Health Innovation Leadership Network
Commitment to Value Action Agenda

The Health Innovation Leadership Network has embarked on a year of commitments to value and concrete, measurable action to fulfill these commitments. Specifically, HILN supports an action agenda to advance Healthier Washington's goals of 80 percent value-based payment in state-financed contracts by 2019 (30 percent by the conclusion of 2017) and progress toward the goal of 50 percent value-based payment in the commercial market by 2019.

We asked Leadership Network members to define what value means to them and the targeted, concrete action(s) their organizations will take in the next year to advance Healthier Washington's value-based purchasing (VBP) goals. While the measurable outcomes are oriented toward payment, we all have a role to play in achieving value—whether it be through payment, measurement, public health levers, changes to clinical delivery, collaboration with social health sectors, person and family engagement, application of an equity lens, or more.

Based on Leadership Network commitments and discussion at the May 5 HILN meeting, an action agenda based on three domains emerged. Over the next year, HILN will advance value by:

- Adopting and spreading value-based payment models and practices;
- Advancing an equitable health system; and
- Increasing person and family engagement and health literacy.

Please note that spread of value-based models, equity, and engagement and literacy are cross-cutting the reinforcing of one another. The domains of the action agenda are intended to come together to advance Healthier Washington's value-based goals.

The following actions and examples draw from commitments made by Leadership Network members since April *(last update July 5, 2017)*. The action agendas map actions and commitments to advance value in Washington state by partner/sector/government and category of the lever (e.g., payment, measurement) that can be activated to meet Healthier Washington's value-based goals.

As you review the action agenda, please consider:

- What action will you/your organization take to advance Healthier Washington's value-based goals? This can be a new action, or a commitment to partner or contribute to an existing action.
- What needs to take place to achieve the actions in the action agenda?
- What barriers are in our way to achieving the actions in the agenda?

If you have additional commitments to contribute, please email them to Laura Kate Zaichkin at laura.zaichkin@hca.wa.gov.

HILN Commitment to Value Action Agenda – Adopt and spread value-based payment models and practices across Washington state
Target/outcomes: 80 percent VBP in state-financed arrangements by 2019 (30 percent by the end of 2017), 50 percent VBP in commercial market by 2019

Levers* → / Partners ↓	Policy / Culture / Leadership	Payment	Clinical practice transformation / Workforce / Clinician engagement & experience	Measurement / Reporting	Person & family engagement & decision making
All Partners	**Agree to a common definition and standard practices for VBP.** *For example:* *Apply and spread standards to commercial market and practices already hitting benchmarks. (Alliance, KMHS)* *For example:* *Convene stakeholders on a regular basis to share information and align strategies to help move the market to value with a focus on purchasers. (Alliance)* **Reproduce successful VBP models and practices across state and nation through the sharing of results, best practices, learnings, etc.** *Actively seek out at least two speaking engagements a month expand visibility and goals of VBP. (Alliance)*		**Implement rapid-cycle evaluation, learning and improvement process for value-based models and practices.** *For example:* *Collect information about ACP early returns, including Bree uptake in ACPs (HCA)* *For example:* *Disseminate Bree report re successful uptake of Bree recommendations—best practices, etc. (Bree)*	**Evolve the statewide common measure set to integrate population, clinical and outcome measures.** *For example:* *Contribute perspective and ideas for priority outcome metrics in community behavioral health (WA Council for Behavioral Health)* *For example:* *Determine and implement new Dental Quality Measures in Dental Practices. (Neighborcare)* *For example:* *Capitalize on the addition of claims line level pricing data to the Alliance's voluntary APCD and execute on first three projects that have*	**Advance health literacy to guide consumer decision making.** *For example:* *Educate consumers in using health services.* *Appropriate care at the right time.* *Consider role for nurses and health care workers in advancing this—ID best practices (1199)*

HILN Commitment to Value Action Agenda – Adopt and spread value-based payment models and practices across Washington state

Levers* → Partners ↓	Policy / Culture / Leadership	Payment	Clinical practice transformation / Workforce / Clinician engagement & experience	Measurement / Reporting	Person & family engagement & decision making
	For example: Promote the work of Washington State in national forums. (Alliance) **Advance and support statewide policy that requires quality and value.** *For example: Participate in legislative and executive branch policy development (WA Council for Behavioral Health)*			*been approved by the Alliance Board. (Alliance)*	
State	**Implement VBP across programs and agencies according to an aligned purchasing philosophy.** *For example: Annually update and implement HCA VBP Road Map. (HCA)*			**Assess the uptake of value-based payment across the state.** *For example: Conduct VBP market survey during summer 2017 (HCA)*	**Certify patient decision aids.** *For example: Certify patient decision aids for total joint in 2017 (HCA)*

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Levers* → / Partners ↓	Policy / Culture / Leadership	Payment	Clinical practice transformation / Workforce / Clinician engagement & experience	Measurement / Reporting	Person & family engagement & decision making
Purchasers		**Procure value-based models for employees.** *For example: Incorporate a new Accountable Care Network plan choice for employees effective January 2018 (via a contract that will link payment, in part, to quality); Assess options/feasibility for using bundled episodes of care in future employee health purchasing strategy (aligned with Bree recommendations) (King County)*	**Require physical-behavioral health integration in health plans.** *For example: Focus on strengthening physical/behavioral health integration, both in community health system overall and in the health plans for King County employees. (King Co)*	**Adopt the statewide common measure set, and integrate into all contracts—reporting and payment.** *For example: All value based contracts include the core measure set -- this includes both Washington Permanente Medical Group and contracted community providers. (Kaiser)*	

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Levers* ➡ Partners ⬇	**Policy / Culture / Leadership**	**Payment**	**Clinical practice transformation / Workforce / Clinician engagement & experience**	**Measurement / Reporting**	**Person & family engagement & decision making**
Plans		**Adopt value-based models.** *For example: Move to APM 4 in 2019 (Neighborcare)*			**Integrate quality and cost reporting into provider selection tools.** *For example: Integrate the Community Checkup in our provider directory. (Kaiser)* **Use consumer engagement and shared decision-making tools.** *For example: Advance consumer engagement tools such as PAM, WRAP, CommonGround (WA Council for Behavioral Health) For example: Advance text based engagement of low income population to activate them in engaging in care, and achieving quality results (Neighborcare)*
Providers/ Professionals **Health Systems**	**Adopt mission and policies that support a commitment to integrated care, quality, value and patient experience.** *For example: Develop policies and procedures related to commitment in services such as integrated care to produce value in clients' outcomes, clients' positive experience with the services and cost saving with values, mission, goals, objectives and practices to support integrated care. (ACRS)* **Involve staff in policy development.** *For example: Continue to provide training and build consensus with BH staff on value based system,*		**Utilize those who do community health work in care decisions.** *For example: Fully utilize peer specialists in decision making process. (ACRS)* **Integrate physical and behavioral health in clinical practice.** *For example: Expand primary and behavioral health integrated care with ICHS. (ACRS) Fully integrate BHS practitioners and services in Primary Medical Care settings. Integrate Primary Medical care into BHS settings. (Neighborcare) For example: Embed practice care coordination in clinical workflows (ICHS) For example:*	**Adopt EHR systems that capture and report actionable process, outcome and access measures.** *For example: Begin selection process to replace current Electronic Health Record system that will easily capture outcome and process measures and allows individual and aggregated reports on outcomes and service utilization. (ACRS) For example: WA Permanente providers have access to their quality performance through dashboards on the Epic medical record system. Quality management tools*	

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	outcome measure, and involve staff in policy and procedure making process. (ACRS)		*In 2015, we launched the Behavioral Health Initiative (BHI) pilot program at three of our Puget Sound area clinics. Kaiser Permanente embedded a brief behavioral health screening questionnaire into the standard work of primary care, allowing clinicians to identify people who are significantly at risk and provide real-time intervention. Further, we have incorporated one or more licensed clinical social workers on staff at each clinic, ready to meet with patients right away if needed to discuss treatment options. The pilot has been so successful it was extended to all of our primary care locations with completion expected by 2018. (Kaiser)*	*are also integrated within the Epic medical record system to allow providers to provide opportunistic care. (Kaiser)* *For example: External contracted providers receive regular performance evaluations with recommendations on clinical tools and actionable data, including patient level data to improve and close quality gaps. (Kaiser)*	*For example: Keep "Own Your Health" website populated with consumer oriented materials that empowers Washington consumers to become active participants in their own health and health care. (Alliance)* **Create mechanisms for real-time consumer feedback on experience.** *For example: Consumers are also able to rate their physicians within our provider directory. (Kaiser)*

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			Train and coach providers in evidence-based practices. *For example:* *Continue to train staff on evidence based practices such as diabetes prevention management, DBT, CBT, etc. (ACRS)* *For example:* *Assist Qualis in the clinical practice transformation work by leading educational efforts on value-based purchasing. (Alliance)* **Identify and adopt promising and evidence-based practices to manage the health of populations.** *For example:* *Develop and implement innovative practices to address population management (ICHS)* *For example:* *Develop partnerships with social service agencies (ICHS)*		

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			For example: *Determine how to utilize dental practices to advance quality measures (diabetic, HTN, etc) (Neighborcare)* **Involve staff in policy development.** *For example:* *Continue to provide training and build consensus with BH staff on value based system, outcome measure, and involve staff in policy and procedure making process. (ACRS)*		
Community			**Create structure and incentives for community-clinical support mechanisms.** **Deploy those who do community health work across communities.** *For example:* *Expand the role of community-based Community Health*		

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Levers* → / Partners ↓	Policy / Culture / Leadership	Payment	Clinical practice transformation / Workforce / Clinician engagement & experience	Measurement / Reporting	Person & family engagement & decision making
			Workers in potential Medicaid Transformation projects by advocating for CHWs to be part of emerging "value bundles" for patients in need of chronic disease management and care coordination services. (Mercy Housing NW)		
City and County Governments	**Commit to fully integrated physical and behavioral health purchasing**				
Local Public Health	**Contribute a systems and population-based strategic focus to ACH decision making.** *For example: As member of ACH and BHO Boards, assure regional BH integration efforts result in improved patient centered care models. (Whatcom Co. Health Dept)*			**Contribute population-level data and analytic support to community health planning and monitoring.** *For example: Provide epidemiology staff resources to our ACH to define population health issues and health disparities in our region. (Whatcom Co. Health Dept)*	

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Levers* → / Partners ↓	Policy / Culture / Leadership	Payment	Clinical practice transformation / Workforce / Clinician engagement & experience	Measurement / Reporting	Person & family engagement & decision making
				For example: Support data and evaluation needs of King County Accountable Community of Health (Public Health-Seattle & King County)	
Tribal Governments and Entities					
Industry (IT, pharma, labor etc.)					
Philanthropy		**Invest in community and statewide grants that focus on social determinants, integration of care, and spread of best practices that support value.** *For example: Grant investments that include a focus on social determinants of*	**Contribute funding to advance an innovative workforce.** *For example: Continue advancing Graduate Medical Education and Undergraduate M.E. in the region through strategic partnerships with WSU, Providence and others. (Empire)*	**Align measurement and outcome expectations across grantees.** *For example: Seek aligned measures, particularly when providing potential start-up to ideas that will advance VBP and population health improvements. (Empire)*	

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		health/educational attainment (Gates) *For example: Investments that support integration of care (oral/behavioral/primary). (Empire)*			
Consumers					**Incorporate consumer voice and experience in VBP models.** *For example: Identify a mechanism and execution strategy to actively incorporate consumer experience and voice in innovation models. (NoHLA)*

* Please note that spread of value-based models, equity, and consumer engagement and literacy are cross-cutting and reinforcing of one another.

HILN Commitment to Value Action Agenda – Advance an equitable health system
Target/outcomes: 80 percent VBP in state-financed arrangements by 2019 (30 percent by the end of 2017), 50 percent VBP in commercial market by 2019

Levers* → / Partners ↓	Policy / Culture / Leadership	Payment	Clinical practice transformation / Workforce / Clinician engagement & experience	Measurement / Reporting	Person & family engagement & decision making
All Partners	**Reproduce successful models and practices across state and nation through the sharing of results, best practices, learnings, etc.** **Agree to a common definition and standard practices for advancing equity.** *(Communities & Equity Accelerator Committee)* *For example:* *Continue to prioritize social determinants of health/social determinants of educational attainment in our conversations, planning and investments in Washington state.* *Ensure equity issues are front and center*				

HILN Commitment to Value Action Agenda – Advance an equitable health system

Levers* → / Partners ↓	Policy / Culture / Leadership	Payment	Clinical practice transformation / Workforce / Clinician engagement & experience	Measurement / Reporting	Person & family engagement & decision making
	in these efforts. (Gates)				
State		**Incorporate health equity into value-based payment contracts.** *For example: Pilot an equity VBP model with through one health system-MCO partnership in 2017. (Communities & Equity Accelerator Committee)*			
Purchasers				**Require reporting of process and outcome measures by race and ethnicity.** *For example: Partner with King County employee health plans to explore options for improving reporting by race/ethnicity. (King Co)*	
Plans				**Collect data, measure and report on process and outcome measures by race, ethnicity, language, income, and geography (rural/urban).** *For example: Pilot improved data collection and stratified reporting through one health system-MCO partnership in 2017. (Communities & Equity Accelerator Committee)*	
Providers/ Professionals			**Apply agreed-to standard practices for advancing equity in clinical and community settings.** *(Communities & Equity Accelerator Committee)*		**Create consumer advisory groups.** *For example: Consumer advisory group will represent our clients' diverse backgrounds including race/ethnicity, language, age, level of acculturation, etc. (ACRS)*
Health Systems			**Ensure evidence-based practices are culturally relevant and competent.**		

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Levers* → Partners ↓	**Policy / Culture / Leadership**	**Payment**	**Clinical practice transformation / Workforce / Clinician engagement & experience**	**Measurement / Reporting**	**Person & family engagement & decision making**
			For example: *Modify evidence based practices to be culturally relevant and competent. (ACRS)* *For example:* *Prepare and support community behavioral health agencies as value-based providers through training, TA and peer learning (WA Council for Behavioral Health)* **Attract and retain a workforce that represents the people they serve.** *For example:* *To improve recruitment and retention of qualified bilingual & bicultural staff, aim to develop more market competitive compensation &*	**Measure and report on access to care, cost and variation.** *For example:* *Measure patient access (clinical scorecards) (ICHS)* *For example:* *Begin selection process to replace current Electronic Health Record system that will easily capture outcome and process measures and allows individual and aggregated reports on outcomes and service utilization. (ACRS)* *For example:* *Start to develop and track outcome and process measures, utilization data and cost of service. (ACRS)* *For example:* *Develop at least three other reports, in addition to the Community Checkup, that point to actionable opportunities*	**Leverage those who do peer-to-peer community health work in decision making.** *For example:* *Fully utilize peer specialists in decision making process. (ACRS)* **Use consumer engagement and shared decision-making tools.** *For example:* *Advance text based engagement of low income population to activate them in engaging in care, and achieving quality results (Neighborcare)*

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Levers* → Partners ↓	Policy / Culture / Leadership	Payment	Clinical practice transformation / Workforce / Clinician engagement & experience	Measurement / Reporting	Person & family engagement & decision making
			benefits package. (ACRS) **Partner with social service providers to serve the needs of the whole person.** *For example: Develop partnerships with social service agencies (ICHS)* **Expand accessibility, office hours, services and populations served.** *For example: Expand opioid treatment services to homeless and low income individuals (Neighborcare)* *For example: Increase access to same day services (ICHS)* **Integrate physical and behavioral health services.** *For example:*	*to reduce variation in health care delivery and cost and that further lay the foundation for, and adoption of, the concept of purchasing for value. (Alliance)*	

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Levers* → / Partners ↓	Policy / Culture / Leadership	Payment	Clinical practice transformation / Workforce / Clinician engagement & experience	Measurement / Reporting	Person & family engagement & decision making
			Focus on strengthening physical/behavioral health integration, both in community health system overall and in the health plans for King County employees. (King Co) *For example:* *Fully integrate BHS practitioners and services in primary medical care settings. Integrate primary medical care into BHS settings. (Neighborcare)*		
Community			**Create structure and incentives for community-clinical support mechanisms.** **Deploy those who do community health work across communities.** *For example:*		

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Levers* → Partners ↓	**Policy / Culture / Leadership**	**Payment**	**Clinical practice transformation / Workforce / Clinician engagement & experience**	**Measurement / Reporting**	**Person & family engagement & decision making**
			Expand the role of community-based Community Health Workers in potential Medicaid Transformation projects by advocating for CHWs to be part of emerging "value bundles" for patients in need of chronic disease management and care coordination services. (Mercy Housing NW)		
City and County Governments	**Commit to fully integrated physical and behavioral health purchasing**				
Local Public Health	**Contribute a systems and population-based strategic focus to ACH decision making.** *For example:* *As member of ACH and BHO Boards,*			**Contribute population-level data and analytic support to community health planning and monitoring.** *For example:* *Provide epidemiology staff resources to our*	

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Levers* → / Partners ↓	**Policy / Culture / Leadership**	**Payment**	**Clinical practice transformation / Workforce / Clinician engagement & experience**	**Measurement / Reporting**	**Person & family engagement & decision making**
	assure regional BH integration efforts result in improved patient centered care models. (Whatcom Co. Health Dept)			*ACH to define population health issues and health disparities in our region. (Whatcom Co. Health Dept)* *For example:* *Support data and evaluation needs of King County Accountable Community of Health (Public Health-Seattle & King County)*	
Tribal Governments and Entities					
Industry (IT, pharma, labor etc.)					
Philanthropy		**Support community based interventions that promote equity.** *For example:* *Support planning and mobilization of community-based interventions that promote partnerships to advance outcomes related to social determinants of health/educational attainment, with a particular focus on those communities and constituencies that have historically not had access to comprehensive opportunities. (Gates)*		**Measure and evaluate health system transformation efforts' impact on equity, including unintended consequences.** *For example:* *Continue to measure impacts of all relevant investments, including Road Map, Building Community Philanthropy,*	

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Levers* → / Partners ↓	**Policy / Culture / Leadership**	**Payment**	**Clinical practice transformation / Workforce / Clinician engagement & experience**	**Measurement / Reporting**	**Person & family engagement & decision making**
				Family Homelessness, Civic Engagement, etc., with a particular focus on equity-related outcomes rooted in disaggregated data from relevant communities. (Gates)	
Consumers					**Incorporate consumer voice and experience in models.** *For example: Identify a mechanism and execution strategy to actively incorporate consumer experience and voice in innovation models. (NoHLA)*

* Please note that ensuring equity in systems requires action from all partners and within all levers.

** Please note that spread of value-based models, equity, and consumer engagement and literacy are cross-cutting and reinforcing of one another.

HILN Commitment to Value Action Agenda – Increase person and family engagement and health literacy

Target/outcomes: 80 percent VBP in state-financed arrangements by 2019 (30 percent by the end of 2017), 50 percent VBP in commercial market by 2019

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<tr><td>All Partners</td><td>Reproduce successful models and practices across state and nation through the sharing of results, best practices, learnings, etc.</td><td></td><td></td><td></td><td>Focus on what matters to people and families—the “why”—when engaging consumers.</td></tr>
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Certify patient decision aids for total joint in 2017 (HCA)</td></tr>
<tr><td>Purchasers</td><td></td><td></td><td></td><td></td><td>Consider active purchasing that encourages enhanced engagement and understanding</td></tr>
<tr><td>Plans</td><td></td><td></td><td></td><td rowspan="3">Measure and report on patient experience.
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Promote “Own Your Health” content via</td></tr>
<tr><td>Providers/ Professionals</td><td rowspan="2">Adopt mission and policies that support a commitment to integrated care,</td><td></td><td rowspan="2">Expand accessibility, office hours, services and populations served.
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HILN Commitment to Value Action Agenda – Increase person and family engagement and health literacy

Levers* Partners	Policy / Culture / Leadership	Payment	Clinical practice transformation / Workforce / Clinician engagement & experience	Measurement / Reporting	Person & family engagement & decision making
	quality, value and patient experience. *For example: Develop policies and procedures related to commitment in services such as integrated care to produce value in clients' outcomes, clients' positive experience with the services and cost saving with values, mission, goals, objectives and practices to support integrated care. (ACRS)*		*Increase primary care service hours at ACRS site to serve from 200 to 300 clients. (ACRS)* *For example: Increase access to same day services (ICHS)* **Ensure evidence-based practices are culturally relevant and competent.** *For example: Modify evidence based practices to be culturally relevant and competent. (ACRS)* **Share in clinical decision making with patients and their families.** *For example: Include patient/consumer feedback in decision making process (ICHS)* *For example: Fully utilize peer specialists in decision making process. (ACRS)* *For example: Consider a role for nurses and health care workers to*	*Measure patient satisfaction (ICHS)* *For example: Consumers are able to rate their physicians within our provider directory. (Kaiser)* *For example: Complete the 4th Patient Experience Survey to assist consumers in evaluating medical groups based on direct feedback from other patients. (Alliance)*	*King County employee newsletters (King Co)* *For example: Advance consumer engagement tools such as PAM, WRAP, CommonGround (WA Council for Behavioral Health)* *For example: Keep "Own Your Health" website populated with consumer oriented materials that empowers Washington consumers to become active participants in their own health and health care. (Alliance)* **Engage people and their families as active participants in their health and in health systems transformation.** *For example: Create consumer advisory group that would participate in*

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			advance health literacy. (1199)		*giving feedback, direction to the BH program. (ACRS)* *For example: Enhance other means of getting consumer input and engagement such as clients satisfaction surveys, focus groups, etc. (ACRS)* *For example: Implement consumer board at each site (ICHS)* *For example: Conduct consumer focus groups (ICHS) For example: Advance text based engagement of low income population to activate them in engaging in care, and achieving quality results (Neighborcare)* *For example: KPWA is working to integrate the Community Checkup in*
Community					

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					our provider directory. (Kaiser) **Provide training to people and their families to ensure literacy, shared decision making and engagement in their own health.** *For example:* *Explore development of leadership training for our clients to empower and enable their meaningful participation. (ACRS)* *For example:* *Educate consumers for improved engagement (ICHS)*
City and County Governments					
Local Public Health	**Contribute a systems and population-based strategic focus to ACH decision making.** *For example:* *As member of ACH and BHO Boards,*				

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Levers* Partners	Policy / Culture / Leadership	Payment	Clinical practice transformation / Workforce / Clinician engagement & experience	Measurement / Reporting	Person & family engagement & decision making
	assure regional BH integration efforts result in improved patient centered care models. (Whatcom Co. Health Dept)				
Tribal Governments and Entities					
Industry (IT, pharma, labor etc.)	**Consider existing policy levers to advance person and family engagement and health literacy.** *For example: Consider collective bargaining as an opportunity to advance literacy and engagement (1199)*				
Philanthropy		**Invest in community and statewide grants that focus on social determinants, integration of care, and spread of best practices that support value.** *For example:*			

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		Grant investments that include a focus on social determinants of health/educational attainment (Gates)			
Consumers					**Incorporate consumer voice and experience in VBP models.** *For example: Identify a mechanism and execution strategy to actively incorporate consumer experience and voice in innovation models. (NoHLA)*

* Please note that ensuring consumer engagement in systems requires action from all partners and within all levers.

** Please note that spread of value-based models, equity, and consumer engagement and literacy are cross-cutting and reinforcing of one another.