Hub Activities

Developing the Hub began with a state tour of listening sessions. These sessions were conducted across the state with providers to hear about specific needs within practices relating to implementing health system transformation. We used the feedback from these sessions to create, through a vendor, the Hub.

Early in award year 2, we released a request for proposals and selected Qualis Health as the Hub vendor. We also selected the University of Washington (UW) Primary Care Innovations Lab to develop the Hub Resource Portal. Meetings to develop the Portal and finalize the Hub scope of work continued through the year, and the Hub launched at the end of the fourth quarter of year 2 with practice transformation coach/connectors embedded in ACH regions.

### Years 3 and 4 Hub Activities

The Hub worked throughout year 3 to recruit 175 practices for intensive coaching services, with a focus on small to medium primary care and behavioral health practices across the state. Around this time, CMMI raised concerns about duplication of services between the Hub and a separate practice transformation initiative, the Pediatric Transforming Clinical Practices Initiative. In response we developed the Practice Transformation Consortium, a group of partners across both initiatives, to facilitate coordination and alignment between these initiatives.

Hub staff and contractors helped develop and deploy many varied practice transformation initiatives through the Hub during this time. In the early months of award year 3, the Portal was launched. In award year 4, continued assessment, coaching, and training services were conducted across the state. A transition plan for practice transformation support as a community asset through ACHs was a focus in year 4, with Hub staff and state leadership working closely with ACHs to support smooth transitions.

### Next Steps

Primary care practices and BHAs that took advantage of training and technical assistance are working to sustain the changes they implemented. Working with their local ACHs and through high-level guidance from the state, we plan to support these practices as they continue evolving to meet the demands of value-based purchasing contracting and integrated service delivery.

The Practice Transformation Support Hub Resource Portal became the Healthier WA Collaboration Portal (WA Portal) in February 2019. A partnership between the UW Department of Family Medicine Primary Care Innovations Lab and the (DOH), WA Portal continues to provide curated resources, trainings, and collaborative workspaces for Washington's health and wellness community.

## Lessons Learned

- Practice transformation requires time to make progress and show impact. Rewards from activities like implementation of new workflows, extended care teams, and clinical integration elements from the Bree Collaborative's recommendations show stronger results over time.
- Empanelment, or the assignment of individuals to a specific primary care provider, is a fundamental requirement for a clinic to manage their patient population. Where patient attribution is not valid or reliable, providers lack confidence in their data and have concerns about it being used as a basis for payment.
- Providers want to understand the business case for transformation work and are more motivated to implement transformation when they see a sustainability pathway for changed systems, processes, or new staff.
- Clinical integration to support whole-person care can move ahead more quickly when the HIT/HIE environment allows behavioral health and primary care providers to share health information.
- Workforce shortages impact providers' abilities to fully staff and fund extended care teams.
- Providers look to payers to work on administrative simplification and alignment of reporting requirements and measures.
- Providers understand the need to connect with community-based organizations and resources to build capacity for effective care coordination.

## Workforce

Our SIM investments in health workforce activities centered on community health worker (CHW) policy recommendations and the Health Workforce Sentinel Network, a body dedicated to data collection and analysis between health system employers and health education institutions.

The Sentinel Network is a collaboration between the state's Health Workforce Council, sponsored by the Workforce Training and Education Board, and the UW Center for Health Workforce Studies, with startup funding from SIM. The Sentinel Network links the health care sector with partners in education and training, policymakers, and workforce planners to identify and respond to new and changing demand for health care workers, skills, and roles.

The Sentinel Network provides online data tools and reporting to capture key recruitment and retention issues by facility type, profession, and geographic area (focusing on ACHs). The data and reporting tools simplify access to timely workforce data that informs educators, policy makers, planners, and the health care industry in their workforce planning activities.

The Community Health Worker Task Force was created to develop recommendations to align the CHW workforce with the Healthier Washington initiative. Over a five-month period, members helped make recommendations that would support the integration of CHWs into our health care system. The task force concluded its work in December 2015, releasing a final report in February 2016. The report contains recommendations, overarching guidelines and strategies, a CHW definition, roles and skills, training and education, and finance and sustainability considerations.

## Workforce Activities

### Community Health Workers

The Healthier Washington project, led by DOH and HCA, convened a Community Health Worker Task Force between August 2015 and December 2015. We released a final report on February 25, 2016. The main goal of this effort was to develop innovative policy recommendations to build the role of CHWs to facilitate equitable health care and better access to social services in diverse communities.

Of the 55-member task force, at least 30 percent were CHWs. This group, with membership from across Washington State, developed recommendations on:

- Definition, roles, skills, and qualities of CHWs.
- Training and education.
- Key tenets for the design of funding and financing mechanisms.
- How to build CHWs into Healthier Washington strategic and operational plans to achieve outcomes.

SIM grant operational leads incorporated elements of these recommendations into their initiative planning, and ACH executive directors and their teams used the recommendations to incorporate CHWs into the design of their SIM projects. Several ACHs included CHWs as a strategic element of their SIM projects.

### Washington Health Workforce Sentinel Network

The Healthier Washington initiative developed and launched the Healthcare Industry Sentinel Network contract with the Health Workforce Council, who subcontracted to UW Center for Health Workforce Studies. "Sentinels," or health system employers' human resource staff, would provide regular data on their workforce needs and descriptions of demand changes.

Data collection and analysis activities began at the end of award year 1 and went through several cycles through award years 2 and 3. Through the SIM years, the Health Workforce Sentinel Network provided valuable on-demand data to support ACHs and provider partners in workforce planning and development. This information helped inform practice transformation and workforce strategies by providing information on the changing roles and competencies required in a transforming health system.

Workforce demand findings since October 2016 are available on the Washington Health Workforce Sentinel Network website. Reports for several data collection periods are available, from 2016 to 2018. Findings are reported by facility type, ACH region, and urban or rural geography. Employer sentinels represent many different settings and provide data to the network from across the state. Initially, 177 sentinels were providing data, and the current average is 117 to 124. Findings over time demonstrate:

- Consistent demand for nurses, including licensed practical nurses, registered nurses, certified nursing assistants, and advanced registered nurse practitioners in all regions and settings.
- Consistent demand for behavioral health occupations, including substance use disorder professionals and mental health counselors.
- Medical assistants are particularly difficult to recruit and retain at community health centers, as well as some behavioral health agencies, hospitals, and primary care clinics.
- Training needs change with physical and behavioral health integration and increasing demand for behavioral health services.
- Rural areas continue to demonstrate significant challenges in recruitment, retention, and access to locally-available health professions training programs.

## Next Steps

SIM-funded workforce development activities acted as a springboard to state-sponsored support of ACH workforce planning under the Medicaid Transformation Project. That work will continue as the ACHs develop, implement, and sustain workforce activities for the new roles and delivery models. In addition, the Health Workforce Council continues to retain ACH membership and to own and sponsor the Sentinel Network. The Governor's Office provided funding to support the Sentinel Network through June 2019, allowing additional time to secure outside funding.

In the meantime, the UW Center for Health Workforce Studies continues to speak about the Sentinel Network at national and regional conferences. At least three other states are working with them to implement or explore using the Sentinel Network tool for workforce development and programmatic use. Interested organizations and activities include:

- Sentinel Network user license signed and CT Sentinel Network data collection in process with Connecticut: CT League for Nursing and CT Center for Nursing Workforce
- Inquiries from and meetings with:
    - Northern California workforce development district
    - City of Los Angeles
    - Hawaii

## Lessons Learned

### CHWs

- CHWs provide services in a broad range of settings and organizations. Their role and integration in health care systems is in the early phases and will require ongoing collaboration with health care system and CHW leaders to integrate their skills.
- Ongoing collaboration between health care systems, community organizations, ACHs, and CHWs is needed to support CHW integration with clinical care systems, ensuring service linkages that address the social determinants of health.

- Sustainable funding for CHW delivery models is impacted by regulatory standards that limit direct payment to CHWs. There are also gaps in current coding and funding models for CHW interventions and services.
- There is potential to design roles and payment for CHWs into future alternative payment models.

### Sentinel Network

- It is challenging to recruit and maintain a diverse set of sentinels who can provide data on a range of health care settings. Additionally, it takes a lot of time to develop and administer a survey while maximizing response rate for busy health professionals.
- We may need additional resources to recruit and maintain an ongoing network of sentinels to participate in long-term data collection.
- The declining number of sentinel responses over time suggests a need for increased engagement. Possible solutions include incentives or wider participation options.
- Successful engagement requires regular review and broad stakeholder participation in survey design to ensure that data reflects current needs.
- Ongoing attention is needed to make sure data informs workforce development strategies.

# Plan for Improving Population Health

Led by DOH, in partnership with HCA, the Washington Plan for Improving Population Health (P4IPH) was implemented to guide how state and local communities can best implement population health improvement strategies. This work started with an intensive community engagement process. Outcomes included a guide for implementing population health approaches and a work plan for implementing these approaches at the community level. Informed by national and local experts, the completed Population Health Planning Guide outlines a structured process to standard population health approaches while allowing flexibility for unique needs and resources of local communities.

The P4IPH is one avenue for ensuring the Healthier Washington initiative addresses prevention, health equity, and social determinants of health. Providing a standardized process and individualized interventions, the guide allows diverse communities to take any health priority and implement strategies that:

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

## Plan for Improving Population Health Activities Summary

Between December 2015 and December 2016, DOH convened the Healthier Washington Plan for Improving Population Health External Advisory Group. This group included representatives from local public health, ACHs, American Indian Health Commission, UW School of Medicine and School of Nursing, Commission on Hispanic Affairs, Kaiser Permanente, Seattle Children's Hospital, provider associations, community groups, and other partners.

Also during this period, DOH convened the Plan for Improving Population Health Interagency Advisory Group. Representatives from DOH, HCA, and DSHS met monthly to discuss population health improvement strategies. The group also discussed how the Healthier Washington initiative could address prevention, health equity, and social determinants of health.

During award year 2, feedback from these groups and CMMI resulted in developing a Population Health Planning Guide to serve as an ongoing resource for partners statewide. DOH created the online guide to align with the CDC's "3 Buckets of Prevention"[6] framework and took an evidence-based approach. Structured by key health issues, the guide allowed partners to apply a population health approach to any health issue in their community, create plans, and take action.

DOH published the first version of the guide online late in year 2, with a specific focus on diabetes, obesity, and tobacco. In the first quarter of award year 3, we moved the guide to the Practice Transformation Support Hub Resource Portal. This helped the state provide resources to the broader health and wellness community and show how the guide related to other resources featured on the Portal. Moving the guide to the Portal also aligned with DOH's commitment to gathering resources and finding collaboration opportunities for partners and stakeholders, which are both chief health strategist approaches.

We explored the role of chief health strategist to address population health improvements in local communities as part of Healthier Washington. In award year 3, we awarded SIM funds to three local health departments (Clark, Snohomish, and Walla Walla) located in three different ACHs (including one covering nine rural counties), to support their ACH participation and to further develop the chief health strategist role in the ACH environment. Their contributions focused broadly on serving in leadership roles, compiling and translating population-level data, recruiting partners, and building communications across multi-county ACH regions.

Local health departments also contributed content expertise (opioids, chronic disease, and adverse childhood experiences) to ACHs as they developed their projects under Medicaid Transformation. Additionally, they have been participating in discussions and activities related to the integration of Medicaid purchasing of physical and behavioral health services in their regions. The group documented best practices, opportunities, and challenges related to participation in their ACHs. Through their leadership, they helped these entities maintain a focus on social determinants of

[6] Learn about the "3 Buckets of Prevention" at https://stacks.cdc.gov/view/cdc/47598.

health, broad population health, and prevention, even as the Medicaid Transformation projects have a clinical focus.

## Next Steps

DOH supports the guide's ongoing maintenance and regularly adds to topics and resources. The guide averages over 1,000 users per month who regularly access 3 to 7 pages per session. DOH is reorganizing the guide based on the agency's new Evidence-Based Public Health Framework, and they added several new resources in July 2019. DOH also continues to weave the chief health strategist role throughout planning, engagement, and program development.

## Lessons Learned

- Moving toward transformation, especially upstream, is challenging and takes time.
- Flexibility within fiscal and contracting procedures is important to support new ways of doing things.
- Online resources can provide easy access across the state, but engagement is needed to ensure people know what is available and how to use online tools.

# Analytics, Research, Measurement, Health Information Technology, and Health Information Exchange

SIM embraced a bold, data-driven strategy to reach health system transformation goals by recognizing that access to population health data, analytic capability, performance measurement, and information exchange were critical foundations for providers, purchasers, payers, and consumers. To support health system transformation, we built several initiatives over time. The initiatives focused on developing the analytic capability of state agencies, creating a state common measure set for value-based contracting, and investing in Health Information Technology (HIT) and Health Information Exchange (HIE) strategies to support population health management.

## Analytics, Research, and Measurement

### ARM Activities Summary

From its inception, the ARM team (formerly known as AIM) was designed to include a mix of roles including analytics infrastructure management, epidemiology, and program management. The strategy was to build capacity for a fully functioning team that could manage complex data initiatives from start to finish (ingesting "raw" data, modeling data, performing high-level analytics, and communicating results to support data-driven decision making).

To promote interagency collaboration and make use of institutional knowledge of disparate data systems, the staffing model included SIM-funded staff at HCA, DOH, and DSHS. In the early years of SIM, we developed a business intelligence and shared analytics roadmap and explored the evolving data needs of the ACHs. Over time, interoperability became the domain of HCA's ARM section.

We developed the Healthier Washington data dashboard to address the need for region-specific data visualization for ACHs. The dashboard was first released early in award year 2, supporting ACHs and local health jurisdictions by providing interactive access to metrics and population health data. This information aided them in identifying and implementing community priorities and strategies that improve health.

The dashboard started with three metrics that were continuously developed throughout SIM. On a 12-week cadence, we refreshed data. We also added additional metrics and functionalities over the years, using measures from the state common measure set. DOH also provided select population health metrics. The dashboards are publicly available on the HCA website. The ARM team also focused on relationship-building with ACH data teams and continuously responded to data requests from ACHs throughout SIM.

Other major efforts from the ARM team included providing support to both the state and federal SIM evaluators. This included efforts to define their qualitative and quantitative data needs, help put data-share agreements in place, coordinate logistics for site visits and focus groups, and facilitate data transmission.

In the final year of SIM, the ARM analytics staff embarked on strategic planning and goal-setting activities intended to set a path toward sustainability. The outcome was a vision of transforming lives through research and analytic support. This vision called for the team to be a center of excellence, bringing research expertise and scientific rigor to analytics, providing technical assistance that advances health transformation, and creating partnerships with other data centers in the state.

The ARM team also launched its own ARM dashboard suite in award year 4. The suite, which complements the Healthier Washington data dashboard, included additional public data supporting ACH data needs regarding health care providers and Medicaid inpatient and outpatient data utilization. These dashboards will provide ongoing critical data infrastructure for ACHs and other transformation partners.

## Next Steps

The ARM team will continue supporting the ACHs and Medicaid Transformation through measure production and new releases of the Healthier Washington dashboard suite. The team will also continue SIM program evaluation, with responsibility to both the federal SIM evaluator and ongoing analyses conducted by UW. The ARM team is available to provide analytic capacity to new initiatives and programs as they are designed and implemented.

Future work includes:

- Supporting data needs of RTI International, the contractor responsible for the multistate federal SIM evaluation. Washington's cooperative agreement with CMMI requires participation in federal evaluation activities.
- Exploring how to support UW's ongoing Washington SIM evaluation, supported by the Robert Wood Johnson Foundation. Refreshed data sets are necessary for this continued work.
- Supporting measure production for ACH data needs and metric calculations through the end of Medicaid Transformation.
- Providing data support for value-based payment and purchasing initiatives and alternative payment models.
- Supporting an SAS analytic environment at HCA; this work began under SIM, and HCA devoted funding for continued development.
- Supporting HCA leadership as data and analytic needs are identified to move agency initiatives and priorities forward.
- Continuing ARM team professional development on performing predictive analytics.

### Lessons Learned

- An advanced analytics team requires more than just analytical and epidemiological expertise; a team with a variety of skill sets, including administrative support, data governance, and effective management is crucial.
- Managing stakeholder expectations is critical. Stakeholder expectations may not be realistic because they are based on limited information/data.
- There is a lack of data about social determinants of health. To best support agency priorities, the ARM team will need access to additional data sources and have the ability to link data.

## Health Information Technology and Health Information Exchange

### Health Information Technology and Health Information Exchange Activities Summary

The HIT and HIE team is housed in HCA and collaborate with DOH, DSHS, and the Department of Corrections. This team has worked with providers, ACHs, and other representatives to support the use of HIT and HIE across Washington's health landscape.

In award year 3, the Healthier Washington team created a HIT Strategic Roadmap and annual HIT Operational Plan. These collaborative documents were developed to identify the HIT/HIE tasks needed to support service delivery and payment transformation, in alignment with SIM strategies and goals. The HIT Operational Plan also provided a platform for managing tasks across agencies.

In 2018 we updated the HIT Operational Plan to identify data needed by health system entities and technology tools needed by providers for interoperable HIE. The update also enhanced existing infrastructure projects (including the Clinical Data Repository [CDR]).

Tasks in the 2018 HIT Operational Plan focused on:

- Data
- Data analytics
- Data governance
- HIT/HIE (including addressing ACH and provider training needs)
- Supporting the exchange of substance use disorder information subject to 42 CFR Part 2[7]

The HIT Operational Plan was updated for 2019. The updates addressed advancing HIE, supporting information sharing across multiple systems, and enhancing the functionality of the CDR. Healthier Washington has also been receiving federal technical assistance on HIT from the Office of the National Coordinator for Health Information Technology. Much of this work aligns with federal HIT/HIE trends and strategies.

## Clinical Data Repository

While not funded by SIM, the Washington State Clinical Data Repository (CDR) formed in response to community feedback about interoperability challenges and the meaningful use program. The CDR supports Healthier Washington by connecting disparate EHR platforms and aggregating clinical information into one location.

Practitioners who take care of Apple Health Managed Care clients can import data from the CDR and easily view it using their standard workflow. By providing access to clinical information, the CDR helps the care team gain a more complete understanding of the patient's medical history. This enables clinicians to achieve better results for their patients and improve overall community health.

### Key Features

- Supports standards for sharing clinical summaries already incorporated into certified EHRs.
- Ensures standardized clinical summary documents to the CDR meet the Meaningful Use Stage 2 requirement[8] for exchanging care summaries with organizations that have different EHR systems.

[7] The federal confidentiality law and regulations protect the privacy of substance use disorder (SUD) patient records by prohibiting unauthorized disclosures of patient records except in limited circumstances. Congress enacted the legislation in the 1970s to encourage individuals with SUDs to enter and remain in treatment. The regulations implementing the law are at 42 CFR (Code of Federal Regulations) Part 2 and are commonly referred to as "Part 2."

[8] Supported by federal legislation, Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing). Meaningful use has multiple stages with qualifications for providers to meet in exchange for incentive funds. The program is meant to modernize the nation's health technology infrastructure.

- Supports clinical data exchange with organizations that do not share similar platforms.
- Supports access to integrated patient records without an EHR through a clinical portal.
- Offers a common place to share information for organizations participating in different arrangements, such as ACOs and MCOs.
- Minimizes administrative burdens by decreasing requests for faxed copies of charts.

HCA has been working closely with both the CDR vendor, OneHealthPort, and stakeholders to develop the CDR. The CDR currently only includes physical health data for Medicaid clients, but HCA is working on adding additional population data.

### Next Steps

HCA will continue to explore opportunities to enhance the type of information exchanged and reused to support service delivery at the point of care, quality measurement, and population health analytics. The HIT team is working with the Health and Human Services multiagency Enterprise Governance process to create a master person index and a provider directory and advance the use and exchange of HCA data.

HCA will continue leveraging contracts with MCOs to encourage HIE to support care coordination. Work may also include creating contract requirements that encourage network providers to transmit clinical information to the CDR. HCA is also pursuing ways to support providers using interoperable EHRs. For example, the state is exploring using Substance Abuse Prevention and Treatment Block Grant funds to support the use of interoperable EHR systems by behavioral health providers who deliver services to clients with substance use disorders.

### Lessons Learned

- Partnership at the state, regional, and local levels is essential for understanding the role HIT/HIE can play in supporting service delivery transformation and creating a case for the value of these investments.
- There are critical gaps in the use of interoperable technologies across the care continuum. These gaps impact the ability to support continuity and coordination of care, quality measurement, and population health analytics.
- Addressing these challenges require ongoing state investment in both technology and staff resources.

## Washington's State Common Measure Set

The state common measure set includes health care quality measures that address preventive health, chronic and acute care, and cost of care. It is the foundation for Healthier Washington value-based purchasing strategies, which requires the use of these measures in our state purchasing contracts — particularly those with value-based purchasing arrangements. Developing a state common measure set to promote transparency and guide value-based purchasing was also a SHCIP

foundational building block. The original guidelines for developing the state common measure set were:

- Be of manageable size.
- Give preference to nationally-endorsed measures (e.g., National Quality Forum).
- Be based initially on claims data, later adding measures based on clinical data.
- Focus, to the extent possible, on the overall performance of the system (e.g., outcomes, functionality, and total cost).
- Be aligned with Results Washington, Governor Inslee's performance management system measures, and Medicaid common measure requirements specified in ESHB 1519 (2013).
- Consider stakeholders' differing needs, including the populations they serve (such as challenges of low census response in some diverse communities), smaller care sites, and rural areas.
- Be used broadly by multiple payers, providers, and purchasers, and communities to move toward improvements in health, health care, provider payment, and design of insurance benefits.

HCA and the Washington Health Alliance convened a governor-appointed Performance Measures Coordinating Committee (PMCC) and three ad hoc workgroups consisting of 45 community stakeholders. These groups reviewed more than 300 performance measures to develop a "starter" set of measures. We released the first version of the measure set December 2014 and have updated it annually.

## State Common Measure Set Years 1 and 2 Activities Summary

With the starter measure set developed, the PMCC developed processes for evaluating the measure set, updating the measure set, and communicating to providers and other health system stakeholders.

As required in statute, the PMCC in 2015 developed a plan for how the measure set would be evaluated annually and continue to evolve, as measurement science and state priorities evolve. Also in 2015, the Alliance and HCA developed a fact sheet about the measure set for providers, plans, and purchasers. We also developed a Savvy Shopper Campaign to help consumers select healthcare based on what is the most important to them.

In response to stakeholder feedback, we created two ad hoc workgroups in award years 1 and 2 that focused on behavioral health and pediatric measures. The behavioral health workgroup added three measures, two of which were later used in the integrated managed care contracts. These included Mental Health (Service) Treatment Penetration (Broad) and Substance Use Disorder (Service) Treatment Penetration. The pediatric workgroup added three measures in 2016. These included Well Child Visits in the First Fifteen Months of Life (W15), Follow-up Care for Children Prescribed ADHD Medication (ADD), and Audiological Evaluation No Later Than 3 Months of Age. A

data expert workgroup met each year to evaluate the measure set and decide which to add and which to retire.

We began annual public reporting about the state common measure set in December 2014 through the Community Checkup. The reports use data from Washington's voluntary all-payer claims database, managed by the Washington Health Alliance. These publicly-displayed results allow consumers to compare quality performance results about health plans, medical providers, ACHs, and counties.

In 2016, we identified a core set of seven measures from the state common measure set as priority measures for value-based purchasing and whole-person care contracting. We tied these seven measures to performance as a way to improve key clinical quality outcomes. These measures are included in the integrated managed care, APM4, and all other Medicaid contracts:

1. Antidepressant medication management: effective acute and continuous phase treatment
2. Childhood immunization status
3. Comprehensive diabetes care: blood pressure control
4. Comprehensive diabetes care: hemoglobin a1c (hba1c) poor control (>9.0 percent)
5. Controlling high blood pressure
6. Medication management for people with asthma: medication compliance 75 percent (ages 5-11 and ages 12-18)
7. Well-child visits in the 3rd, 4th, 5th, and 6th years of life

## Common Measure Set Years 3 and 4 Activities Summary

Award years 3 and 4 activities focused on the continued evolution of the measure set. Many activities and processes that started in years 1 and 2 continued, including:

- Quarterly convening the PMCC.
- Annually reporting the state common measure set in the Community Checkup report.
- Continuing to use high-priority measures in state contracting.
- Communicating to the community on measure set activities.

Ad hoc workgroups convened in 2017 to review additional measures to add to the measure set. New measures focused on care coordination and population health.

We developed a fact sheet for employers encouraging them to use the state common measure set reports when selecting employee health plans and contract measures. We also presented on the measure set at national meetings and several forums across the state. The audiences for state presentations included to the Washington State Medical Association, individual ACHs, and the Bree Collaborative.

HCA developed a process to provide oversight in how we select measures for state purchasing contracts. This process helped ensure we were aligning quality efforts across the agency. The core

guiding principle for the Quality Measurement and Monitoring Improvement program is that all measures will come from the state common measure set where possible. This process also includes partner state agencies and helps drive quality improvement by leveraging the measure set, monitoring performance results through data dashboards, and identifying strategies to address low performance.

In 2018 the measures were publicly reported through the mandatory all-payer claims database, as required by state statute, on the Washington HealthCareCompare website.

## Next Steps

Stakeholders around the state would like to see the state common measure set continue. HCA will provide committee staff support, and we hope that holding some virtual meetings and fewer in-person meetings will help us engage with fewer resources.

In award year 4, the PMCC developed a plan to evolve the committee's role to focus more on monitoring results of the current measure set, rather than adding new measures. Members are also interested in using the state common measure set as a tool to advance health equity[9] and coordinating it with emerging national measurement efforts to continue to achieve more alignment whenever possible. We intend to sustain these evolved functions, as HCA and the PMCC are committed to continuing to promote the measure set as our main tool for measuring quality in Washington.

## Lessons Learned

- It is challenging to reach full agreement on a core set of measures to drive quality in Washington. Although all health plans were at the table from the beginning, each health plan had preferred measures, and it was not always possible to agree. While this is an ongoing issue, we continue to work toward a true core set of quality measures on which everyone can agree.
- More effort should have gone into engaging providers at a broad level, including educating them on the state common measure set purpose. More effort could help dispel the idea that this was "just another state requirement."
- There will likely always be hesitance from some to align with a state common measure set. Many programs already have preferred measures. However, we have worked diligently to ensure we are aligning as much as possible.

[9] Health inequity refers to the uneven distribution of social and economic resources that impact an individual's health. Inequities often stem from structural racism or the historical disenfranchisement and discrimination of particular marginalized groups, including racial and ethnic minorities, low-income populations, and members of the LGBTQ community. Conversely, health equity is the concept of addressing these inequities so that all people can achieve optimal health.

- The way we first displayed measures was confusing to some providers and payers. We attempted to solve this problem in 2018 by reworking the way the measures are displayed, taking input from external stakeholders into account.

# All-Payer Claims Database

The Washington State Office of Financial Management (OFM) established the all-payer claims database (APCD), per RCW 43.371.020.

Although APCD was funded with other federal funding, some initial efforts to launch the APCD — including expanding the reporting scope and activities — were supported by SIM. In addition to improving public health care reporting transparency, the APCD is to:

- 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 (and focus on best practices).
- Enable purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time.
- Promote competition based on quality and cost.

The law also required OFM to use a competitive procurement process to:

1. Select a lead organization to coordinate and manage the database.
2. Select a data vendor subcontracted to the lead organization to establish and operate the APCD system.

In July 2016 OFM selected Oregon Health & Science University, Center for Health Systems Effectiveness (OHSU-CHSE) as lead organization and Onpoint Health Data as data vendor.

Since July 2018 data from the APCD database has been available on the Washington HealthCareCompare website. Washington residents can search for health care costs for more than 100 procedures and treatments and see provider and hospital quality ratings. Website visitors can also see results for the Washington state common measure set results by viewing ACH and type of insurance coverage.

Moving forward, the database will collect all medical, pharmacy, and dental claims from private and public payers, with data from all settings of care possible. The APCD also has an analytic enclave for analysts to access data so they can create their own analyses. The ongoing sustainability of the APCD is proposed through a fee-based model. Consistent with legislative direction, the APCD administration is moving from OFM to HCA by January 1, 2020 (ESSB 5742, 2019).

# Shared Decision Making

Washington's SHCIP highlighted the importance of engaging people and their families in their health decisions in a meaningful and person-centered way. HCA carried out this goal by focusing on shared decision making (SDM), becoming the first state in the nation to develop a process for certifying patient decision aids (PDAs).

SDM allows patients and their providers to make health care decisions together, taking into account both the best scientific evidence available and the patient's values and preferences. When used consistently and correctly, PDAs can reduce unnecessary procedures, promote health equity, and ensure that patients from different cultures can engage meaningfully in their health care decisions with providers.

Over the course of the SIM grant, we developed a process for assessing and certifying PDAs in several areas of care. We also provided education and training to the health care community about the use and benefits of PDAs.

## Shared Decision Making Year 1 Activities Summary

In May 2015, we brought together over 100 state and national experts to identify key elements needed for a PDA certification. After this discussion, we developed a process for the state to certify PDAs, using a modified version of the International Patient Decision Aids (IPDAS) certification criteria.

## Shared Decision Making Years 2, 3, and 4 Activities Summary

We have certified 36 PDAs to date:

- Round one: maternity (2016); certified five PDAs
- Round two: total joint replacement/spine care (2017); certified seven PDAs
- Round three: end of life care (2017–2018); certified 24 PDAs
- Round four: cardiac care (2018); certified no PDAs, but we are still receiving resubmits

Following the maternity PDA certification, we implemented an SDM pilot within two ACPs. The pilot focused on whether to attempt a natural birth after having a caesarean. The pilot included technical assistance and in-person and online training provided to staff at three provider sites. We conducted a formal evaluation and compiled a final report.

In addition to certifying PDAs, we also needed to ensure providers knew how to use them. In award year 2, HCA collaborated with the Agency for Healthcare Research and Quality (AHRQ) to hold a provider training on SDM. More than 200 clinicians and staff from across the state attended this training.

In addition, we collaborated with Healthwise© to offer an interactive SDM online skills course for providers. We received positive feedback from providers, and the training was widely circulated. More than 400 providers completing the training between 2016 and 2019.

Washington remains the only state in the nation to certify PDAs. As pioneers of this work, we have presented at numerous national forums and participated in the development of a national set of certification criteria with the National Quality Forum in 2017. We also received private foundation funding to support SDM development statewide.

During the latter part of the SIM period, we developed a certification process sustainability model. We seamlessly transitioned all activities to HCA's Clinical Quality and Care Transformation Division in the middle of award year 4. This is a fee-based model that uses developer fees to support the expert review process needed to complete certification.

This model was tested in 2018 with our fourth round of certification and was found to be successful. We had the same level of interest as in previous rounds, indicating that the fee did not pose a barrier for developers. Aside from the sustainability of the certification process, spread and scale — as well as provider training — are important elements of this project to sustain.

Also in award year 4, the Bree Collaborative accepted our application to have an SDM-focused workgroup in 2019 to review evidenced-based practices for implementing SDM. Workgroup recommendations will inform a roadmap for spreading SDM across Washington, which we will present at a 2020 community stakeholder meeting.

## Next Steps

HCA will continue to offer the SDM online skills course for providers through 2019. We strive to reach as many providers as possible to educate them on what SDM is and how to use certified PDAs in their practices. In addition, we will partner with the Bree Collaborative shared decision making workgroup to develop recommendations and create a roadmap for spreading SDM across Washington. Bree members represent organizations across the state. With their support we have a higher likelihood of spreading SDM more broadly in Washington, moving "ownership" from the state to the community.

Private foundations have expressed interest in our SDM work, and we will continue to seek private funding opportunities to fund specific events. In 2020, using funding from the Gordon and Betty Moore Foundation, we will hold a second community stakeholder meeting. At the meeting, stakeholders will react to the Bree workgroup draft roadmap and identify roles and next steps. We will invite national and state experts in SDM, payers, providers, patients, IT experts, and developers.

We intend to apply for a grant from the Coverys Health Foundation to conduct an implementation project at the conclusion of the Bree workgroup. The funding will be used to support practices' SDM implementation, with certified PDAs, using the recommendations from the Bree workgroup. We

will also continue presenting on the innovative work Washington is doing at state and national forums, as invited.

We began to require SDM in our bundled-payment contracts with our commercial payers. We are also in the beginning stages of discussions with Medicaid payers to determine how to best proceed with those contracts. We hope to have language included in contracts in 2020.

## Lessons Learned

- While there is national interest in the importance of SDM and PDA certification, this is not always the case at the clinical practice level. Through our pilots and evaluation, we learned there are a lot of assumptions about SDM: what it is, whether or not it is already occurring, and its value. To increase SDM use in our state, we need to find the right balance of provider incentives and investment in clinical champions and executive sponsors.
- Our pilots were successful, but the challenges to doing SDM remain. These challenges include lack of time, high cost and complexity of EHR-based PDAs, and lack of standardized training. We will work with partners to address these elements as we move forward.
- The timing of our maternity pilot was ambitious; we had not completed our first round of certification when the pilot launched. Without having certified PDAs to use, the pilot was not as immediately successful as it could have been.
- For our certification process, we learned it is more efficient to contract with one entity to conduct the evidence review. Overall certification process coordination is an ongoing challenge, but the certification of PDAs is worth the effort. There is a lot of interest in the development of PDA certification programs. Until a national program is developed, we will continue our efforts in Washington, in spite of resource challenges.

# Next Steps

Washington State is a national leader in implementation and achievement of the triple aim. Foundational legislation, the State Innovation Model grant award, and the agreement with CMS to implement a Medicaid Transformation Demonstration Project have accelerated action toward the state's goals to pay for value, integrate care to serve the whole person, and link clinical and community supports.

Building on the capacity created under SIM, achieving success through the Medicaid Transformation Project Demonstration (and its amendments), continuing collaborative work across agencies, and responding to new CMMI model opportunities will keep Washington moving toward achieving better care, smarter spending, and healthier populations.