Medicaid Transformation Project Demonstration
Health Information Technology (HIT) Strategic Plan

Medicaid Transformation Project Demonstration

A key policy priority in Washington State is achieving the triple aim -- better care for individuals, better population health management, and lower health care costs -- for residents of the State. To that end, a variety of service delivery and payment transformation initiatives have been underway in the State for several years, including but not limited to: State Innovation Model (SIM) planning and implementation activities, payment reform activities, and Medicaid transformation efforts.

On January 9, 2017, the Centers for Medicare and Medicaid Services (CMS) approved Washington State's request for a Section 1115 Medicaid waiver entitled the Medicaid Transformation Project Demonstration.

Over the next five years, through implementation of the Demonstration, Washington aims to:

- Integrate physical and behavioral health purchasing and service delivery to better meet whole person needs;
- Convert 90 percent of Medicaid provider payments to reward outcomes instead of volume;
- Support provider capacity to adopt new payment and care models;
- Implement population health strategies that improve health equity; and
- Provide new, targeted services that address the needs of the state's aging population and address key determinants of health.

The State will address the aims of the Demonstration with three critical initiatives:

- Delivery System Reform Incentive Program (DSRIP) through Accountable Communities of Health
- Long-term Services and Supports (LTSS) - Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA)
- Foundational Community Supports (FCS)

Accountable Communities of Health (ACHs) play a key role in service delivery and payment transformation activities in the state. Through the state's DSRIP initiative, ACHs will be required to

implement Transformation projects that support system-wide planning and capacity-building, innovative models of care, and regional and population health management.

In an environment in which service delivery and payment models are being transformed, the use of interoperable Health Information Technology (Health IT) and Health Information Exchange (HIE) technologies will be a key enabler to achieving the state's Demonstration goals. Interoperable Health IT and HIE has the potential to improve the quality, continuity, and safety of patient care; while at the same time reducing the provision of unnecessary and costly services. The use of interoperable Health IT will permit the efficient exchange and re-use of data across Health IT systems.

The Washington State Health IT Strategic Plan identifies activities necessary to support and advance the use of interoperable Health IT and HIE across the health continuum in support of the programmatic objectives of the Demonstration. The Health IT Strategic Plan focuses on obtaining interoperable data at the point of care across the care continuum to enable the re-use of this data in support of Demonstration activities, including improving coordination of care, and supporting analytics and reporting.

Clinical Data Repository

Current State

Washington State understands the role of and need for interoperable Health IT to enable the efficient exchange and re-use of health information, a foundational requirement to achieving the triple aim. In April 2009, the Washington State Legislature passed Substitute Senate Bill (SSB) 5501 designed to accelerate the secure electronic exchange of high-value health information within the state. SSB 5501 directed the Health Care Authority (HCA) to designate a private-sector organization to lead implementation. In October 2009, the HCA designated OneHealthPort (OHP) to serve as the lead HIE organization. To address some of the challenges with interoperable health information exchange and support service delivery and payment reform, HCA sponsored and collaborated with OHP to create the Clinical Data Repository (CDR).

The CDR is the statewide repository to which interoperable clinical information is sent and from which this information can be utilized over time. It is a Software as a Service (SaaS) tool that leverages the State HIE to allow for the submission of claims, administrative and clinical data to support patient

management at the point of care. It supports the goal of integrating health information, including physical and behavioral health information, by providing a platform that can be used by all providers, regardless of Health IT/EHR system, and enabling access to health information by providers, even those that lack this technology. Linking clinical information across providers (e.g., primary care, acute care, and behavioral health providers) enables the construction of a "longitudinal health record" that will provide a more complete picture of individuals and their health needs, interventions, and outcomes. Such longitudinal information will support providers and payers in their ability to more effectively manage the care and services delivered to individuals.

The CDR was added as a module to the state's Medicaid Management Information System (MMIS), ProviderOne and is being implemented in stages. Currently, Summary of Care Records are transmitted to the CDR using the Continuity of Care Document (CCD)/Consolidated- Clinical Document Architecture (C-CDA) on behalf of Medicaid-eligible, managed care beneficiaries who have encounters with health care providers eligible for the EHR Incentive Program (e.g. acute care hospitals and physicians). These C-CDA documents are transmitted via direct messaging and other standard protocols.

A soft-launch of the CDR Stage 1 occurred early in 2017 and by summer 2017, CCDs are expected to flow to the CDR as a Medicaid program requirement for most health care encounters involving Medicaid-eligible managed care beneficiaries and providers eligible for the EHR Incentive Program. In addition to the clinical data submitted by providers, HCA loaded claims and encounter data from January 2016 onward.

In addition, the next phase of Stage 1 of the CDR will support any authorized providers to view Summary of Care Records (including those providers who do not have certified Health IT/EHR technology).

Future State

Washington's decision to pursue a longitudinal health record does not stop with Apple Health (i.e., Medicaid) enrollees. The long-term goal for the CDR service is based on the concept that the technology is a "community asset" and will have a number of data sponsors. The Health Care Authority is the initial data sponsor and will populate the repository with its covered lives. Other health care payers, providers and employers may opt to subscribe to the service as transformation efforts gain further momentum and analytics are required for future payment models.

Stage 2 planning for the CDR is underway, with some aspects targeted for deployment in 2018 and later during the Demonstration period. Subsequent stages of the CDR implementation will focus on:

- Expanding the provider types who send and retrieve data from the CDR (e.g., behavioral health, long-term care providers, allied health providers and others)
- Engaging trading partners (e.g., jail health providers) in health information exchange activities
- Expanding the sponsored lives for whom information is sent to the CDR (e.g., fee for service lives, public employee lives)
- Expanding the services available through the CDR (e.g., tools managing the re-use of sensitive information [e.g., substance use disorder content])
- Expanding the types transactions (e.g., other C-CDA templates) supported in the CDR
- Expanding the data types/sets (e.g., substance use disorder data) included in the CDR

As a result, services offered by OHP through the CDR will expand and the opportunities to leverage and re-use clinical data in the CDR will grow. For example, we anticipate that OHP will support the exchange, management, and re-disclosure of sensitive information (e.g., substance use disorder information) contributed to the CDR by behavioral health providers, the exchange of care plan content between providers who are eligible and ineligible for the EHR Incentive Program, and increase access to prescription monitoring information.

When fully populated with clinical information, the CDR will enable near real-time access to integrated medical, dental, behavioral health and social service support data to authorized providers at the point of care.

Health IT Strategic Plan

Washington is undertaking an innovative and ambitious agenda through the Medicaid Transformation Project demonstration to advance coordination of care and improve patient outcomes that will be supported in part through its use of the CDR and additional activities identified in the Health IT Strategic Plan needed to support statewide electronic exchange of interoperable clinical information.

The Health IT Strategic Plan outlines activities necessary to realize the vision of the Demonstration. The State anticipates that the Health IT Strategic Plan will evolve as additional Health IT and information exchange activities are identified by ACHs and the State.

In addition, as activities in the HIT Strategic Plan are being implemented, the state, in collaboration with ACHs, providers, payers, and others, will identify opportunities where:

- The state will provide resources to support the adoption and use of interoperable Health IT and information exchange by providers in support of the goals of the Demonstration; and
- Resources could be pooled and shared to support interoperable health information exchange.

The Health IT Strategic Plan is divided into the following clusters:

- **Policies and Procedures.** Advancing the widespread use of interoperable Health IT HIE across the care continuum will require consideration, development and implementation of supportive policies and procedures at the State, ACH, payer, and provider levels. Activities in this cluster are focused on identifying and implementing various policy levers that will be used by the State, ACHs, payers, providers, and other entities to support the widespread use of interoperable Health IT and information exchange across the care continuum in support of the Demonstration goals and ACH project objectives. Particular attention will be paid to identifying policy levers that will accelerate the use of interoperable health information exchange technologies by providers who are not eligible for the EHR Incentive Program (e.g., behavioral health providers). Toward that end, in developing and implementing state policies—and in all applicable state procurements (e.g. including managed care contracts), the state will incorporate federally-required Health IT standards and implementation specifications and emerging standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA).

  The activities listed in this section focus on identifying and developing policies and procedures (e.g., related to emerging Value Based Payment (VBP) models, managed care organization (MCO) contract provisions, and ACH project priorities) that could support the:

  - Acquisition and use of interoperable Health IT/health information exchange technologies particularly for providers who do not qualify for the EHR Incentive Program

(e.g., behavioral health (BH) including mental health and substance use disorder providers, long-term services and supports (LTSS), care managers);

- Supporting communities of health in the development and adoption of privacy rules and procedures which enable secure and private exchange of protected health information;
- Re-use of interoperable health data to support service delivery at the point of care, in ACH projects, and meet State Demonstration goals;
- On-boarding of providers to the CDR;
- Tracking tools that could be used by ACHs/the State to track the exchange and re-use of data (using Health IT) to support VBP transition; and
- Recommendations for quality metrics (including the availability of any CMS eCQMs) concerning the use of interoperable Health IT/health information exchange to support ACH priority projects.

In addition, this section also identifies activities related to establishing, updating, and communicating data governance policies and data sharing frameworks that are needed for the appropriate exchange and re-use of health information in support of identified ACH and other Demonstration priorities.

- **Supporting Implementation and Data Re-Use.** To the greatest extent possible, the state will use interoperable Health IT and HIE tools to link services and core providers across the care continuum in support of the goals of the Demonstration. Toward that end, the state recognizes that support will be required to:
    - Acquire and implement interoperable Health IT particularly for providers who are ineligible for the EHR Incentive Program; and
    - Re-use interoperable clinical data by the State, ACHs, payers, and others to support a variety of activities required under the demonstration.

The activities listed in this section rely heavily on collaborations between the state, ACHs and providers across the care continuum, will apply the policies and procedures developed to support Health IT and information exchange, and focus on:

- Removing barriers to and supporting the acquisition, adoption, and use of interoperable Health IT and information exchange technologies at the point of care for activities prioritized by ACHs;
- Refining and implementing data governance policies at the state and local levels;
- Supporting care providers (particularly those who are not eligible for the EHR Incentive program (e.g., behavioral health providers)) in their acquisition and use of needed Health IT and interoperable information exchange activities, including:
  - Implementing methods (e.g., VBP methods, direct incentives/contract provisions) that support the acquisition and use of such technology, and
  - Addressing workforce gaps (including education, training, and technical assistance) related to the acquisition, implementation, and use of interoperable (and certified if available) Health IT; and
- Implementing interoperable Health IT and information exchange solutions to support ACH priority projects.

- **Infrastructure and Technical Issues.** The need to accurately identify patients and their care providers is increasingly important as we seek to support widespread interoperable information exchange across the care continuum and enable the appropriate re-use of information to support care giving, quality measurement, and other activities.

  The Strategic Plan identifies several critical infrastructure activities that are needed to extend the services available through the CDR and provided by OHP including:
  - Supporting data reporting by providers and MCOs;
  - Maturing the application of industry standard privacy and security practices as they pertain to clinical data exchange;
  - Linking clinical information in the CDR with data in other state databases to strengthen the analytic capacity;
  - Expanding access to data in the CDR by providers across the care continuum;
  - Expanding interoperable content represented included in the CDR;
  - Ensuring a comprehensive Medicaid enterprise master patient index and provider directory strategy to support Demonstration activities; and
  - Other needed HIT actions to support and expand activities related to the EHR Incentive Program.

Other key pieces of infrastructure are managed through a partnership between HCA and the Department of Health (DOH) to support population health and management across the state. Over the period of the Demonstration, DOH seeks to expand existing population health applications by both creating new applications for provider reporting, supporting additional onboarding, and expanding the methods of access for key activities. Activities currently expected to be maintained and expanded include:

- Electronic lab reporting
- Cancer and Immunization registries
- Prescription drug monitoring
- Syndromic surveillance
- Newborn screening
- Electronic case reporting

The table below identifies Health IT activities and enhancements necessary to support the state's programmatic objectives under the Demonstration, and proposes a timeline for implementation. Identified activities include actions to:

- Improve coordination and integration between behavioral health, physical health, Home and Community Based Services (HCBS) providers and community-level collaborators through the adoption of provider-level, interoperable Health IT infrastructure and software;
- Support and require the electronic exchange of interoperable clinical health information, using standards identified in ISA (e.g., vocabulary, content/structure standards) including use of the C-CDA and patient consent to share standards;
- Support use of a Medicaid enterprise master patient index;
- Support use of a comprehensive provider directory strategy; and
- Support a comprehensive Health IT-enabled quality measurement strategy.

The state will provide quarterly reports regarding progress on completing activities identified in the Health IT Strategic Plan and support the stated goals of the Demonstration.

Legend:

	Complete		Underway		To be undertaken

		2017				2018				2019				2020				2021			
	STC	Q 1	Q 2	Q 3	Q 4	Q 1	Q2	Q3	Q4	Q 1	Q2	Q3	Q4	Q 1	Q2	Q3	Q4	Q 1	Q2	Q3	Q4
Policies and Procedures																					
The State, in collaboration with ACHs, payers, and providers (including BH, LTSS providers, care managers, and other community-based services/providers) will: • identify how the use of interoperable Health IT/HIE technologies could support the transition to VBP (including Fully Integrated Managed Care (FIMC)) and implementation of other ACH activities; • identify policies and procedures that are needed to address barriers to adoption and use of interoperable Health IT/HIE; and • consider the need for and develop policies and procedures to support the acquisition and use of interoperable Health IT/HIE technologies (including for providers ineligible for the EHR Incentive Program) in VBP models (including FIMC) and other ACH activities. Such considerations and policies will include the need for supports/guidance related to:	39 a b c d e f g h																				

bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information needed for population health management and quality improvement processes. Policy levers that will be considered and developed include the use of: financial and non-financial incentives, VBP models/methods, MCO payment and contract provisions, ACH models, and other levers; and • consider the need for and develop policies and procedures for whether and if so, how and when the state, ACHs, payers, and/or others will support on-boarding for providers (including BH and LTSS providers, other community-based services/providers, care managers, correctional facilities, etc.) not yet participating in interoperable HIE with the CDR.																					
The State, OHP, and ACHs will collaborate with state, regional, and local level representatives (including BH, LTSS providers, other community-based services/providers, and care managers) to gather information on the current and future data governance policies and data sharing frameworks needed to support the exchange and re-use of patient-level data among payers and providers including: BH	39 a b c g																				

and LTSS providers, other community-based services, and care managers. Information gathering activities will include a focus on the current and future uses of interoperable HIT/HIE technologies to support service delivery transformation activities that are targeted in the ACHs and the interoperable exchange of: summary care records, electronic care plans, medication information, other information between: physical health and behavioral health providers; care managers; correctional health and community-based providers, and others.																					
Evaluate policy and technical options for establishing a statewide Master Patient Index within Link4Health CDR for all health care consumers in the State, including persons not associated to a Managed Care Organization, and persons covered by Public Employee Benefits, Worker's Comp, Teachers, Veteran's Affairs, correctional and jail-based clients, others.	39 e																				

		2017				2018				2019				2020				2021			
		Q 1	Q 2	Q 3	Q 4	Q 1	Q2	Q3	Q4	Q 1	Q2	Q3	Q4	Q 1	Q2	Q3	Q4	Q 1	Q2	Q3	Q4
Develop an inventory and tracking tools to be used by the State, ACHs, and providers to track the exchange and re-use of interoperable data (including the use of standards identified in 45 CFR §170 or otherwise in ISA) to support VBP transition and other priority projects identified by ACHs.	39 c d g h																				
Provide recommendations for quality metrics (including the availability of any CMS eCQMs) concerning the use of HIT/HIE to support transition to VBP and other ACH priority projects. Potential metrics could focus on: the creation, transmission, and incorporation of: summary care records, electronic care plans, medication orders, alerts/notifications, etc. between: physical health and behavioral health providers; care managers; correctional health and community-based providers, etc.	39 h																				
The State, in collaboration with ACHs, BH providers, payers, and SAMHSA, will identify and streamline as much as possible BH data reporting requirements to support and align with HIE standards	39 a b c g																				

Evaluate and update consent management strategy in order to support the integration and sharing data between BH and physical health providers (given modifications to 42 CFR Part 2).	39 a b c d g																				
Supporting Implementation and Data Re-Use																					
Activities described is this section will apply/follow policies and procedures developed above.																					
The State, in collaboration with state, ACH, other regional, and local level representatives (including BH, LTSS providers, other community-based services/providers, and care managers) will: -Identify and develop the education, training, and technical assistance needs related to acquisition, adoption, implementation, and use of interoperable and certified (if available) HIT and data by at least: BH (MH and SA, and state psychiatric hospitals), LTSS, and other community-based providers/ services, care managers, payers, and programs; state and local agencies responsible for social and health services; other programs (e.g., Department of Correction, jails, education, etc.). Particular focus will be given to: • integration of Health IT tools and concepts into leadership considerations across organizations;	39 a b c d e f g																				

• technology requirements including the use of ISA identified Health IT standards in state funded programs, procurements, and Health IT systems/applications; • vendor evaluation and selection criteria (including considerations related to paying for initial and on-going costs); • workflow considerations and staff training needs related to Health IT and HIE; • use of the CDR; • benefits of HIE to the provider/ patient/ client; and - provide recommendations for metrics to track implementation of Health IT/HIE training activities across ACHs by provider, payer, program, and ACH levels																					
The State, in collaboration with ACHs, providers, and payers, will identify and support a mechanism(s) to regularly convene, coordinate, develop, and disseminate resources to give BH, LTSS and other community-based services/providers, care managers, payers, and programs the training, coaching and tools they need to: • support the identification of interoperable/certified (if available) Health IT/HIE technologies that could be used to support bi-	39 a b c d g h																				

directional information exchange and data re-use; • accelerate the adoption and use of interoperable HIT/HIE across the care continuum including by BH and LTSS providers to support: integrated and bi-directional information exchange and re-use, population health management (including by aligning and integrating community-based services information); • identify strategies and plans to address the legal, policy, and technical barriers that inhibit HIE between entities within the ACH and State (and addresses HIPAA and 42 CFR Part2) • identify resources to subsidize/offset the costs of acquiring and using interoperable and certified (if available) HIT/HIE technologies by BH, LTSS and other community-based services/providers, care managers; • improve data management capacity to strengthen data driven decision-making, contract negotiations; • provide recommendations for metrics related to the use of HIT/HIE to: - track implementation of training activities across ACHs by provider, payer, and program;																				

- demonstrate health improvement/ outcomes; and • connect care delivery transformation success with cost reduction (performance, outcome, value-based approaches).																					
Focusing on identified priority projects, ACHs, with assistance provided by the State, OHP, and in collaboration with providers in their communities, will develop a strategy and timeline for implementing Health IT/HIE in their communities to support prioritized projects. The strategy shall: • consider the ability to exchange and use data across the care continuum including by: BH and LTSS providers, other community-based services, and care managers. The assessment will address provider's ability to create, exchange, and transmit interoperable health information using certified (if available) technology needed for the projects that are the focus of the ACH activities (e.g., summary care records, electronic care plans, medication orders, alerts/notifications, etc. between: physical health and behavioral health providers; care managers; correctional health and community-based providers, etc.);	39 a b c d e f g h																				

• identify the type of data that needs to be exchanged to support: the projects to be implemented at the ACH, quality measurement, reporting for state and federal activities, and other activities; • address data governance issues, in conformance with the updated data governance policies and data sharing frameworks, at the level of the ACH across the care continuum including the appropriate and secure access and use/re-use of data; • indicate how the acquisition and use of interoperable HIT/HIE tools by BH and LTSS providers, other community-based services, and care managers will be supported (e.g., subsidies, VBP methods/contracts, etc.); • address workforce gaps and training needs, including addressing BH, LTSS, other community-based service provider, and care manager workforce competencies related to the acquisition and use of interoperable HIT and HIE needed for service delivery and payment transformation that will be supported at the ACH and state levels;																				

• address how interoperable and certified (if available) HIT will be used by providers (including by: BH and LTSS providers, other community-based services, and care managers) in the region to support information exchange and data re-use (including the use of notifications (such as when individuals enter or leave correctional facilities)); • support population management and quality measurement activities; • address how the CDR will support HIE between providers and data re-use by providers, payers, and other authorized users to support; • address the use of a patient and provider IDs; • address the need for providers to register and how to register to participate in the CDR; and • address issues related to the use of telehealth to support information exchange and coordination of care.																						
The State, in collaboration with ACHs, will identify interoperable and certified (if available) HIT/HIE tools and vendors and establish milestones for the adoption and use of such technology to support ACH projects involving: • BH, LTSS, and other community-based providers; • Providers of correctional health services; and • cross-care manager coordination.	39 c d e f																					

At least once per quarter, the State in collaboration with ACHs will synthesize and disseminate information across ACHs. ACHs will further disseminate information to providers in their communities. Topics will include: • vision around the service delivery transformation goals in Washington; • various clinical and claims health databases in the state (e.g., MMIS, CDR, APCD, MMCOs, PDMPs, population health registries, etc.), the sources of this data, and relationships between and uses and users of this data; • the policies and practices that are available/needed: (i) to govern access and use/re-use of data; and (ii) at the regional, payer, and state levels to enable appropriate and secure data exchange and re-use for improved information sharing and patient centered outcomes; • strategies and plans to address the legal, policy, and technical barriers that inhibit HIE between entities within a state (and addresses HIPAA and 42 CFR Part2); • how information exchange by BH and LTSS providers, other community-based organizations, and care managers is/will be supported, including	39 a b c d e f g																					

assistance to providers to share health information with each other through CDR (including the need to and how to register to participate in the CDR, case management tool, and other means; • information on consolidating/streamlining reporting for multiple purposes (e.g., BH health data reporting); and • current and future roles of Behavioral Health Organizations (BHOs)																					
Data governance policies and data sharing frameworks will be refined/ developed and implemented as needed in collaboration with the State, OHP, ACHs and providers.	39																				
ACHs will begin to support implementation activities to address the HealthIT/HIE needs in their region and include a focus on the use of interoperable and certified (if available) Health IT/HIE to meaningfully to support care integration and coordination for the populations, providers, and payers targeted in their priority projects. In supporting implementation, the State and ACHs will collaborate to identify opportunities for the state to lead particular activities and where the state could facilitate sharing of resources across ACHs.	39 a b c d e f g h																				
Providers will submit and retrieve health information to and from the CDR. Information in the CDR will be	39 c																				

interoperable to support re-use (e.g., by ACHs, payers, State) for continuity and coordination of care, quality measurement, and population health clinical decision support and outcomes monitoring;	d e f g																				
The state in collaboration with OHP will provide on-going technical assistance services for provider groups to access and use Link4Health CDR to exchange clinical data	39 b c d e f																				
The State, in collaboration with the ACHs, will explore the availability of Health IT/HIE options that could support unpaid caregivers of beneficiaries who will receive MAC or TSOA benefits. Technology options that will be explored include applications that could assist in scheduling, medication reminders, service planning, identification of community resources and supports (e.g., respite services, support groups, home delivered meals, etc).	39 a c d e g																				
As part of the Waiver, the state will establish a new eligibility category and benefit package for individuals who meet functional eligibility criteria (but not financial eligibility criteria). The state, in collaboration with ACHs, will explore the availability of interoperable HIT options that could support	39 a c d e g																				

interoperable functional eligibility assessments and how such data could be re-used for service delivery and other activities (e.g., eligibility determinations in the MMIS).																						
ACHs, in collaboration with the State will begin implementation of Health IT/HIE options to support the Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA) Benefits.	39 a c d e g																					
The State, in collaboration with ACHs, will explore whether and if so how Health IT/HIE options could support (for purposes of the Foundational Community Supports (FCS) benefit) the identification of housing alternatives and tenant support to maintain housing; and methods of linking qualifying Medicaid enrollees to these services.	39 a c d e g																					
ACHs, in collaboration with the State, will begin implementation Health IT/HIE options that are identified to support the FCS Benefit.	39 a c d e g																					
Infrastructure: CDR and Technical Issues																						
Support HIE through the use of Application Programming Interface (API) access to Link4Health CDR to support reporting for provider operations, MCO reporting (e.g.,	39																					

MCO data points for HEDIS and PQRS reporting) and CDR system statistics																					
The State and OHP will collaborate with ACH providers, payers, to determine needed CDR reports.	39 b h																				
Extract longitudinal health records from the Link4Health CDR and transmit to Medicaid Enterprise Data Warehouse (EDW) for significant data analysis by Analytics, Interoperability, and Measurement teams	39 b																				
Evaluate options for leveraging APIs for ACHs and other community-based quality measurement bodies to support statewide Common Measure Set	39																				
Implement Link4Health CDR as a shared portal for client information between providers eligible and ineligible for EHR incentives	39 a b d g																				
Enable Link4Health CDR to ingest C-CDA documents through standardized Direct and XDS.b submission pathways	39 a b c d g																				
Implement Medicaid Master Patient Index application to support clinical data exchange through Link4Health CDR	39 e																				

for stage 1 clients (i.e., Apple Health individuals covered by Medicaid Managed Care Organizations)																					
Support care coordination and evaluation by making available health care provider portal for reviewing patient records that are assigned a unique CDR number within Link4Health CDR (provider portal will make patient data accessible to providers without MU certified EHRs).	39. b e g																				
To establish a statewide provider directory, leverage the State's Health Information Exchange, OneHealthPort's provider credentialing system and implementation of Healthcare Provider Directory Plus (HPD+) standard	39 c f																				
Allow integration of EHR specific Organizational Identifiers into OneHealthPort's provider directory and crosswalk to the provider number assigned by OneHealthPort.	39 f																				
Evaluate provider directory status, scope and specificity. Determine plan and path forward to: improve provider directory specificity for providers, include other provider types (e.g., BH, LTSS, etc.), and support state to state or HIE to HIE provider directories.	39 f																				
Begin expansion of provider types included in statewide Provider Directory /Registry (e.g., BH, LTSS, correctional health services)	39 f																				
Begin to enhance Link4Health CDR to display and enable access to Health Action Plans (shared care plan developed as part of Health Home program)	39 b g																				

Begin to expand Link4Health CDR functions and HIE tools to support integration of BH (MH and SUD) data consistent with updated consent management strategy and ACH Project Priorities	39 b g																				
Begin to expand Link4Health CDR and HIE tools to enable LTSS data submission	39 b d g																				
Evaluate utilizing Link4Health CDR as a portal to the Prescription Drug Monitoring and Immunization registry platforms	39 b g h																				
Other Needed HIT Actions																					
Expand Washington MU strategy to include optometrist and podiatrist providers	39 a																				
Continue to utilize electronic Medicaid Incentive Payment Program (eMIPP) service for reporting Meaningful Use Measures using the QRDA I and III standards	39 c h																				
Evaluate CALIPHR product to support quality measurement and reporting at the provider, ACH, and State levels (including a focus on QMs for eMIPP)	39 c h																				
Perform an annual HIT roadshow to evaluate improving access to Meaningful Use incentives, ensuring compliance with state and federal requirements, and receive provider	39 a c																				

input on how to advance standards-based Health IT adoption																					
Perform quarterly outreach to Tribal Providers on Health IT adoption and EHR incentives	39. a																				
Evaluate options for Record Locator Service through Link4Health CDR.	39 b																				
Evaluate options and determine which services to submit a decision package for additional funds allocated in the state fiscal year 2019 budget, such as improving coordination and event notifications for jail services Question: are there only two budget requests? More frequently? Other topics for which funds need to be requested?]	39 a b g h																				
Prepare budget requests for newly identified HIT/HIE tools and services	39 a b c d g h																				