

The Quality Improvement Strategy is a living document and is continuously updated; this version of the Strategy reflects updates from January to December 2020.

Introduction

HealthierHere sees effective quality improvement (QI) as a key building block for population health and quality care. Within King County, QI infrastructure varies significantly within and across providers in various healthcare sectors, including hospital systems, Federally Qualified Health Centers (FQHCs), tribal health care providers, behavioral health agencies (BHAs), community-based organizations (CBOs), and social service providers that address the social determinants of health (SDoH). HealthierHere is committed to equity and reducing health disparities and continues to make targeted investments to support partners that have traditionally been under-resourced, with the goal of building a more robust QI infrastructure in King County and establish a strong foundation for population health activities in service to improved outcomes on Pay for Performance (P4P) metrics.

Throughout this document, HealthierHere uses the term “clinical partner” to refer to the group of providers the Health Care Authority (HCA) calls “traditional Medicaid providers” – organizations that provide clinical care. “Community partner” is used for CBOs and other non-clinical entities, called “non-traditional Medicaid provider” by the HCA. “Tribal partner” will be used for Indian Health Care Providers, tribally operated providers, or urban Indian health programs. HealthierHere has conducted extensive current state assessments (CSAs) of clinical, tribal, and community partners’ QI capabilities and needs. Please see the Appendix for a summary of findings.

(1) Expectations and responsibilities for partnering providers in continuous quality improvement

HealthierHere’s QI expectations for clinical and tribal partners were shaped by the results of CSAs, Organization Change Plans, and site visits conducted in the fall of 2019. Similarly, QI expectations for community partners were shaped by the results of the Community Partner Assessment and System Transformation Plans conducted in the spring and fall of 2019 (see Appendix for more details). To promote equity, HealthierHere meets clinical, community, and tribal partners “where they are” with QI and sets reasonable expectations to help them improve. For example, with BHAs and FQHCs, HealthierHere will initially focus on their abilities to use and analyze electronic health record (EHR) data.

HealthierHere has adopted the Plan Do Study Act (PDSA) framework for clinical and tribal QI activities. PDSA is an established and proven protocol that has been adapted for healthcare delivery and promoted by the Institute for Healthcare Improvement, among other organizations. PDSA fosters rapid-cycle improvement strategies. By their very design, PDSA cycles allow an organization to begin improvement from any starting point, regardless of existing QI infrastructure or past efforts. This flexibility aligns with HealthierHere’s commitment to meeting all partners where they are. The community partner QI strategy uses a similar rapid-cycle improvement approach that tests and assesses changes over six-month periods including through site visits, reporting, partner meetings, and ongoing communication supported by training and technical assistance (TA).

HealthierHere’s expectations around clinical and tribal partner QI are further detailed in the [clinical summaries](#) section of our website under “What is our Approach?” Expectations include:

- Use EHRs and registries to (1) identify individuals and the services they need and (2) share integrated care plans and summaries of care, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (e.g., supportive housing), individuals, and their caregivers.

HealthierHere Quality Improvement Strategy

- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Just as partners tailor their services to an individual’s unique situation and goals, HealthierHere provides support for improvement based on each partner’s starting point. Clinical and tribal partners with less developed population health infrastructure may start with defining high-risk narrowly and scale to reach more of their patient population as they build their internal QI infrastructure. Further information on how HealthierHere will provide training and TA to help clinical and tribal partners improve is detailed in Section 2.

When creating its community partner QI strategy, HealthierHere considered long-standing disparities, at both the individual and organizational levels. The community partner QI strategy seeks to build a shared understanding of QI language, strategies, and goals. The strategy integrates a culturally responsive and respectful framework, including an approach that seeks to understand appropriate measures of progress based on where partners are in their work and how they define culturally responsive and appropriate care.

HealthierHere’s QI expectation for community partners is that their quality monitoring approaches are value-driven and based on the unique needs of the organizations and the communities they serve. Informed by clinical measures, HealthierHere worked with community partners to establish culturally responsive measures, including “proxy measures” that track progress related to the impact of SDoH on clinical outcomes. For example, HealthierHere asked community partners to provide a narrative description on the impact their services are having on increasing access to physical and behavioral healthcare services, substance use disorder treatment and prevention services, community-based chronic disease support and self-management programs, and traditional healing and medicine. Allowing partners to provide narrative descriptions versus quantitative reporting has proven effective at providing a culturally responsive approach to understanding and tracking quality improvement over time. These proxy measures help capture the impact SDoH services provide in a community setting and the anticipated correlation to improved health outcomes, through demonstrating a positive impact on the Medicaid Transformation Project (MTP) metrics. This reporting takes place semi-annually, in sync with the reporting calendar for clinical partners.

(2) Regional framework for supporting partnering providers’ quality improvement processes

HealthierHere conducted extensive assessments to inform QI strategies and tests of innovations to improve patient experience as well as overall health outcomes, especially those related to the P4P metrics within HealthierHere’s MTP Portfolio.

HealthierHere’s core value of equity is woven throughout the organization’s work. QI success is not simply achieving clinical metrics, but also moving partnering providers on the continuum of being increasingly culturally and linguistically appropriate and relevant for the people they serve. Across clinical, tribal and community partners, HealthierHere is implementing various strategies to help partners advance equity:

- Providing resources, including guidance and financial incentives, for partners to develop an Equity Action Plan
- Monitoring partners’ progress on implementing their Equity Action Plan
- Developing and sharing an [Equity Definition and Guidelines](#) to help guide partners in their efforts to advance equity

HealthierHere Quality Improvement Strategy

- Providing training to help partners implement equity best practices
- Developing a set of equity measures, led by HealthierHere's Equity Measures work group and based on feedback from HealthierHere governance committees and stakeholders
- Collecting and reporting data for the equity measures annually, starting in 2021 and using 2020 data as a baseline year

Three pillars inform HealthierHere's overall regional QI framework to support transformation efforts. In each of these pillars – indeed, within all of its work – HealthierHere leads with equity and remains mindful of historically under-resourced services and the populations they serve. The three pillars are:

1. Build infrastructure and capacity, both within organizations and at the system level.
2. Co-design and create blueprints for tools that enable integrated care, such as a shared care plan and community information exchange (CIE).
3. Catalyze tests of innovation.

QI is most strongly emphasized in pillar 1, the components of which are described below.

1. Build Infrastructure and Capacity

HealthierHere is focusing on building infrastructure and capacity in three primary ways: Learning and Co-Design Collaboratives, training and TA, and an incentive package that supports Pay for Progress (clinical and tribal partners) and attainment of benchmarks and milestones (community partners).

Learning and Co-design Collaboratives – All Partners

HealthierHere established Learning Collaboratives for each of its four transformation projects, and these convenings evolved into Co-design Collaboratives in the second half of 2019. These in-person meetings provided an opportunity for partners from different sectors – along with representatives from managed care organizations (MCOs), key stakeholders, and subject matter experts – to collaboratively identify common challenges, work toward solutions, and share best practices. As a result of COVID-19, the Co-design Collaboratives were suspended in 2020 to give partners additional capacity to respond to the pandemic. HealthierHere is currently evaluating how to evolve the Co-Design Collaboratives in light of COVID.

Training and TA – Clinical and Tribal Partners

Clinical and tribal partners identified training needs and participated in a prioritization process with HealthierHere to guide initial training investments. Based on clinical partner input, HealthierHere has invested in trainings that will directly address their needs. Initial investments supported a Value-Based Payment (VBP) Academy for BHAs, Collective Ambulatory optimization, Whole Person Integrated Care training for clinical partners, the development of a training fund that partners can access to support their unique needs, and a summit of community and clinical partners to develop innovations. *See the appendix for a detailed overview of training and TA offerings for clinical and tribal partners*

Training and TA – Community Partners

HealthierHere provides training and TA to community partners focused on building organizational capacity and infrastructure to provide SDoH services in a culturally responsive manner. The TA and training will continue to include implementing culturally appropriate and responsive QI strategies and processes including ongoing health system transformation support, coaching on financial sustainability leading to value-based payment partnerships with

healthcare providers, equity training, and SDoH service delivery support. All training and TA provision will be based on feedback from community partners on how HealthierHere can best support system transformation efforts.

Incentive Package: Semiannual Clinical Reporting Requirements

To encourage and reward ongoing QI activities for clinical and tribal¹ partners, HealthierHere created a 'Pay for Progress' incentive package. Clinical partners earn payments for completing various assessments and improving on selected metrics. Initially some incentives focused on hitting defined targets, others emphasized improvement over self (IOS). One of the changes HealthierHere made due to the COVID-19 pandemic was to eliminate the 'IOS' system, now clinical partners earn incentive funds based on fulfilling reporting requirements only. HealthierHere continues to monitor clinical and tribal partners' progress to learn about and share best practices, adjust investments and/or training opportunities, and identify clinical partners that may need a higher level of support. The clinical reporting incentives are described in more detail in Section 3. Incentives for 2021 and future years will be determined annually.

Beginning in July 2020, due to the COVID emergency and the overwhelming demands placed on providers, HealthierHere suspended self-assessment metrics for whole person screening, risk stratification, registry functionality, risk stratification, and use of Collective Ambulatory were removed; the MeHAF integrated health assessment and opioid survey were still collected. In the second reporting period of 2020 (Q3 and Q4) all eight incentives were reactivated. HealthierHere will continue collecting the majority of these metrics in 2021 but will reevaluate the reporting requirements based on partners capacity and the COVID-19 pandemic.

Benchmarks and milestones are included within community partner contracts. These benchmarks and milestones are developed according to HealthierHere's determination of system transformation needs based on available data, partner meetings, semi-annual reporting and site visits.

2. Co-design and Create Blueprints for Improved Models of Care

HealthierHere brings clinical, community, and tribal partners together to co-design blueprints for system-wide integrated care in King County. The focus areas for exploration in 2019 and 2020 included shared care planning, SDoH screening, cross-system data infrastructure/integration, and a regional CIE. *See HealthierHere's semi-annual report #6 for details on how these items are progressing.*

3. Catalyze Tests of Innovations

In the fall of 2019, HealthierHere established an Innovation Fund to support innovations proposed by partners to test innovative care models that improve community-clinical linkages and achieve P4P metrics. Included in this strategy is a focus on building organizational capacity to use community health workers and peer support specialists, as well as supporting these staff in expanding their scope related to MTP strategies. The tests of innovation will utilize continuous QI to ensure innovations achieve desired improvements and inform strategies for scaling and sustaining.

HealthierHere is currently funding ten projects through the Innovation Fund:

¹ Tribal partners have a modified Pay for Progress incentive package, with some metrics being pay for reporting.

HealthierHere Quality Improvement Strategy

- Two projects that aim to build community-based capacity for low-barrier and drop-in medication-assisted treatment access
- One project that aims to reduce the volume of low-acuity 911 calls by improving community support linkages via first responders
- Seven projects that aim to test new models for integrated whole person care, all centered on a partnership between behavioral health and primary care and how the two systems can work together to improve health outcomes for individuals who are diagnosed with serious mental illness (SMI) and a chronic physical health condition.

See appendix for additional details on these projects

Additionally, HealthierHere is exploring launching community partner-led innovation projects in 2021 that will test innovative solutions to SDoH service provision related to P4P metrics.

(3) Monitoring transformation efforts by understanding partnering providers' progress and connecting with resources and technical assistance

HealthierHere uses QI methods to track clinical, tribal, and community partners' progress on implementation of Medicaid transformation activities through:

1. A semi-annual assessment measuring progress on foundational incentive measures
2. Site visits
3. Co-design Collaborative and other partner convenings
4. Ongoing communication with training and TA contractors

These methods are described briefly below.

1. Semi-annual Assessment

The primary method HealthierHere uses to measure progress is to establish a set of process measures or milestones tied to payments through clinical, tribal, and community partner contracts and assessed through semi-annual reports. Payment to clinical, tribal, and community partners are tied to completion of the reports and/or achievement of certain targets to ensure progress toward transformation. At this stage, the milestones are foundational and are tied not to any specific project but to the infrastructure and SDoH services (for community partners) necessary to support population health, QI processes, and value-based care. All clinical, tribal, and community partners are expected to implement and make progress on these foundational activities. HealthierHere recognizes that clinical, tribal, and community partners are all starting in different places. Therefore, the incentives have been structured to reward improvement no matter the baseline.

Progress will be supported through HealthierHere's investments and linked to the training, TA, and practice coaching described in Section 2.

Clinical and Tribal Partners

Initially, clinical and tribal partners earned payments for completing various assessments and improving on selected metrics. Some incentives focused on hitting defined targets, others emphasized IOS, thereby encouraging more mature partners to improve above and beyond their current state.

HealthierHere Quality Improvement Strategy

Beginning in July 2020, due to the COVID emergency and the overwhelming demands placed on providers, HealthierHere suspended partners' self-assessment metrics related to whole person screening, risk stratification, registry functionality, risk stratification, and use of Collective Ambulatory were removed; the MeHAF integrated health assessment and opioid survey were still collected. In the second reporting period of 2020 (Q3 and Q4) all eight incentives were reactivated. *See "Pay for Progress Methodology" in the appendix for the list of incentive metrics for clinical and tribal partners*

HealthierHere will continue collecting the majority of these metrics in 2021 but will reevaluate the reporting requirements based on partners capacity and the COVID-19 pandemic.

Clinical and tribal partners are measured semi-annually through a report electronically submitted to HealthierHere. All of the milestones are currently measured as a binary – completed or not completed, but many of the incentives are designed as a simple scale inspired by validated tools such as the MeHAF, IHI Pathways to Population Health Compass, and Patient-Centered Medical Home Assessment. The use of self-assessment scales allows HealthierHere to quickly and easily monitor how clinical and tribal partners are progressing in various areas and provide targeted assistance to clinical and tribal partners who may be stalled or falling behind. The equity assessment follows a similar structure, allowing HealthierHere visibility into the progress clinical and tribal partners are making toward becoming more equitable and culturally/linguistically accessible organizations with authentic community and consumer voice incorporated into decision-making. All clinical and tribal partners will submit their self-assessments with the contractual understanding that HealthierHere will perform site visits and conduct routine audits to ensure accuracy of the information submitted to HealthierHere. Although it was originally planned for partners to each develop a QI project that ties to one of HealthierHere's P4P metrics, due to the COVID emergency, HealthierHere removed this requirement beginning with the July 2020 reporting period. We are now inviting our partners to report on how they've used formal QI techniques to support transformation goals. The AIMS Center and Comagine Health will support partners in both project development and implementation. For more details on the Pay for Progress requirements and methodology for calculating progress, see the Appendix.

Community Partners

Annually, HealthierHere establishes benchmarks and milestones for community partner transformation efforts and tie them to financial incentives. HealthierHere works with partners to clearly define benchmarks and milestones that allow for quantitative and/or qualitative measurement of progress. Final benchmarks/milestones are captured in community partner contracts along with agreed-upon deliverables and deadlines. Community partners will report on progress twice a year.

2. Annual Site Visits

Site visits are used to discuss and better understand the information submitted in partners' semi-annual reports and collect information about partners' progress. Site visits give HealthierHere practice transformation managers and community and tribal engagement managers the opportunity to troubleshoot and provide more guidance on targeted TA opportunities to aid in continuous QI.

Annually, practice transformation managers and community and tribal engagement managers conduct site visits with partners. Additional visits are scheduled as needed.

3. Co-design Collaborative and Other Partner Convenings

In mid-2019, as community partners began to work more closely with clinical and tribal partners, HealthierHere's Learning Collaboratives transitioned to the Co-design Collaborative. As a result of COVID-19, the Co-design Collaboratives were suspended in 2020 to give partners additional capacity to respond to the pandemic. HealthierHere is currently evaluating how to evolve the Co-Design Collaboratives in light of COVID.

4. Ongoing Communication with Training and TA Contractors

The fourth method HealthierHere uses to monitor progress of implementation activities is via regular communication with contracted vendors providing training and TA to clinical and tribal partners. HealthierHere hosts regular meetings with contractors and receives status reports on how partners are progressing. This regular communication provides an opportunity for HealthierHere to get information quickly, with the opportunity to change course and provide more immediate assistance if needed.

Annually, HealthierHere enters into contracts with external organizations for training and TA for community partners. At the outset, HealthierHere's community and tribal engagement managers worked directly with community partners to provide coaching on reporting progress toward transformation. HealthierHere views reporting and monitoring as tools for identifying areas of need and will work with partners to reduce power dynamics that occur in the course of what could be perceived as audits.

(4) Support of partnering providers in making necessary adjustments to optimize transformation approaches

As outlined above, HealthierHere developed a set of incentives that align with transformation goals, key milestones, and efforts to reduce health disparities. Organizations report progress every six months, giving HealthierHere the opportunity to monitor clinical, community, and tribal partners' progress and identify opportunities for intervention, including enhanced training, TA, and practice coaching. In addition, HealthierHere continues to provide and expand other avenues for monitoring and open communication, including, but not limited to, dashboards derived from regional and clinical, tribal, and community partner-level performance data, planned tests of innovation, partner learning webinars, TA, practice coaching, and in-person seminars and summits. Ideally, the mechanisms described above will enable HealthierHere to identify the need for intervention before a clinical, community, or tribal partner's scores drop below the established benchmark(s). Regardless of the timing, once HealthierHere identifies the need for intervention, a HealthierHere practice transformation manager or community and tribal engagement manager will:

1. Inform the clinical, community, or tribal partner that their scores indicate they are not making sufficient progress. This initial outreach is likely to happen via both email and a phone call, from the assigned practice transformation or community and tribal engagement manager.
2. Regardless of communication channel, emphasize HealthierHere's desire to help the practice succeed in our Pay for Progress or milestone incentive metrics and, ultimately, in practice and system transformation.

HealthierHere Quality Improvement Strategy

3. Involve leadership and additional staff as necessary and support partners in developing workflows/processes to improve issue.
4. Follow-up with partners, as needed, including through site visits.

HealthierHere maintains open dialog with clinical, tribal, and community partners and encourages ongoing communication. HealthierHere strives to provide many opportunities for our clinical, tribal, and community partners to express concerns and provide feedback. Although each clinical and tribal partner is assigned to a practice transformation manager and community partners are assigned to a community and tribal engagement manager as that organization's primary contact, partners are encouraged to interact with any member of the HealthierHere staff as they see fit. HealthierHere provides formal and informal opportunities for communication. At the same time, HealthierHere actively monitors our partners' progress and concerns. Opportunities for interaction include, but are not limited to:

- Semi-annual reporting
- Annual site visits
- Governing Board and committee meetings
- Partner meetings

Through all of these interactions, as well as others, HealthierHere monitors and tracks the barriers identified by partners, whether those barriers arise from adherence to the clinical summaries or challenges of the implementation process.

During site visits to community partners, community engagement managers discuss progress related to partnership building and system transformation traction towards equity, access to care, infrastructure, and capacity. Community engagement managers request feedback from community partners and assess needs related to technical assistance.

During the site visits to clinical and tribal partners, practice transformation managers discuss general project and transformation progress with partners, enabling HealthierHere to distinguish between general progress and action driven in response to barriers. From there, HealthierHere and the clinical and tribal partners can move forward to assess, determine, and monitor mitigation strategies.

Specific to the Pay for Progress incentives, HealthierHere will:

1. Solicit feedback on the Pay for Progress incentive metrics at regular intervals (between the six-month reporting deadlines).
2. Integrate Pay for Progress messaging, when appropriate, into ongoing communications channels and in-person events to encourage additional feedback and requests for support.
3. Maintain open communication with partners via partner meetings, trainings, and other informal communications, and encourage partners to self-identify and seek HealthierHere's assistance if they are struggling, in order to prevent them from falling behind.

(5) Disseminating successful transformation approaches and lessons learned across ACH partnering providers, and potentially across ACHs

HealthierHere Quality Improvement Strategy

HealthierHere brings together clinical, tribal, and community partners and other stakeholders, with the goal of sharing best practices that can facilitate collaboration and address common barriers. Those venues also provide the opportunity to find ways to scale and sustain successful QI initiatives. In addition, these initiatives could evolve into ongoing projects supported by HealthierHere's innovation fund.

HealthierHere is aware that not all partners are part of all initiatives. To that end, HealthierHere strives to relay relevant information in the way that is most accessible to a given audience.

HealthierHere's regular activities, convening, and communication channels are described earlier in this document and include:

- Regular in-person Learning and Co-design Collaboratives
- On-site practice coaching on whole-person care and the Collective Platform
- Ongoing partner learning webinars
- Community partner meetings

In 2021 HealthierHere will offer our partners access to a series of trainings via self-paced online modules. The AIMS Center is developing these modules with HealthierHere input. They should be available to partners via HealthierHere's website in early Q2 2021. The online modules are oriented to BHAs, particularly case managers at BHAs, to provide a self-paced training series on how to support patients with chronic physical health conditions in addition to behavioral health diagnoses. The AIMS Center has designed the modules to be in a user-friendly online format, using the RISE web-based learning tool (rise.com), with careful attention to adult learning issues. Included would be the use of practical job aids, such as checklists for routine activities of care management teams, including interactions with primary care, medication reconciliation, case load review, etc.

Modules will cover the core issues in the medical care of persons experiencing serious mental illness:

- Background information on the mortality gap for seriously mentally ill persons.
- Highly practical and easily referenced information on the relatively small number of medical conditions, such as diabetes, that are relevant to the care of this population.
- Time-tested AIMS Center implementation support materials to guide agencies as programs are developed.
- Interacting effectively with medical providers.
- Behavioral techniques to support health behavior change.

In addition, HealthierHere disseminates best practices through regular touch points and communications with clinical, tribal, and community partners, including:

Workshops, Summits, and Other Supports

HealthierHere sponsors periodic workshops on topics of interest to our stakeholders. In the fall of 2019, for example, HealthierHere – through its partnership with the King County Integrated Care Network – hosted a workshop for BHAs on negotiating VBP arrangements from a place of power;

the workshop featured Adam Falcone, a nationally known lawyer with VBP expertise. In April 2020, HealthierHere produced a tutorial for partners to introduce new functionality created by Collective Medical to share COVID-related information on the Collective Platform, including information about positive COVID lab tests from King County and the Washington State Department of Health and other diagnostic-related information that would be helpful to providers. MCOs and the clinical providers with whom HealthierHere works have reported that having access to this timely information has been invaluable to them in following up on COVID patients with recent hospital stays and ED visits. The [slide deck for this tutorial](#) continues to be available on the HealthierHere website.

Newsletter and Blog Posts

HealthierHere's in-house communications team disseminates valuable announcements and information across all stakeholder groups. In addition to sharing our own news and best practices we have gathered through our work, HealthierHere promotes other Accountable Communities of Health's (ACHs') events and webinars, as appropriate, to connect work across the state and give our partners more opportunities to learn.

HealthierHere COVID-19 Resource Hub

HealthierHere maintains a comprehensive [COVID-19 Resource Hub](#) to provide a vast range of continually updated and curated information for providers, community organizations, housing/homeless organizations, and consumers and their families about COVID topics--from where to find emergency food resources to what the latest Medicaid billing policies are for telehealth visits. This COVID-19 Resource Hub also contains a [Telehealth Implementation Resource Guide](#), which provides links to useful webinars and other information for providers to help them get started using telehealth.

Cross-ACH Collaboration

Together with the eight other ACHs in Washington, HealthierHere participates in cross-ACH discussions and events that focus on data collection and sharing and programmatic activities, among other topics. As appropriate, HealthierHere shares this information with partners.

Statewide Care Coordination Platform Standards Workgroup

As of December 2019, HealthierHere leads a statewide workgroup assembled to draft and promulgate standards for sharing care coordination information using Collective Platform. Representatives from all of the ACHs--as well as other stakeholders such as MCOs, behavioral health provider groups, the HCA, and tribal providers--have participated in this group's biweekly meetings, while they have also solicited feedback from care coordinators and other providers with whom they work. In September 2020, a final draft of a set of standards was produced. In 2021, the Workgroup plans to introduce these standards to users across the state and will support the ongoing sharing of this information.

Community and Consumer Voice (CCV) Committee

The CCV committee is a formal committee of the Governing Board. The purpose of the CCV committee is to proactively engage CBOs and the beneficiaries of services to ensure that their voices influence and guide the decision-making of HealthierHere. The Equity and Engagement team reports recommendations and committee updates to the Governing Board on a semi-annual basis.

Indigenous Nations Committee

The Indigenous Nations Committee is a formal committee of the Governing Board. The purpose of this committee is to proactively engage Native-serving CBOs, Indigenous professionals, traditional healers, American Indian (AI)/Alaskan Native (AN)/Indigenous (I) story-tellers, AI/AN/I Elders, AI/AN/I cultural experts, and beneficiaries of services to ensure that their voices influence and guide the decision-making of HealthierHere. The Equity and Engagement team will report recommendations and committee updates to the Governing Board on a semi-annual basis.

Community Grants Program

The goal of the Community Grants Program is to engage CBOs and Medicaid beneficiaries in King County to ensure their voices guide and influence HealthierHere's work. Through the 2018 and 2019 Community Grants Program, HealthierHere resourced CBOs to engage with Medicaid beneficiaries in their communities and collect surveys to understand their experience with the healthcare system. Community members who participated in the 2018 and 2019 surveys include Medicaid recipients in King County identified as people of color, low income, immigrants, refugees, Asian American, Pacific Islander, LGBTQ/Two Spirit, AI/AN/I, houseless/homeless, youth (ages 18-26), and those dealing with behavioral health conditions. The 2018 and 2019 Community Grants Program results were shared with stakeholders, committees, partners, and community members during meetings and workshops throughout 2020. Alumni of the Community Grants program were engaged with HealthierHere in a continuous and ongoing manner throughout 2020.

APPENDIX

Current State of Clinical, Tribal, and Community Partners' Quality Improvement Capabilities and Needs

Clinical and Tribal² Partners

Our analysis of clinical and tribal QI infrastructure by healthcare sector was informed by HealthierHere's CSA, distributed and completed in April and May of 2018. The results of the CSA analysis showed that of those responding, 42 partners, including 14 hospital systems, seven FQHCs, and 21 BHAs, completed the assessment that included questions about QI capacity. Of the organizations that completed the assessment, 100% of hospital systems and FQHCs had QI processes, as did 80% of BHAs. Over 80% of hospital systems reported practicing continuous QI strategies, with 70% of FQHCs reporting the same. Only 50% of BHAs reported practicing continuous QI. HealthierHere also asked whether clinical and tribal partners supply comprehensive performance measures to their providers on a regular basis. More than 80% of hospital systems and FQHCs reported that they provide reports regularly, but only 20% of BHAs did the same, signaling that this is a major area for improvement. BHAs are also in need of greater support in how they use EHR data for QI. No BHAs reported using clinical EHR data for decision support, as compared with 70% of hospital systems and 40% of FQHCs. And only 10% of BHAs reported that they use EHR data for QI and population health management, as compared with 80% of hospital systems and 40% of FQHCs.

According to HealthierHere's CSA, hospital systems (which include primary care physicians' networks) are generally the best resourced, with established QI departments, processes, and committees. FQHCs tend to have mature QI infrastructure as well, due to a regional focus on Patient Centered Medical Home accreditation over the past decade. However, FQHCs still have opportunities to strengthen and standardize QI methods to support transformation and improve patient outcomes. BHAs currently have the least developed QI infrastructure of our clinical partners and are the most under-resourced.

Community Partners

HealthierHere completed its assessment of community partners in April 2019. Fifty-five community partners completed an assessment asking about their QI capacity, through which HealthierHere determined that 80% of community partners reported having a QI monitoring system regarding services to clients/members; 20% did not. The assessment indicated that staff capacity is a key factor contributing to whether community partners have QI monitoring systems; approximately 72% of community partners reported having staff dedicated to quality monitoring activities, while around 16% did not and 12% reported that QI responsibilities were distributed across multiple individuals but there were no dedicated staff. Quality monitoring activities among community partners include review of client/member outcomes data, client/member satisfaction surveys, internal work groups focused on monitoring/QI, grievance and compliance tracking, and client/member focus groups. Quality monitoring data is often used by community partners to identify and address differences across demographic groups, set and monitor benchmarks, and determine resource allocations. Related to equity goals and QI, community partners were asked about their quality monitoring activities related to cultural and linguistic accessibility of services and a slight majority (51%) said they conduct monitoring, while the rest said they either do not monitor it at all or do not monitor it in any formal way. HealthierHere will be

² Current tribal partnerships with HealthierHere include Seattle Indian Health Board (SIHB) and Cowlitz Indian Tribe. For QI purposes, SIHB is treated as an FQHC and Cowlitz Indian Tribe is treated as a BHA.

contracting with a subset of community partners who demonstrated readiness for partnering with HealthierHere to implement transformation efforts.

Community partners also completed System Transformation Plans in the fall of 2019, describing how they measure impact or success, and all community partners have systems and processes in place to measure performance, giving HealthierHere a baseline for measuring QI moving forward. Some of their performance measurement approaches include intake and exit surveys, confirmation of referral linkages, and direct community feedback. HealthierHere will work with partners to build on these baseline capabilities.

Training and TA Offerings for Clinical Partners

VBP Academy. In 2019 HealthierHere contracted with Comagine Health (formerly Qualis Health) to provide 17 BHAs with training, TA, and practice coaching to support ongoing QI. The VBP Academy ended in January 2020 and was an intensive 10-month curriculum that guides BHAs through practice transformation. The curriculum includes population health, risk stratification, QI, and PDSA cycles. Throughout the 10 months, Comagine Health Supported practices in the development and implementation of a QI transformation project that focuses on one of the P4P metrics within HealthierHere's MTP Portfolio. As a culminating event for the academy, six agencies provided presentations on QI projects developed in the program, which addressed challenges such as increasing timely "no wrong door" access to services and reducing ED visits and psychiatric hospitalizations in high utilizers.

Collective Ambulatory Optimization. Comagine Health is also supporting the optimization of the Collective Ambulatory platform (also known as EDIE or PreManage) as HealthierHere and King County ensure broad implementation to BHAs and FQHCs. The Collective Ambulatory platform gives organizations a key tool for tracking patient emergency department (ED) utilization and to share information about care guidelines and care teams. With access to ED utilization data, providers can improve and refine follow-up processes relevant to P4P metrics. Comagine Health practice coaches emphasize the use of PDSA cycles in the development of clinical workflows to improve ED follow-up.

In 2019, Comagine Health provided 25 BHAs with TA and practice coaching; 13 of these had previously not used Collective Ambulatory. In addition, four BHAs and three FQHCs were receiving coaching to optimize their use of Collective Ambulatory. As of December 31 2020, Comagine Health was still in contact with 12 of these organizations to assist them with using the platform. Working with Comagine Health practice coaches, these agencies are receiving notifications and adapting workflows to serve identified sub-populations. Many BHAs plan to scale these processes and improvements over time. For HealthierHere's partners with more mature QI infrastructure, many of whom were already using Collective Ambulatory, the Comagine practice coaches offer guidance in optimizing use of the platform. Examples of optimization include risk stratification and creating advanced tools for tracking post-discharge follow-up. For partners with less mature QI infrastructure, the Comagine coaches are focusing on initial implementation and setting up new workflows.

In 2021, HealthierHere will be providing training and technical assistance to providers regarding the sharing of care-coordination-related information using the Collective Platform (the larger suite of tools of which Collective Ambulatory is a part), using standards developed by the Statewide Care Coordination Platform Standards Workgroup.

Whole Person Integrated Care Training and TA. HealthierHere is also contracting with the Advancing Integrated Mental Health Solutions (AIMS) Center of the University of Washington to provide Whole Person Integrated Care training, TA, and practice coaching tailored to organizational needs and capacity. Under this contract, the AIMS Center is offering both individualized and small-group training and TA to clinical partners to help them develop sustainable models of whole-person care. AIMS Center practice coaches will emphasize the use of PDSA cycles in the development of clinical workflows that support whole-person integrated care. In September 2019, AIMS Center coaches began working with four hospital systems and three FQHCs that have more advanced QI infrastructure. Since launching, AIMS Center coaches have expanded that number, checking in regularly with all HealthierHere partners open to TA and practice coaching. As of December 2020, 12 HealthierHere clinical partners were actively engaged in AIMS Center coaching and TA: four BHAs, four FQHCs, and four hospital systems. By meeting partners where they are, AIMS Center coaches have experienced high levels of interest and engagement, regardless of starting point. For both Comagine Health and AIMS Center coaching, PDSA cycles inform the work, regardless of an organization's starting point.

Partner Training Fund. With the understanding that partners may be in different places with respect to their training needs, HealthierHere established a partner training fund in late 2019 (DY3 Q4) to support partners that pursued additional training opportunities beyond HealthierHere's system-wide training investments. The Partner Training Fund had two main components,

- **The purchase of 250 licenses to participate in the [Institute for Healthcare Improvement's Open School³](#) courses**, to be shared with partners that would not otherwise have access to that resource. As of the December 2020, 24 individuals have accessed the Open School, representing eight organizations. HealthierHere will continue offering these enrollments in 2021.
- **A flexible fund with up to \$10,000 being made available to all 25 clinical practice partners to pursue additional training opportunities.** By the end of March 2020 (DY4, Q1), only one organization that received a Partner Training Fund award was able to fully expend that award for a staff training. Due to the COVID-19 pandemic and limits on business travel, the cancellation of conferences, and social distancing mandates, HealthierHere learned that other partners who had submitted applications to the Partner Training Fund would not be able to fulfill their plans and that many organizations would have limited capacity for additional trainings due to the COVID-19 crisis. In April 2020 HealthierHere decided to sunset the flexible funds piece of the Partner Training Fund, reallocating the remaining funds to COVID response activities.

Partner Summit. In Q2 2019, in collaboration with [Bridging Health & Community](#), HealthierHere convened community, clinical, and tribal partners for a full day to build and deepen partnerships; work toward a shared vision for how community, clinical, and tribal partnerships will improve health outcomes; and begin a conversation about focusing on collaborative innovations designed to impact P4P metrics. In 2020, HealthierHere suspended this summit, in order to reduce the meeting burden on providers dealing with the COVID emergency. HealthierHere will revisit whether to host a 2021 partner summit.

³ The IHI is a well-known provider of online tools and instruction in healthcare quality improvement, with more than 700,000 students around the world having completed at least one course within their Open School curriculum. Students have access to more than 30 hours of instruction, and learning is at each student's own pace.

Summary of Innovation Fund Projects

Medication Assisted Treatment (MAT) Innovation Projects. Beginning in October 2019, HealthierHere provided funding to two FQHC partners to enhance their existing MAT programs to better serve individuals who has received their initial doses of buprenorphine in an Emergency department or jail setting, and needed to be connected to a community MAT provider for ongoing treatment. Country Doctor (in partnership with the Sound BHA and the Hepatitis Education Project) and Pubic Health Seattle & King County (in partnership with the Navos BHA) took similar approaches, expanding service hours to include nights and weekends, establishing referral workflows to streamline the experience of taking on new patients, and adding Navigator or CHW positions to provide additional support to MAT patients. Country Doctor successfully completed their first year of the innovation in September 2020 and contracted with HealthierHere for a second year of funding. PHSKC is currently negotiating a no-cost extension of their year 1 contract due to a COVID-19 related delay in hiring resulting in an unspent balance. By the end of January 2021 Country Doctor should be in contract for a second year of funding, pending completion of their year 1 activities.

Community Paramedicine/Mobile Integrated Health. In November 2019, HealthierHere provided funding to support the Seattle Fire Department (SFD) in creating a mobile response unit dedicated to reducing the volume of hospital emergency department visits that result from “low-acuity” 911 calls, linking those individuals, instead, to case management and community support provided by a network of partnering agencies. From the time the SFD’s unit (deemed “Health One”) was stood up in November to October 31, 2020, the unit has arrived on scene at 829 occasions, with 95% of those encounters for low-acuity or aid-related response. In 2021, HealthierHere will still support the development of this program as the SFD builds their capacity to assist this population.

Testing Models for Integrated Care Innovation Projects. In June and July 2020 HealthierHere provided funding to support seven partnerships centered on testing models of integrated, whole person care to improve health outcomes for individuals experiencing serious mental illness (SMI) and cooccurring chronic physical health conditions. The structure of these innovation projects is not uniform, with HealthierHere supporting different approaches and partnership structures. Two of the innovation projects focus on enhancing Behavioral Health services within an FQHC primary care setting via a stronger partnership with a BHA focusing on a shared panel of patients. HealthPoint (partnering with the Valley Cities BHA) and ICHS (partnering with the ACRS BHA) are representative of this model. The second type of innovation projects are hospital primary care systems implementing a collaborative care model by embedding a behavioral health provider from a BHA partner and testing collaborative care billing codes to sustain the partnership. Multicare (partnering with Sea Mar’s BHA division) and CHI Franciscan (partnering with Valley Cities) are representative of this second model. The three remaining innovation projects are pursuing their own models. DESC (a BHA focused on a high needs population such as those with SMI and experiencing homelessness) partnered with Harborview (a safety net hospital which serves many from the DESC population) to develop a more robust model of care coordination for their shared patients, exploring ways to implement a shared care plan across agencies and hiring care coordinators at different levels (from Peers to an RN) to see which level of staff is most effective. Additionally, DESC was funded for a separate innovation project where they are partnering with an MCO (CHPW) and local government (King County Behavioral Health and Recovery Division) to develop a bundled payment model for MAT patients who are unhoused and have other special needs, making them difficult to reach and encourage to maintain services. The seventh integrated care innovation project funds Seattle Children’s Care Network to implement a learning collaborative to further a pediatric collaborative care model and expand those services to a number of pediatric primary care practices.

Pay for Progress Methodology

The Pay for Progress IOS methodology was shared with partners in the attached *2020 Clinical Practice Transformation Reporting Workbook*.

HealthierHere’s partners will report on Pay for Progress milestones on a semi-annual basis. All incentives are measured as binary – completed or not completed, but many of the measures are designed using a simple scale inspired by validated tools such as the MeHAF and PCMH-A so that partners and HealthierHere can track their progress. The Pay for Progress reporting workbook includes the scale for each relevant milestone. Partners review the characteristics of each level of the scale and self-identify where they stand.

Figure 1. **Pay for Progress Measures**

2020 Incentives by Designated Reporting Level

Incentives	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
1) MeHAF Assessment		X	X	
2) Opioid Survey		X	X	X
3) Whole Person Care Screenings/Assessments		X	X	
4) Use and Optimization of the Collective Platform	X			
5) Registry Functionality		X	X	
6) Risk Stratification		X	X	
7) Equity	X			
8) Quality Improvement	X			



HealthierHere

2020

Clinical Practice Transformation

Reporting Workbook

For July 1 – December 31, 2020 ONLY

Last Revised, 10/30/2020

Contents

About HealthierHere’s Clinical Practice Transformation Reporting Workbook	3
Reporting Requirements	3
Test Sites vs. Reporting Sites.....	3
Suggested Best Practices for Completion	3
Incentives by Designated Reporting Level	Error! Bookmark not defined.
1) MeHAF Site Self-Assessment to measure level of physical and behavioral health integration	4
2) Opioid Survey.....	10
3) Whole Person Care Screenings/Assessments.....	12
4) Use and Optimization of Collective Platform	14
5) Registry Functionality	15
6) Risk Stratification	16
7) Equity	17
8) Quality Improvement.....	20

About HealthierHere's Clinical Practice Transformation Reporting Workbook

This workbook details HealthierHere's 2020 Pay for Progress incentives. Please use this Clinical Practice Transformation Reporting Workbook (Workbook) as the tool to collect your responses and report your progress on HealthierHere's Clinical Practice Transformation Pay for Progress Incentives for 2020. You are encouraged to edit this document to collect information for your organization, but your final responses must be submitted using HealthierHere's online tool, called FormAssembly. The FormAssembly link is available here: <https://www.healthierhere.org/clinical-reporting-site/>.

Reporting Requirements

Reporting requirements for each incentive will vary depending on the incentive. Some incentive metrics warrant reporting at the **organizational level**, one response for the organization as a whole. The HealthierHere champion is likely the best person to collect this information and report on behalf of the organization.

Other incentive metrics are best answered at the **individual site level**. HealthierHere has outlined three types of sites: Primary Care (**PCP**) Clinic Sites, Behavioral Health Agency (**BHA**) Clinic Sites, and Hospital Emergency Departments (**ED**).

PCP Clinic Sites: Both FQHC and hospital-affiliated primary care clinics are considered PCP Clinic Sites. HealthierHere requires one submission/response for each contracted reporting site (please refer to Exhibit B of your contract for the complete list of reporting sites).

Behavioral Health Agency (BHA) Clinic Sites: Community (outpatient) behavioral health clinical sites are considered BHA Clinical Sites. HealthierHere requires one submission/response for each contracted reporting site (please refer to Exhibit B of your contract for the complete list of reporting sites).

Hospital Emergency Departments (ED): The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care are considered ED sites. HealthierHere requires one submission/response for each contracted reporting site (please refer to Exhibit B of your contract for the complete list of reporting sites).

Test Sites vs. Reporting Sites

Practice Partners will be required to provide HealthierHere with their responses to the metrics on the semiannual assessment at the designated reporting levels described above.

Reporting sites are listed in Exhibit B of the HealthierHere 2020 contract. The FormAssembly version of the survey has a drop-down menu with all of the contracted reporting sites so that whomever is submitting their site's response can do so easily. All reporting sites will need to submit site specific responses to the incentive metrics designated to be reported at reporting specific sites for the organization to receive credit for 'flat rate for submission.'

The reason HealthierHere continues to ask for information on all reporting sites is due to our own reporting requirements to the Health Care Authority (HCA). The HCA asks all ACHs to submit information (specifically the MeHAF and Opioid survey) at the site level every 6-months and they are actively tracking the number of clinics participating in ACH efforts in HealthierHere's region. To continue reporting an expansive list of clinics to the HCA the clinics must be involved in basic reporting to HealthierHere, which is why we are continuing to have partners submit semiannual assessments for all reporting sites.

Suggested Best Practices for Completion

Organizational level incentives can be completed by the HealthierHere Champion, with input from relevant departments. For incentives that are to be completed at the site level, the Champion is encouraged to play a coordinating role, but the appropriate site administrator at each reporting site should respond based on the reality at their clinical site with input from the clinical care team.

For the MeHAF assessment, HealthierHere recommends a more intensive approach. This incentive should be completed by the clinical care team. A best practice is for clinical care team members to respond individually, then compare their answers with other team members, editing collectively to answer as a team. A staff or team meeting is an ideal venue for that discussion. Each site will then submit their own assessment to HealthierHere using the link provided by their HealthierHere Champion. If your clinical teams need support with this process, please reach out to HealthierHere.

Defining the Clinical Care Team

HealthierHere defines a clinical care team as group of primary care and/or behavioral health practice personnel who identify as members of a team and who work together to provide care for a panel of patients. Care teams could include the following positions depending on the setting: Primary Care Provider (MD, DO, ARNP, PA), RN Case Manager, Medical Assistant, Mental Health Professional, Chemical Dependency Professional, Social Worker, Pharmacist, Care Coordinator, Dietitian, Community Health Worker, Peer Support Specialist.

Incentives by Designated Reporting Level

Incentives	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
1) MeHAF Assessment		X	X	
2) Opioid Survey		X	X	X
3) Whole Person Care Screenings/Assessments		X	X	
4) Use and Optimization of the Collective Platform	X			
5) Registry Functionality		X	X	
6) Risk Stratification		X	X	
7) Equity	X			
8) Quality Improvement	X			

1) MeHAF Site Self-Assessment to measure level of physical and behavioral health integration

Background:

The Maine Health Access Foundation (MeHAF) developed the Site Self-Assessment (SSA) Survey to assess levels of primary and behavioral care integration. The SSA Survey focuses on two domains: 1) integrated services for patient and family services and 2) practice/organization. Each domain has characteristics to rate on a scale of 1 to 10 depending on the level of integration or patient-centered care achieved.

The Washington State Health Care Authority (HCA) adopted the 21 question MeHAF+ as a required pay for reporting requirement for all Accountable Communities of Health (ACHs), all ACHs are required to have participating sites complete the survey every six months and submit the results to the HCA.

Instructions:

The purpose of this assessment is to show your current status along several dimensions of integrated care and to stimulate conversations among your integrated care team members about where you would like to be along the continuum of integrated care. Please focus on your site's current extent of integration for patient and family-centered primary care and behavioral health care. Future repeated administrations of the SSA form will help to show changes your site is making over time. Organizations working with more than one site should ask each site to complete the SSA. Please respond in terms of your site's current status on each dimension. Please rate your patient care teams on the extent to which they currently do each activity for the patients/clients in the integrated site. The patient care team includes staff members who work together to manage integrated care for patients. This often, but not always, involves primary care providers,

behavioral health specialists, specialty care providers, case managers or health educators and front office staff. Using the 1-10 scale in each row, circle select one numeric rating for each of the 21 characteristics. If you are unsure or do not know, please give your best guess.

If you would like more guidance on how to complete the MeHAF please consult the MeHAF Facilitation Guide developed by Comagine.

https://depts.washington.edu/fammed/wp-content/uploads/2019/01/MeHAF-Facilitation-Guide-Tool_190128.pdf

Incentive	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
1) MeHAF Assessment		X	X	

* indicates required questions.

1) Did a care team collectively give feedback to develop your site's response to this incentive? *

(Yes/No)

2) If yes, please list the names and roles of the care team members who contributed to your response:

3)

I. Integrated Services and Patient and Family-Centeredness (Circle one NUMBER for each characteristic)				
1. Level of integration: primary care and mental/behavioral health care *	... none; consumers go to separate sites for services	... are coordinated; separate sites and systems, with some communication among different types of providers; active referral linkages exist	... are co-located; both are available at the same site; separate systems, regular communication among different types of providers; some coordination of appointments and services	... are integrated, with one reception area; appointments jointly scheduled; shared site and systems, including electronic health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings.
	1	2 3 4	5 6 7	8 9 10
2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse) *	... are not done (in this site)	... are occasionally done; screening/assessment protocols are not standardized or are nonexistent	... are integrated into care on a pilot basis; assessment results are documented prior to treatment	... tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/assessment protocols are used and documented
2. (ALTERNATE: If you are a behavioral or mental health site, screening and assessment for medical care needs) *	1	2 3 4	5 6 7	8 9 10

3. Treatment plan(s) for primary care and behavioral/mental health care *	... do not exist	... exist, but are separate and uncoordinated among providers; occasional sharing of information occurs	... Providers have separate plans, but work in consultation; needs for specialty care are served separately	... are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care
	1	2 3 4	5 6 7	8 9 10
4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care *	... does not exist in a systematic way	... depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases	... evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers	... follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently
	1	2 3 4	5 6 7	8 9 10
5. Patient/family involvement in care plan *	... does not occur	... is passive; clinician or educator directs care with occasional patient/family input	... is sometimes included in decisions about integrated care; decisions about treatment are done collaboratively with some patients/families and their provider(s)	... is an integral part of the system of care; collaboration occurs among patient/family and team members and takes into account family, work or community barriers and resources
	1	2 3 4	5 6 7	8 9 10
6. Communication with patients about integrated care *	...does not occur	... occurs sporadically, or only by use of printed material; no tailoring to patient's needs, culture, language, or learning style	... occurs as a part of patient visits; team members communicate with patients about integrated care; encourage patients to become active participants in care and decision making; tailoring to patient/family cultures and learning styles is frequent	... is a systematic part of site's integration plans; is an integral part of interactions with all patients; team members trained in how to communicate with patients about integrated care
	1	2 3 4	5 6 7	8 9 10
7. Follow-up of assessments, tests, treatment, referrals and other services *	... is done at the initiative of the patient/family members	... is done sporadically or only at the initiative of individual providers; no system for monitoring extent of follow-up	... is monitored by the practice team as a normal part of care delivery; interpretation of assessments and lab tests usually done in response to patient inquiries; minimal outreach to patients who miss appointments	... is done by a systematic process that includes monitoring patient utilization; includes interpretation of assessments/lab tests for all patients; is customized to patients' needs, using varied methods; is proactive in outreach to patients who miss appointments
	1	2 3 4	5 6 7	8 9 10
8. Social support (for patients to implement recommended treatment) *	... is not addressed	... is discussed in general terms, not based on an assessment of patient's individual needs or resources	... is encouraged through collaborative exploration of resources available (e.g., significant others, education	... is part of standard practice, to assess needs, link patients with services and follow up on social support plans using household, community or other resources

			groups, support groups) to meet individual needs	
	1	2 3 4	5 6 7	8 9 10
9. Linking to Community Resources *	... does not occur	... is limited to a list or pamphlet of contact information for relevant resources	... occurs through a referral system; staff member discusses patient needs, barriers, and appropriate resources before making referral	... is based on an in-place system for coordinated referrals, referral follow-up and communication among sites, community resource organizations and patients
	1	2 3 4	5 6 7	8 9 10
MeHAF Plus Items				
10. Patient care that is based on (or informed by) best practice evidence for prescribing of psychotropic medications *	... does not exist in a systematic way	... depends on each provider's own use of the evidence; some shared evidence-based approaches occur in individual cases	... evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers	... follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently; support provided by consulting psychiatrist or comparable expert
	1	2 3 4	5 6 7	8 9 10
11. Tracking of vulnerable patient groups that require additional monitoring and intervention *	... does not occur	... is passive; clinician may track individual patients based on circumstances	... patient lists exist and individual clinicians/care managers have varying approaches to outreach with no guiding protocols or systematic tracking	... patient lists (registries) with specified criteria and outreach protocols are monitored on a regular basis and outreach is performed consistently with information flowing back to the care team
	1	2 3 4	5 6 7	8 9 10
12. Accessibility and efficiency of behavioral health practitioners (for PCP sites) or... Availability and efficiency of medical providers (for BHA sites) *	... behavioral Health practitioner(s) OR medical providers are not readily available	... is minimal; access may occur at times but is not defined by protocol or formal agreement; unclear how much population penetration behavioral health OR medical care has into patient population	... is partially present; behavioral health OR medical practitioners may be available for warm handoffs for some of the open clinic hours and may average less than 6 patients per clinic day per clinician (or comparable number based on clinic volume)	... is fully present; behavioral health OR medical practitioners are available for warm handoffs at all open clinic hours and average over 6 patients per clinic day per clinician (or comparable number based on clinic volume)
	1	2 3 4	5 6 7	8 9 10
II. Practice/Organization (Circle one NUMBER for each characteristic)				
1. Organizational leadership for integrated care *	... does not exist or shows little interest	... is supportive in a general way, but views this initiative as a "special	... is provided by senior administrators, as one of a number of ongoing quality improvement	... strongly supports care integration as a part of the site's expected change in delivery

		project” rather than a change in usual care	initiatives; few internal resources supplied (such as staff time for team meetings)	strategy; provides support and/or resources for team time, staff education, information systems, etc.; integration project leaders viewed as organizational role models
	1	2 3 4	5 6 7	8 9 10
2. Patient care team for implementing integrated care *	... does not exist	... exists but has little cohesiveness among team members; not central to care delivery	... is well defined, each member has defined roles/responsibilities; good communication and cohesiveness among members; members are cross-trained, have complementary skills	... is a concept embraced, supported and rewarded by the senior leadership; “teamness” is part of the system culture; case conferences and team meetings are regularly scheduled
	1	2 3 4	5 6 7	8 9 10
3. Providers’ engagement with integrated care (“buy-in”) *	... is minimal	... engaged some of the time, but some providers not enthusiastic about integrated care	... is moderately consistent, but with some concerns; some providers not fully implementing intended integration components	... all or nearly all providers are enthusiastically implementing all components of your site’s integrated care
	1	2 3 4	5 6 7	8 9 10
4. Continuity of care between primary care and behavioral/mental health *	... does not exist	... is not always assured; patients with multiple needs are responsible for their own coordination and follow- up	... is achieved for some patients through the use of a care manager or other strategy for coordinating needed care; perhaps for a pilot group of patients only	... systems are in place to support continuity of care, to assure all patients are screened, assessed for treatment as needed, treatment scheduled, and follow-up maintained
	1	2 3 4	5 6 7	8 9 10
5. Coordination of referrals and specialists *	... does not exist	... is sporadic, lacking systematic follow-up, review or incorporation into the patient’s plan of care; little specialist contact with primary care team	... occurs through teamwork & care management to recommend referrals appropriately; report on referrals sent to primary site; coordination with specialists in adjusting patients’ care plans; specialists contribute to planning for integrated care	... is accomplished by having systems in place to refer, track incomplete referrals and follow-up with patient and/or specialist to integrate referral into care plan; includes specialists’ involvement in primary care team training and quality improvement
	1	2 3 4	5 6 7	8 9 10
6. Data systems/patient records *	... are based on paper records only; separate records used by each provider	... are shared among providers on an ad hoc basis; multiple records exist for each patient; no aggregate data used to identify trends or gaps	... use a data system (paper or EMR) shared among the patient care team, who all have access to the shared medical record, treatment plan and lab/test results; team uses aggregated data to identify trends and launches QI projects to achieve measurable goals	... has a full EMR accessible to all providers; team uses a registry or EMR to routinely track key indicators of patient outcomes and integration outcomes; indicators reported regularly to management; team uses data to support a continuous QI process
	1	2 3 4	5 6 7	8 9 10

7. Patient/family input to integration management *	... does not occur	... occurs on an ad hoc basis; not promoted systematically; patients must take initiative to make suggestions	... is solicited through advisory groups, membership on the team, focus groups, surveys, suggestion boxes, etc. for both current services and delivery improvements under consideration; patients/families are made aware of mechanism for input and encouraged to participate	... is considered an essential part of management's decision-making process; systems are in place to ensure consumer input regarding practice policies and service delivery; evidence shows that management acts on the information
	1	2 3 4	5 6 7	8 9 10
8. Physician, team and staff education and training for integrated care *	... does not occur	... occurs on a limited basis without routine follow-up or monitoring; methods mostly didactic	... is provided for some (e.g. pilot) team members using established and standardized materials, protocols or curricula; includes behavioral change methods such as modeling and practice for role changes; training monitored for staff participation	... is supported and incentivized by the site for all providers; continuing education about integration and evidence-based practice is routinely provided to maintain knowledge and skills; job descriptions reflect skills and orientation to care integration
	1	2 3 4	5 6 7	8 9 10
9. Funding sources/resources *	... a single grant or funding source; no shared resource streams	... separate PC/MH/BH funding streams, but all contribute to costs of integrated care; few resources from participating organizations/agencies	... separate funding streams, but some sharing of on-site expenses, e.g., for some staffing or infrastructure; available billing codes used for new services; agencies contribute some resources to support change to integration, such as in-kind staff or expenses of provider training	... fully integrated funding, with resources shared across providers; maximization of billing for all types of treatment; resources and staffing used flexibly
	1	2 3 4	5 6 7	8 9 10

4) Please provide any additional information you would like to share on your site's progress with physical and behavioral health integration, including challenges, barriers, and any additional assistance needed.

2) Opioid Survey

Background:

The HCA has developed a series of questions relevant to the 'Addressing the Opioid Crisis' Medicaid Transformation Project. This series of questions constitutes a required pay for reporting requirement for all ACHs. All ACHs are required to have participating sites complete the survey every six months and submit the results to the HCA.

Please complete the applicable questions. Responses to the follow-up questions are encouraged, though not required. Your answers may inform future strategies. This incentive will be assessed for completion only.

	Designated Reporting Level			
Incentive	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
2) Opioid Survey		X	X	X

'*' indicates required questions.

1) Does the ED site have protocols in place to initiate Medication Assisted Treatment (MAT) and offer take home naloxone for individuals seen for opioid overdose? *

Select all that apply:

- MAT initiation
- Take-home naloxone
- Our ED site does not offer these services.
- Not applicable. Our site is not an ED.

Follow-up questions (optional):

- When patients present with opioid overdose, are these protocols followed always, sometimes or rarely?
- Can you describe these protocols?
- If neither of these practices are occurring, describe why not.

2) Do providers at your site follow the [AMDG / Washington State prescribing guidelines](#), [Bree Collaborative](#) and/or [CDC prescribing guidelines](#)? *

Select all that apply:

- Agency Medical Directors' Group (AMDG) guidelines / Washington State prescribing guidelines
- Bree Collaborative (BREE) guidelines

- CDC guidelines
- None of the above

Follow-up questions (optional):

- For sites indicating at least one set of guidelines:
 - Are chart audits conducted to assess compliance with identified guidelines? Describe the findings of the most recent chart audit conducted at the site, and any next steps that may have been identified.
 - If chart audits are not conducted, why not?
- What kind of training on prescribing guidelines are practice/clinic sites offering?
- What metrics are practice/clinic sites tracking based on their training on prescribing guidelines?
- If your practice/clinic site does not use prescribing guidelines, why not?

3) What features does the practice/clinic site's clinical decision support for opioid prescribing guidelines include? *

Select all that apply:

- Integrated morphine equivalent dose calculators
- Links to opioid prescribing registries
- Links to Prescription Drug Monitoring Programs (PDMPs)
- Automatic flags for co-prescriptions of benzodiazepines
- None of the above

Clinical decision support may occur through the EHR or through another system. Guidelines could include AMDG guidelines, Bree Collaborative guidelines, or others.

Follow-up questions (optional):

- Does your practice or clinic site EHR have a clinical decision support module that prompts prescribing providers regarding opioid prescribing?
 - Can you describe the module?
 - Under what circumstances is it initiated?
 - Are you aware of any changes in provider prescribing patterns due to the module?
- If not through an EHR, do you offer clinical decision support around opioid prescribing through another system? (for example, opioid prescriptions review by a clinical pharmacist?)
 - Can you describe the (non-EHR) module? Under what circumstances is it initiated?
 - Are you aware of any changes in provider prescribing patterns due to the (non-EHR) module?

4) What protocols are in place to provide a pathway for all patients with opioid use disorder to be evaluated for behavioral health interventions? *

Select all that apply:

- Screening and treatment for depression and anxiety occurs on site
- Screening for depression and anxiety occur on site, patients are referred for treatment
- Contracting with providers who offer these services
- Formalized referral relationship (through MOU or a similar arrangement) with providers who offer these services
- Informal referral relationships with providers who offer these services
- None of the above

5) What protocols are in place to provide a pathway for all patients with opioid use disorder to be evaluated for medication-assisted treatment? *

Select all that apply:

- Medications are provided on site
- Contracting with providers who offer these services
- Formalized referral relationship (through MOU or a similar arrangement) with providers who offer these services
- Informal referral relationships with providers who offer these services
- None of the above

Follow-up questions (optional):

- Is MAT offered to some or all patients with OUD?
- Is behavioral care offered to some or all patients that screen positive for depression and/or anxiety?
- Do patients with OUDs who get care from your practice or clinic site typically get these services from you, or do they go elsewhere?
- What systems are in place to ensure the beneficiary is connected to the acute care and recovery services that are needed?

6) Please provide any additional information you would like to share on your site's progress providing care for individuals with opioid use disorder, including challenges, barriers, and any additional assistance needed.

3) Whole Person Care Screenings/Assessments

Background:

HealthierHere is incentivizing the use of evidence-based screenings and assessments in primary care and behavioral health settings in order to improve the ability of Medicaid individuals to receive appropriate whole person care no matter the setting they first seek care. This incentive will allow HealthierHere greater visibility into how screenings are being used, whether screenings are integrated into workflows and clinical decision making, and which priority screenings are currently being used at participating organizations. The question and scale were adapted from the [MeHAF](#), question I.2.

	Designated Reporting Level			
Incentive	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites

3) Whole Person Care Screenings/Assessments		X	X	
--	--	---	---	--

‘*’ indicates required questions.

1)

	Level D	Level C	Level B	Level A
If I am a hospital or FQHC... screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance use disorder) *	... are not done (in this site)	... are occasionally done; screening/assessment protocols are not standardized or are nonexistent	... are integrated into care on a pilot basis; assessment results are documented prior to treatment	... tools are integrated into practice pathways to routinely assess MH/BH needs of all patients; standardized screening/ assessment protocols are used and documented.
	1	2 3 4	5 6 7	8 9 10

	Level D	Level C	Level B	Level A
If I am a BHA... screening and assessment for medical care needs (e.g., blood pressure, weight, body mass index (BMI) diabetes) *	... are not done (in this site)	... are occasionally done; screening/assessment protocols are not standardized or are nonexistent	... are integrated into care on a pilot basis; assessment results are documented prior to treatment	... tools are integrated into practice pathways to routinely assess primary care needs of all patients; standardized screening/ assessment protocols are used and documented.
	1	2 3 4	5 6 7	8 9 10

2) If you are a PCP site, does your site perform any of the following screenings for behavioral health conditions? *

Select all that apply

- [Alcohol Use Disorders Identification Test \(AUDIT\)](#)
- [Drug Abuse Screening Test \(DAST\)](#)
- [Generalized Anxiety Disorder subscale \(GAD-7\)](#)
- Patient Health Questionnaire for Depression ([PHQ-2](#) / [PHQ-9](#))
- None of the above

3) If you are a BHA site, does your site perform any of the following screenings for physical health conditions? *

Select all that apply

- Blood pressure
- [Body Mass Index \(BMI\)](#)
- Diabetes (A1C)
- None of the above

4) Does your site currently screen for any of the following social needs/social determinants? *

Select all that apply

- Food Security/Access Needs
- Housing Needs
- Transportation Needs
- Other (write in answer, if selected)

5) Does your site currently use any of the following social need/social determinant screening tools? *

Select all that apply

- Accountable Health Communities (AHC) tool (also known as the Health-Related Social Needs (HRSN) tool)
- Daily Living Activities—20 (DLA-20)
- Health Leads Social Needs Screening
- PRAPARE
- WellRx
- Other (write in answer, if selected)
- None of the above – our site does not currently use a screening tool

6) What additional support do you need to continue to show improvement on the scale for this incentive?

4) Use and Optimization of Collective Platform

Background:

Improving rates of follow-up visits after Emergency Department visits and hospitalizations is a priority area for HealthierHere. We are providing coordination, training, and technical assistance to implement and optimize use of the [Collective Platform](#) (AKA Collective Ambulatory or EDIE) software within our region. The software provides notifications to enrolled providers when their assigned/empaneled patients experience an ED visit, providing an opportunity for the community primary care or behavioral health provider to reach out to the patient and encourage them to schedule and complete a follow-up visit. The Collective Platform also provides a means for providers to share information regarding care guidelines, patient history, or care team members that would be helpful for Emergency Departments, hospitals, or even first responders to know.

Incentive	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
4) Use and Optimization of the Collective Platform	X			

'*' indicates required questions.

1) How are you using the Collective Platform to improve patient outcomes? *

2) Does your organization have the Collective Platform integrated into your EHR? *

3) If your organization is using the Collective Platform to share care guideline, patient history, and/or care team member information, what challenges/successes have you experienced? If not, what are the barriers? *

5) Registry Functionality

Background:

A registry is defined as a list of all people in a specific population, those specific populations can be based on a range of factors, including conditions (Diabetes, Asthma, Opioid Use Disorder), social determinant needs, and others. Registries help care managers see a target population and gaps in an evidence-based standard of care for the population, giving them the ability to see key health parameters of an entire population in a single view and fill those care gaps for the patients assigned to them.

HealthierHere is committed to increasing the use of registries and improving registry functionality as part of our foundational population health infrastructure building efforts. While registries range from simple manual entry Excel spreadsheets to more advanced queries of Electronic Health Record (EHR) data, HealthierHere is encouraging our partners to use available technology, ideally advancing their use of registries that originate with real-time EHR data.

HealthierHere's primary question and scale for this incentive was adapted from question 7 on the [Quality Improvement Change Assessment](#).

Incentive	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
5) Registry Functionality		X	X	

'*' indicates required questions.

1)

	Level D	Level C	Level B	Level A
Registry or panel-level data *	... are not available to assess or manage care for practice populations.	... are available to assess and manage care for practice populations, but only on an ad hoc basis.	... are regularly available to assess and manage care for practice populations, but only for a limited number of diseases and risk states.	... are regularly available to assess and manage care for practice populations, across a comprehensive set of diseases and risk states.
	1	2 3 4	5 6 7	8 9 10

2) Does your organization's EHR have registry functionality for any of the following conditions? *

Select all that apply:

- Asthma
- Cardiovascular Disease (CVD)
- Chronic Obstructive Pulmonary Disorder (COPD)
- COVID-19 positive
- Depression
- Diabetes
- Homelessness
- Opioid Use Disorder
- Serious Mental Illness
- Other
- None of the above

3) What additional support do you need to continue to show improvement on the scale for this incentive?

6) Risk Stratification

Background:

The process of separating patient populations into high-risk, low-risk, and the ever-important rising-risk groups is called risk stratification. Having a platform to stratify patients according to risk is key to the success of any population health management initiative. HealthierHere sees risk stratification as one of the three focus areas for building population health infrastructure over the course of the Medicaid waiver. We are interested in improving routine use of risk stratification at our partner organizations. For the purposes of this incentive we are defining risk as “risk of a bad clinical outcome.” HealthierHere’s primary question and scale for this incentive was adapted from question 9 on the [Quality Improvement Change Assessment](#).

Incentive	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
6) Risk Stratification		X	X	

* indicates required questions.

1)

	Level D	Level C	Level B	Level A
A standard method or tool(s) to stratify patients by risk level *	... is not available.	... is available but not consistently used to stratify all patients.	... is available and is consistently used to stratify all patients but is inconsistently integrated into all aspects of care delivery.	... is available, consistently used to stratify all patients, and is integrated into all aspects of care delivery.

	1	2 3 4	5 6 7	8 9 10
--	---	-------	-------	--------

2) What data does your site use to stratify risk? *

Select all that apply:

- Demographics (race, ethnicity, sex, etc.)
- Diagnosis codes (including complicated behavioral and physical health conditions)
- Emergency Department utilization
- Geocoding (by home address)
- Inpatient utilization
- Insurance status
- Medication lists
- Social Determinants of Health (housing status, food insecurity, etc.)
- Other
- None of the above

3) What additional support do you need to continue to show improvement on the scale for this incentive?

7) Equity

Background:

HealthierHere is committed to advancing health equity and reducing health disparities in our region. Building on the work partners did in 2019, going forward we will ask partners to reflect on their progress on the institutional Equity Action Plan.

	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
Incentives				
7) Equity	X			

* indicates required questions.

1) Does your organization disaggregate your quality monitoring/performance data by any of the following categories in an effort to identify and address outcome differences? Please check all that apply*

- a. Race/ethnicity
- b. Gender
- c. Language
- d. Age
- e. Patient geography
- f. Other demographic areas (write in answer, if selected)
- g. Our site does not currently disaggregate our quality monitoring/performance data

2) If your site does disaggregate, which of the following ways is that quality/performance data used? Please check all that apply*

- a. Set and monitor benchmarks, targets, and/or goals for individual service teams/programs
- b. Set and monitor benchmarks, targets, and/or goals for the organization as a whole
- c. Determine funding/resource allocations
- d. Identify external organizations/providers to partner with
- e. Identify necessary changes to improve service accessibility
- f. Other (write in answer, if selected)
- g. None of the above

3) Do your quality monitoring activities monitor the cultural and linguistic accessibility of your services? (Yes/No) *

4) Does your organization use community health workers/peer support specialists/other similar staff to connect patients with housing, transportation and food access services? (Yes/No) *

5) Does your organization provide discharge planning and follow-up instructions in languages other than English? (Yes/No/Not applicable to my organization) *

6) If yes, please list the languages these materials are available in.

7) From the perspective of your organization, what percentage of your CBO contract partners are ready to partner with your organization under a Value Based Payment (VBP) model? *

- a. 75% or more
- b. 50-74%
- c. 25-49%
- d. Less than 25%
- e. None

Equity Action Plan Update

8) HealthierHere recognizes that the landscape has shifted significantly due to COVID-19 since the submission of your Equity Action Plan in December 2019. The COVID-19 pandemic and the nationwide Black Lives Matter racial justice protests have brought the issues of equity and health disparities for severely impacted

communities to the forefront of the national conversation and racism has been declared a public health crisis in our community. In light of the recent events, please describe how your institutional equity goal may have changed and how your institution is working to address equity for the communities most impacted by systemic racism and the COVID-19 pandemic. Please be as specific as possible and describe actions you plan to take over the next 12-18 months. (Please limit your response to this question to 1,000 characters, including spaces.) *

9) Does your organization currently have a formal program on equity, diversity and inclusion that includes annual staff training? (Yes/No) *

10) Please detail any resources (training, TA, practice coaching, other) your organization feels you will need to fulfill your revised institutional equity goal. *

Special Populations Served

11) HealthierHere is continually working to increase our understanding of the services offered in our region and the communities and individuals reached by those services. To support this understanding, we are asking our clinical partners to think about any programs, care models, staffing, etc. that exists in your organization that is tailored to any of the following populations. Please select from the list below if your organization has any programs, care models, staffing, or other supports aimed specifically at serving the populations below. *

Please select all that apply:

- Elders
- Individuals experiencing gender-based violence
- Individuals experiencing homelessness
- Individuals with mental health/substance use needs
- Individuals with co-occurring mental health and chronic illnesses
- Individuals with disabilities
- Individuals with limited English proficiency
- LGBTQI individuals
- Recently incarcerated individuals
- Recently unemployed/underinsured individuals
- Refugee and immigrant individuals
- Socially isolated individuals
- System involved youth (foster care, housing instability, etc.)
- Veterans

8) Quality Improvement

Background:

Having robust Quality Improvement (QI) infrastructures is an essential element of org readiness in Value Based Payment (VBP) contracts. Partners will be asked to answer four QI background questions one VBP question.

Incentive	Designated Reporting Level			
	Organizational Level	PCP Clinic Sites	BHA Clinic Sites	Hospital ED Sites
8) Quality Improvement	X			

Quality Improvement Background Questions

1) Select which option best describes your organization's Quality Improvement activities: *

- Not organized or supported consistently
- Conducted on an ad hoc basis in reaction to specific problems
- Based on a proven improvement strategy in reaction to specific problems
- Based on a proven improvement strategy and used continuously in meeting organizational goals

2) Select which option best describes your organization's Performance Measures: *

- Not available for clinical sites
- Available for clinical sites but limited in scope
- Comprehensive (including clinical, operational, and patient experience measures) and available for the practice, but not for individual providers
- Comprehensive (including clinical, operational, and patient experience measures) and fed back to individual providers

3) Was your organization able to undergo a rapid process change in recent months using systematic Quality Improvement methods (e.g., starting with a small-scale Plan-Do-Study-Act test, then scaling up further activity in terms of scope or population)? If so, briefly describe. (Please limit your response to this question to 1,000 characters, including spaces.) *

4) What types of assistance can HealthierHere provide to help you with your Quality Improvement activities? (select all that apply) *

- Face-to-face (or virtual) training on Quality Improvement methods
- Technical assistance with platforms to perform Quality Improvement work
- Facilitation of Quality Improvement discussion groups
- Enrollments in online Quality Improvement curriculum (e.g., Institute of Healthcare Improvement's Open School)
- Focused Quality Improvement webinars
- Web access to curated Quality Improvement tools

Transition to Value Based Payment Models

5) As you consider your organization’s attitudes, behaviors, or actions currently underway around **payment**, please select the description that best fits.*

We are entirely fee for service and do not take on financial risk or incentives for the health outcomes of any defined populations.	We are having preliminary discussions with payers to take on financial risk or incentives for defined populations.	We have several risk or incentive-based contracts for defined populations	We are actively exploring adding new patient populations or additional payers over time. We embrace new financial models to improve the health of our patients and communities.	We are expanding to create mechanisms to share risk/incentives and savings across sectors in our communities.
At the beginning	Making initial progress	Making moderate progress	Making substantial progress	Implementing broadly

6) Does your organization need additional support for VBP activities?